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**Reflections On My Work**

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*Schizophrenia and Human Value: Chronic Schizophrenia, Science and Society.* Basil Blackwell 1984; paperback edition 1986. 2nd edition, with a new preface, Free Association Books 1993.

*Relocating Madness: From The Mental patient to The Person.* Free Association Books 1995, paperback edition with new chapter; first published by Routledge in 1991 under the title *From the Mental Patient to The Person. Kindle Edition. 2002.*

*Closing the Asylum: The Mental Patient in Modern Society.* Penguin Books 1992. 2nd edition with new chapter 1997.

*Forgotten Lunatics of the Great War* Yale University Press, 2004. paperback edition 2007

**Schizophrenia & Human Value**

 Though I had been much influenced by iconic critiques of orthodox psychiatry from the 1960s such as Michel Foucault's *Madness and Civilization*, Erving Goffman's *Asylums,* R. D. Laing's *The Divided Self*, and Thomas Szasz's *The Myth of Mental Illness,* overall I did not find in them the resources I felt I needed in developing my understanding of troubled lives. At the end of the 1970s, and in the early 1980s, however, there appeared a number of trailblazing critiques of the foundations of modern epistemology such as Richard Rorty's *Philosophy and the Mirror of Nature* and Alasdair MacIntyre's *After Virtue.* Then, at the end of the 1980s, there was also Charles Taylor's *Sources of the Self*.

 Taken together, these (and other) works opened up for me a new vista both on the dominant psychiatric tradition (especially the science of schizophrenia), and on schizophrenic lives themselves, that promised to throw light on the problem of the social worth or value of the mentally ill in modern societies. So far as *Schizophrenia and Human Value* possesses any originality it is, perhaps, in conveying the excitement of discovering the significance of these works for the debate about the nature, meaning and history of schizophrenia.

 The other key figure in this book is the Swiss psychiatrist Manfred Bleuler (1903-94). The late 1970s saw the publication in translation of Bleuler's magisterial *The Schizophrenic Disorders: Long-term Patient & Family Studies* (first published in 1972). Not only did Bleuler produce a far-reaching study of the long-term course of schizophrenic disorders, he also delivered an incisive and critical account of the history of schizophrenia, notably the dogma of ‘incurability in principle’ that held sway in the inter-war years, and the plethora of dogma and mistaken biases in which the lives of schizophrenic people have become entangled. And entwined with both of these strands is the narrative of Bleuler himself reflecting on his struggles to understand his patients, and on the intellectual and institutional currents with which he has had to contend.

 Manfred Bleuler holds great importance in this book, and I returned to his contributions and reflections at numerous points, mainly because we derive from him a keen sense of how all along the way he is engaged in what is above all a moral project, regardless of how else it may also be defined, and hence a recognition of how, as Alasdair MacIntyre frames it, 'our knowledge of others–or our lack of it–depends on what the form of our moral relationships are.

 Above all this is a book about schizophrenia and history, or, more accurately, about schizophrenia *in* history, and especially about the designated chronic schizophrenic as a historical agent. The alignment of schizophrenia and history may, on first reading, appear jarring or contradictory since in the conventional psychiatric wisdom the schizophrenic is assumed to belong to a human-independent class of natural kinds that, in the words of the philosopher Ian Hacking, 'represents nature as it is, and reflects the network of causal laws'. The ambition of some of the most influential theories in the human sciences has been to model the study of human beings on the natural sciences.

 My intention is to demonstrate the limitations of an approach to mental disorder that is exclusively bound by naturalistic assumptions about what it is to think scientifically. In actuality, I argue, what has traditionally been called the ‘course of schizophrenia’ more closely resembles a life process open to a great variety of influences than an illness with a determined course and schizophrenia is not, after all, an all-encompassing illness which sets the patient apart from other human beings.

 I consider a number of dimensions: the major studies of the life histories of people with schizophrenic disorders, especially those of Manfred Bleuler and his associates; the philosophical constructs and psychological theories requisite for an understanding of the sufferer not simply as a patient but as an historical agent; a review of dominant psychological paradigms such as cognitivism and their limitations; and an empirical examination of how a group of chronic schizophrenics grapple with their life projects. One of the main findings (and, from a treatment angle, challenges) in my research concerned the lack of worth, or crisis of value, among people with a schizophrenia diagnosis that (at the time of writing) was insufficiently addressed by current approaches, both theoretical (many of them an ironic reflection of just that negative outlook) and practical, both inside and outside the hospital.

 The theoretical construct that holds most promise, I propose, is the idea of the narrative self, that is borrowed here from Alasdair MacIntyre's discussion of human agency, but has subsequently fruitfully been deployed in other studies of human affliction and in psychology more widely. MacIntyre provides a perspective on the enterprise of human self-understanding, and on the epistemological pretensions of the human sciences, that is invaluable in grappling with the vicissitudes of the scientific project of schizophrenia and the wider intellectual and social history in which the problem of schizophrenia emerged.

 Human lives are not devoid of causal properties but the extraction of these from the historical texture within which lives are lived is a more hazardous affair than has sometimes been supposed. I mean to show that if we are to take proper account of what we are actually like as human agents (schizophrenics, scientists or whoever), we stand in need of a wider and more robust battery of intellectual and moral resources than the natural sciences can offer. To get to grips with the problem of schizophrenia, and to try to understand what is going on in schizophrenic lives, we have to get to grips with the problems of an intellectual legacy that has produced a considerably distorted understanding of human life and action.

 Some of these philosophical themes may seem abstruse but their import is, I believe, concrete and intimate: they have to do with the most basic concepts that we entertain of ourselves as human beings and hence also with the resources that we bring to bear in trying to make sense of others. What I am trying to engage in is an ethically and psychologically informed reflection on the intrinsically moral, and hence evaluative, character of human lives, whether these are the lives of schizophrenic patients or of scientists.

 I explore the context of emergence of the type of the chronic schizophrenic in the social circumstances of England in the late nineteenth century and the reception accorded to Kraepelin’s theory of Dementia Praecox in the first decade of the twentieth. Against the background of the celebration and invigoration of the market economy as the essential condition of life, we can identify the emergence in the second half of the nineteenth century of a sharpened sense of a range of human types as essentially incompatible with the onward march of social and industrial progress

 The figure of the chronic mental patient was not produced by the asylum as such but by an act of exclusion generated from within a wider field of social forces. At the same time, in virtue of its transformation into a custodial institution, the asylum came to play a pivotal role in making the mental patient more nearly resemble what in any case others took him to be and providing the conditions of observation in which psychiatric doctrines could be given authoritative scientific ratification. In doctrines of deterioration and degeneracy, mental symptoms came to exemplify the regression to a lower evolutionary level, together with the erasure of the very possibility of meaning and of rational interpretation.

 In my discussion of schizophrenic lives I say a good deal about the schizophrenic person's concern with his or her own sense of worth or value. By no means is this peculiar to the schizophrenic person for, as the Canadian philosopher Charles Taylor argues, 'to be a full human agent, to be a person or self in the ordinary meaning, is to exist in a space defined by distinctions of worth'. Taylor writes about human lives as a moral enterprise in which human agents struggle to be ‘rightly placed’ in relation to the good. Human lives, Taylor suggests, are led in a space of moral concerns that turn, not around moral issues in a narrow sense, as crucial discriminations around what makes life worth living. Being a self ‘is inseparable from existing in a space of moral issues, to do with identity and how one ought to be. It is being able to find one’s standpoint in this space, being able to occupy, to *be* a perspective in it’.

 In Taylor's argument a focus on distinctions of worth provides the key to a reading of the history of scientific and philosophical consciousness in Western societies since the seventeenth century. We have been taught to think that the intellectual revolution of the seventeenth century was in essence an epistemological one but on Taylor's argument it is also an ethical and moral one. Scientific naturalism is ultimately a moral project, he claims, grounded in a commitment to a particular set of background distinctions of worth, especially that esteem a disengaged image of the self. From this angle, the history of a science such as psychiatry cannot be written in independence from a history of morals. It is against this background that I am all the time preoccupied with distinctions of worth or value in my discussions of mental patients and also with uncovering the suppression of such distinctions in the writings of others.

 As I argue, the most influential doctrines of late nineteenth century psychiatry lent expression to a systematic devaluation of people with mental illness. The legacy of scientific naturalism has served as weapon and as mask in this enterprise by severing the links between the mental patient and moral community in the name of a supposedly neutral and value-free line of enquiry. It is in the mesh of underlying interpretations of self and agency that the doctrines of dementia praecox were forged and pauper lunatics of the late nineteenth century asylum portrayed as the negative opposite of the disengaged, objective scientist.

 To bring out the significance of the schizophrenic person's sense of his or her own worth or value, I devote considerable space to the consideration of a very disturbed but human and engaging hospitalised working-class chronic schizophrenic whom I call Joseph. Joseph's deepest preoccupation was with his sense of his own value. 'If things get worse', he state at one point, 'I won't be able to cope with my direction gear. I see myself heading for the life of a recluse, being valued at 7 and ½ pounds per calendar month'. As I construed it, Joseph's concern was to be helped to find the means to participate in social life on terms that took account of his need both for shelter or retreat (for asylum in the proper sense) and equally for recognition as a valued person who was as much capable of bestowing care and consideration on others as he was in need of care himself.

 In the final section of the book I address the problem of community as the locus of powerful deceptions and misunderstandings. Though, under the conditions of market capitalism, economy of location may provide the motive force, the ideological representation of what is being done not infrequently borrows from the moral vocabulary of a very different type of society in which the bonds of moral community still counted for something. And here there are plentiful grounds for misunderstanding and deep disappointment. Those for whom notions of community are a genuine focus of moral aspiration may find themselves bewildered at how their expectations and vocabularies can have let them down so badly when, in the historical present, they are brought to recognize that they have now arrived at destination ‘community’. From my exploration of Joseph's experience, it was plain that the question of how he might come to live a valued life (where and on what terms) was not to be settled by any amount of gesturing at the actually existing 'community'.

 As Charles Taylor puts it, it is not a matter of showing that the attachment to a disengaged identity is simply wrong or misguided, but of freeing it of its 'illusory pretensions to define the totality of our lives agents'. *Schizophrenia & Human Value* is, in this sense, an exercise in retrieval that attempts to demonstrate the yield (both for our interpretations of ourselves and those we make of people with mental disorder) in reclaiming what I consider to be a more accurate and truthful understanding of human agency; and attempts also to express something of the wonderment in rediscovering what was previously hidden or lost to view.

 The claim of this book has been that in order to make any headway in clarifying the kind of problem that schizophrenia is, we must be willing to range across, and engage, key questions and considerations on a number of fronts. What, perhaps, we can now say with some assurance, is that we are now able to see the issues more clearly than heretofore; to cut through the illusions and distortions imposed by the wholehearted dependence on a naturalist picture of human life and action; and to identify buried sources of potential, both in ourselves as human scientists and in the subjects whom we seek to understand. Whether it is possible to activate this potential on any significant scale in a modern society is a much more difficult question to answer. The struggle to maintain hope for people with a history of mental illness in social life can never be taken for granted and has always to be renewed.

**Relocating Madness**

 In *Schizophrenia & Human Value* I complained that our knowledge of the actions of schizophrenic lives in community, as distinct from hospital, settings was extremely limited’ (186). An earlier generation of studies had explored the ‘moral careers’ of institutionalised mental patients but the study of the vicissitudes of former mental patients in the community was still very much unbroken ground. The aim of *Relocating Madness: From the Mental Patient to the Person* is to remedy this deficiency and further our understanding of the social fate of people with a history of schizophrenic illness in a society such as Britain. Contemporary mental health policy urges the inclusion in social life of a category of people who for a century and more had been exiled in the Victorian asylums. But what is this to mean precisely? Is it simply a case of the administrative substitution of one locus of care for another (or perhaps for none at all) or does it implicate something else besides, a reshaping, even, of our ways of think about people with mental illness?

 There are formidable obstacles in the way of such an enquiry, not least that the traditional psychiatric account of schizophrenia is a narrative of loss in which the pre-illness person goes missing, seemingly irrevocably. On this view, schizophrenia is ‘more than an illness that one *has*: it is something a person *is* or may *become’.* This being so, the individual who emerges from the asylum is scarcely in a full sense a person, and may even be considered a non-person. The unruly mental patients of the asylum have, with the assistance of powerful medicaments, merely been replaced by more tractable mental patients in the community. Built around a series of lengthy semi-structured interviews with a group of 24 ex-mental patients, who had a long history of schizophrenic illness of on average 16 years, and were living mostly on their own in a town in the north of England, this book challenges this view and shows that the ‘missing person’ in schizophrenia is more readily found than has been supposed.

 I consider different dimensions of the personal and social upheaval which the experience of a schizophrenic illness may inflict on a person. Typically, 'mad people' find themselves thrown into a field of social and cultural forces in which they must confront exclusion (structural constraints in areas such as housing and employment); and burden (the cultural freight that derives from the disclosure of their psychiatric histories and the ambiguous meanings enforced upon them by official psychiatric frameworks). They must try to re-orientate themselves in respect of their vulnerabilities to the kinds of experiences that are regarded as symptoms of schizophrenia, learn to cope with and account for them, and assimilate them into their understandings of themselves.

 Asserts Henry: “With schizophrenia, you’re not living, you’re just existing . . . I think schizophrenia will always make me a second-class citizen”. This is a richly ambiguous declaration about the relation of schizophrenia to the fabric of biological, social and historical life that is open to multiple interpretations. It is at once thoroughly reductive and intensely political. The lives at the heart of this book cannot escape the tensions that such ambiguities generate and it is the purpose of the book to disclose them, without pretending that it can resolve them. Where the transition from ordinary living to mental illness and its consequences is not infrequently abrupt and shocking, the road back is long and arduous and the great majority of our participants existed in a constant struggle to secure trust and respect as ordinary human beings and to establish a reliable material foundation to their lives that, despite variations and movements, was invariably unsettled, though a minority as they grew older managed to find points of contentment and repose.

 Borrowing a metaphor that I introduced in *Schizophrenia & Human Value*, I suggest that a significant minority of people with a schizophrenia diagnosis are estranged in various ways from society, living ‘on the edge of the common’, on the fringes of what we may think of as a common life. Though sometimes the effects of illness may indeed be particularly severe, the chain of causality involves a number of factors and it may be more helpful to view such experiences as variants within a common struggle, as examples of a shared structural predicament at its point of maximal severity. Agents who are currently estranged and unanchored might, if the options open to them were enlarged, prove themselves more viable strategists in the conduct of their lives.

 Without exception, these were all people whose personhood was easily put in question in ordinary life. One man was able to secure friendships, particularly in a local railway society to which he belongs, but it is apparent just how precarious he feels the terms of his acceptance to be. Though he has a foothold in ordinary relationships, his personhood is constantly on probation and he feels that he could easily find himself thrust back into isolation. He believes that if he doesn’t hide the fact that he has had mental problems, the other members of the society would shun him. Another individual describes how a few nights earlier, after he revealed to a man in a pub that he had been schizophrenic, the man became aggressive and threatened him. At stake here was a problem common to all our participants of how to account for themselves to others.

 Related to this is the common experience of feeling that their credibility as persons capable of taking decisions, of behaving responsibly, of providing a rational respective on their situations, is always liable to be put in question. As Simon puts it: ‘People wonder, “is he really better or is he still poorly? Is he OK with the children, or is he going to beat them up . . . ?” People get all sorts of funny ideas’. When Ben presented at the surgery with an itching hand he had to work hard convince the doctor that his complaint was real, not imaginary. Many of people felt that the diagnosis of schizophrenia had been unhelpfully foisted on them by psychiatric professionals, and had received no guidance in tackling the resonant cultural burden that the diagnosis imposes. In Henry’s experience of the popular imagination the schizophrenic dwells at the heart of darkness. Sarah describes how if she were to disclose her schizophrenic past to a stranger, the person would immediately associate her with someone else.

 Though people may up to a point feel ‘better’ after a stay in hospital, medical treatment alone will not help them to pick up the pieces of their life again and restore their confidence in themselves as viable members of society and many find themselves relegated to the margins of social life and brought to regard themselves as some sort of social rubbish. They have to contend with the ideologies held by psychiatric professionals as to how ex-mental patients ought to think of themselves, conduct their lives and, in the jargon of psychiatric containment, ‘fill their time’. Perhaps the most consistent message that came through in survivors’ experience of services was that the significant questions that concerned them about the direction and value of their lives were either obscured or left unaddressed.

 For the most part services appeared merely to offer people a form of protective containment within the identity of a community mental patient. The questions and issues that specially concerned them were not so much medical questions as questions relating to a broader understanding of their well-being and their place in a moral community. Overall they were asking that we should relocate the discussion of the lives of people with a history of mental illness in the community away from ‘illness’ (the management of illness and of patients) as the dominant frame of reference to the frame of ‘well-being’, which puts personhood rather than patienthood in the foreground of analysis.

 In the discussion I theorise this perspective by locating it in the context of a number of debates and inquiries such as discussions by the philosopher Charles Taylor of the moral enterprise of human lives (largely drawn from his magisterial *Sources of the Self*) that show how human lives are led in a space of moral concerns that involves not so much moral issues in a narrow sense as crucial discriminations around what makes life worth living; and studies of person-disorder interactions in schizophrenia pioneered by psychiatrist John Strauss and anthropologist Sue Estroff in particular, as well as Estroff’s classic study, *Making it Crazy*, based upon fieldwork with people with a history of chronic mental illness in Madison, Wisconsin. Significantly, though, the clients in Estroff’s study were more heavily incorporated into a service system, and more closely resembled the domesticated mental patients of traditional asylum regimes, than the survivors in our study.

 Estroff’s study was undertaken in the late 1970s and my suggestion is that in the meantime an increasing number of consumers had become disenchanted with the roles of domesticated mental patients that had heretofore been offered them and no longer ‘use services in the tractable fashion of their predecessors but rather as wary, often angry’ consumers demanding response to their broad needs for social and economic support’. On the evidence of our survivors, there is still some way to go in order to achieve this. In their efforts to negotiate their way into a manner of ordinary living survivors have, among other things, to battle against versions of psychiatric ideology (‘once a schizophrenic, always a schizophrenic’); professional ideology (‘how are you filling your time?’); and social prejudice (‘can’t trust them with the children’).

 In an epilogue for the paperback edition we address some of the changing fortunes in the implementation of inclusionary mental health policies, such as the inquiries into the circumstances surrounding a number of tragic incidents involving people with a history of severe mental illness, notably the searching report of the inquiry into the killing of an occupational therapist by Andrew Robinson. It is now clear that if an inclusionary mental health policy is to succeed it must take on board a rather more robust and less whimsical understanding of what care in the community is to mean.

 Close the asylum and many of the problems of chronic mental illness will vanish, some supposed. The relocation of madness meant leaving it behind in the discarded asylum–it was to be chased into history. If some of the recent tragic events can legitimately be read as nature’s revenge on this kind of whimsy, it is equally fallacious to lend support to a form of naturalism that supposes that the schizophrenic always runs true to type. The argument of this book is that we must jostle and struggle with these tensions, for as the American historian of medicine, Charles Rosenberg, has powerfully argued, neither biological reductionism nor an exclusive social constructionism constitute viable intellectual positions.

**Closing the Asylum**

 Around 1990 I was commissioned by Penguin Books to write an account of the origins and outcomes (so far as they could be assessed) of the move towards community mental health care, or “deinstitutionalization”, as it is also known. This gave me the opportunity to try to locate and apply the psychological knowledge I had been developing in previous years in a wider policy context. As well as giving some historical depth to the contemporary debate, the book draws upon my own psychological studies and those of others to examine the predicament of discharged psychiatric patients, or the new generation of community psychiatric patients, in a policy context forged (at the time the first edition of the book was written) by the “contract culture” and the Griffiths Report.

 Though the conclusions are less than sanguine, the book also identifies grounds for home in the growing involvement and empowerment of consumers, or mental health service survivors as they are more commonly known today, in the planning and development of services and in regaining control over their own lives. By no means have the problems of “devaluation” I had identified previous disappeared, but the strategies for engaging with them have perhaps become more refined.

 In Britain, as elsewhere, the asylum has always had a troubling, and frequently degrading, history. Colney Hatch Lunatic Asylum opened in 1851 as Europe’s largest and most modern institution yet in 1865 the Lunatic Commissioners alleged that in the unrelieved gloom of ‘what are called the refractory wards’ in the basement none of the male inmates, excepting two individuals, had knives and forks to eat their dinners with. In this period already, a small but vocal group of alienists was inveighing against the tendencies of these burgeoning institutions to produce ‘asylum-made lunatics’, critiques which were in many respects as trenchant as those of mid-twentieth century iconoclasts such as Erving Goffman.

 Even though another century was to pass before the concept of the ‘asylum-made lunatic’ acquired any significant political leverage, it is a mistake to suppose that very little changed in mental hospitals before the late 1950s and early 1960s. In the inter-war period, especially, there were notable changes, stimulated especially by the Mental Treatment Act of 1930 which provided for the first time in public institutions for ‘voluntary’ admissions to mental hospitals. Physical treatments such as ECT, insulin therapy, and transorbital lobotomies also appeared to promise a more optimistic approach to the relief of mental disorders. However, even though the relationship between mental hospital and society gradually became more permeable, with a growing population of short-term admissions, mental hospitals still remained in essence custodial institutions.

 In a detailed study of a large mental hospital in the London area from 1957 to 1972 anthropologist and psychoanalyst Elizabeth Bott documented the resilience of the ‘chronic culture’ of the mental hospital. Like other critics of the asylum, Bott remarks on the duplicity of the mental hospital, the pretence, for instance, that patients are in hospital entirely for medical reasons when in actuality they are there largely for social reasons. Yet this is a consequence, she suggests, not so much of psychiatric imperialism but of the tendency of modern societies to ostracize the mentally ill, and treat them as non-persons, while claiming to be doing something else. In Bott’s account, people who get stuck in hospital are people for whom there is no viable place in society (10). Implicitly, she issues a warning to community care enthusiasts that for lack of a revolution in social consciousness the elimination of mental hospitals is unlikely to achieve its aim.

 Enthusiasm for deinstitutionalization has generated paradoxical, and not infrequently ironic, alliances between, among others, right-wing libertarians, radical critics of psychiatric orthodoxy, and psychiatric drugs enthusiasts, all of whom converged in supposing that any need for specialized support facilities in the community was at best temporary. One might have supposed that this was a moment when the knowledge and wisdom accumulated by the therapeutic community movement would have come into its own but in actuality they were mostly disregarded. Professional expertise around social and communal relationships could conveniently be set aside for the technical 'fix' provided by the drug treatments, it was supposed. Ironically, the arrival of ‘community care’ in the 1960s signals the emergence of a politics which entertains the hope that the moral and communal dimensions of mental suffering need no longer be the focus of specialized attention, or of elaborate public provision, in the care of people with mental illness. Under this impress, the 'community' now possesses null value, no longer as a site for therapeutic intervention, or as the arena for an interrogation of the moral crisis in the relation between mad people and the larger society, but just as the place to which people are sent back after psychiatry has cured them.

 The closure of the mental hospitals began in earnest in the 1980s. Though much of the focus in the public debate was on the population who were moving out of the mental hospitals, just as important was the much larger group of younger patients with frequent short-stay admissions, the so-called ‘revolving door’ patients, for whom the option of permanent residence in an asylum was no longer available. From the ‘showcase’ evaluation of the closure of Friern and Claybury Hospitals it was clear that the vast majority of these discharged patients could be helped to cope in the community; by and large they welcomed independence, they did not want to be career mental patients, nor did they need to be. At the same time it also revealed the risks in this whole undertaking that in less benign circumstances might have produced serious problems.

 Other studies have borne out the limitations of community provision, for if there are pockets of excellence, it is also obvious that in inner city areas of London, for instance, a sizeable group of people is not well catered for by the community-care schemes developed so far. On the evidence of these studies it is clear that people with long-term mental illness in the community may find themselves as structurally isolated as ever they were in the asylums and in addition their physical health needs may now be ignored. Furthermore, the pressure on acute mental health services has sometimes produced conditions in the psychiatric wards of district general hospitals that a responsible doctor would not want to wish on a*nyon*e, let alone someone in a state of acute distress.

 The backlash against the failings of community care provision has frequently turned the spotlight not so much onto a history of social failings as onto the failings of schizophrenics themselves. What we discover in the community, the argument runs, are neglected mental patients who are not properly recognised as such. They may be i*n* the community but they are not integral members *of* the community. The project of closing the asylum is founded on mistaken assumptions. Sadly, but inevitably, many of these unfortunates must be dealt with benignly but securely as secondary sorts of people judged by the benchmark of the capable majority. Where critics such as Elizabeth Bott had tried to locate the vicissitudes of mad people in modern society in a consideration of the politics of ‘place,’ here the kernel of the problem is to be accounted for by the innate deficiencies of mad people themselves.

 The history of the asylum, critics have alleged, is in large part the story of how mad people have been marginalized and excommunicated from social life. The question for the present moment is thus: how can such people feasibly be brought back onto the map and new lines of communication with them opened? Despite all the pronouncements about the benefits that care in the community may bring to former mental patients, surprisingly little has been done to explore their experiences and draw them directly into the debate about mental health policy. At stake here are entrenched power relationships. Remarks social policy campaigner Ann Davis: ‘It is a fundamental change in the hearts and minds of those working in our mental health services that has been missing over the past three decades’. Ben, a participant in one of my studies, kindly undertook to reserve a meeting room in the psychiatric department of the local general hospital. On presenting his request, he was rebuked for his audacity in trying to secure a space normally reserved for doctors and nurses: “Don’t be so silly, get back to your ward!”. That Ben had in fact no ward to get back to is only part of the point, for the ward in this piece of professional invective is effectively a figure for the former mental patient’s place in society. We have to understand this type of response as an expression of an attitude towards mad people, and their place in the human and social scheme of things, that is rooted in the social organization of responses to insanity over the past two centuries.

 If any period merits the title of what Michel Foucault termed the Great Confinement, one historian has argued, it is the nineteenth century. The population of England doubled in the last half of the nineteenth century but the number of certified lunatics increased more than fivefold. From being ‘the instrument of regeneration’, the asylum became ‘the dustbin of the incurable’. How did this happen? Within the competing pressures of the Victorian order of things, asylums became refuges for distressed people for whom there was no viable social place. Confronted by this ‘motley crowd of persons of weak minds or low spirits’, psychiatry delivered the final sentence upon them. The locus of psychiatric exclusion was reproduced in the scientific frameworks in which insane people were analysed and classified; they were abandoned both to an asylum and to an intellectual framework which declared them incomprehensible.. The relationship between mental patient and society was all but severed and the mental patient isolated from ordinary understanding.

 As the Swiss psychiatrist Manfred Bleuler has shown, influential concepts in psychiatric theory, and in the management of madness, served to legitimate a process of sealing off in which the humanity of asylum inmates was systematically denied. Taken to an extreme, this history of segregation and excommunication may culminate in a severance of rationality and ethics that, on the argument of the sociologist Zygmunt Bauman, may be inherent in the modern civilizing process. Thus in lending their support to the murder of mental patients in the euthanasia programme of the Third Reich, psychiatrists saw themselves merely as bystanders to a suffering to which they felt no connection. The communal meaning of suffering had been erased and the psychiatrist had ceased to be a partner with the suffering patient.

 Bleuler has drawn attention to the dehumanisation and debasement of schizophrenic lives in modern societies. In a masterly study, psychiatrist and anthropologist Richard Warner gives a more critical analysis of schizophrenic destinies by locating them within political economy, and demonstrating that changes in the outcome of schizophrenic illness reflect changes in the perceived usefulness of the schizophrenic in the productive process. The historical evidence suggests that the treatment ‘of the great majority of the mentally ill will always reflect the condition of the poorest classes of society. In the absence of some powerful political counter-force, the outlook in schizophrenia is unlikely to get better’.

 Bequeathed to us by the Victorian asylum, Warner suggests, is the legacy of a public psychiatry which has become the science of regulating paupers, a legacy which is still alive today in the official operating perceptions of the mentally ill. If patients are to recover, implies Warner, they will need to reject a lot of what psychiatrists and other mental health professionals have come to believe in. Warner sets out a provocative agenda for deinstitutionalization that puts some moral spine into the discussion. He asks that we envision deinstitutionalization not merely as the transfer of mental patients from one location to another but as embracing a more systematic revaluation of the kind of people we take mad people to be and of the disadvantage to which they have been subject.

 The problem of an asylum is the problem of a society. The new history of psychiatry, inspired largely by the writings of Michel Foucault, is being written not simply as a history of affliction or disease but as a history of power relationships. The lessons of deinstitutionalization show that there are other forms of power to reckon with apart from the psychiatric profession. The Victorian asylum became what it did because powerful social forces willed it to be so.

 The real questions, then, are not about dismantling the mental hospitals as such but about manufacturing the social and political will adequate to the task of bringing back, and re-assimilating into society, what had been thrust into the mental hospitals. Mental health policy has for long been embedded in a complex field of social and political forces and at each point new developments soon find themselves locked in a conflictual struggle, such that what seems to presage a new chapter in the struggle for citizenship and social rights by a disenfranchised group may, from an opposing position, dangle the prospect of more efficient means of managing the socially marginal, and more cost-effective rationalities of disposal.

 What can be said with confidence is that the conflictual struggles around deinstitutionalization, not least the arguments over how such policies are to be understood and defined, are as much a typical product of modern societies as the creation of the asylum itself. Are we able, I ask at the beginning of this book, to give people with mental illness something to hope for? The real question, I believe, is about the grounding of hope. We must face the possibility that by investing the project of closing the asylum with the hope of creating a more promising set of career prospects for people with mental illness, we shall discover that these historical hopes of ours are mere fellow-travelers on a vehicle that is bound elsewhere. These hopes are certainly clinically well enough grounded, but we may be justly sceptical as to whether they are politically securely grounded, grounded that is in an accurate apprehension of the type of outcome that is at all plausible within the antagonistic processes of a modern society.

**Forgotten Lunatics of the Great War**

 Though from the outset my work had always possessed a historical dimension, I had never undertaken any intensive historical research. However, in the mid 1990s, with the encouragement of the late Roy Porter, whose work on the social history of madness had for some time been a stimulus and source of inspiration to me, and who as a publisher's reader for my first books was already familiar with my work, I was enabled to embark on a historical study, based at what was then the Wellcome Institute for the History of Medicine at University College London, of the psychiatric aftermath of the First World War with special emphasis on the 12,000-odd psychiatric veterans, ordinary soldiers rather than officers, who had been given a diagnosis of psychosis. I was alerted to the existence of this forgotten population –forgotten by historians as much as by their contemporaries--by a footnote and it was obvious to me from the outset that here, potentially, was a window on some critical human and social realities of the war that had been obscured, hidden or even denied by a mental health historiography that had largely fastened around the diagnosis and label of 'shell-shock', with an almost exclusive emphasis on the neurasthenic officer rather than the ordinary soldier, nurturing the image of an 'officers' war'.

 Based on research in a variety of archives across England, my study interweaves representative life-histories with broader communal, political, and national concerns to chart an area of the mental health map (and, equally, of the social fabric) of the Great War from 1914 to 1939 that has very largely been *terra incognita.* As the journey of my inquiry got under way, it slowly dawned on me that I was engaged in the excavation of a cultural mass grave, a 'pauper's pit' unrecognizable as a burial place because there were no signs of individuation or commemoration. In this period public lunatic asylums fell within the bailiwick of the Poor Law authorities who did not consider mourning rites for a deceased pauper to be at all necessary, frequently prohibiting them, and leaving the pauper corpse to rot in anonymity in a common grave. Moreover, across the decades before the war, the bodies of the mad poor had frequently been sold for dissection to repay their welfare debts to society, and to sate the appetites of anatomy departments, before their fragmentary remains were finally disposed of in a common grave, broken again in death as they already had been in life.

 During the war, the pensions authorities were obliged to pay heed to the entreaties and sensibilities of relatives, yet in their niggardly gestures they frequently gave the impression that officialdom had *already* buried these lunatic miscreants in common graves and were being reluctantly forced to disinter, and attach names and signs, to them. Shocking though these physical depredations undoubtedly are, we must understand them as the counterpart, if not the reflection, of a depredation that had *also* taken place through the assimilation of these unfortunate souls into the categories and frameworks of traditional asylum psychiatry in which their individualities had to a large extent been dismembered, and discarded as meaningless, in the official asylum ledgers and case histories. There is an important sense, I came to realise, in which public psychiatry itself functioned as a form of pauper burial.

 My task in this study was to set about the historical retrieval (incomplete, inevitably) of this forgotten population, making it available to a community of memory. The First World War inaugurated 'the era of the common soldier's name', in Thomas Laqueur's phrase; hence, a community such as the forgotten lunatics, as I styled them, could only achieve equality of remembrance through being named and recognised as individuals. In the official, not to say military, mind, a certain ambivalence, embarrassment even, has long hung–and may still hang–over these ex-servicemen and they have, I believe, been unjustly neglected and sometimes disparaged. My aim has been to restore them to our memory as honourable members of the community of serving citizens in the Great War, to be valued for themselves, regardless of whether they made good as soldiers.

 The result of this inquiry was a long and dense book, *Forgotten Lunatics of the Great War* (hereafter FL) that strives to engage with a number of agendas, though admittedly only rather partially in some cases. One, as I have already mentioned, and I say a bit more about below, is to redress the class bias in the mental health historiography of the Great War. A second is to find ways in which to describe these soldier lunatics in terms that reflect and respect their subjectivities and are not wholly marked by the definitions and categories of psychiatry or of the military authorities. An example here would be those individuals who turned out to be hopelessly inefficient soldiers and were labeled as 'mental defectives' and placed in mental wards. As I wrote:

*'It is, no doubt, understandable that some of these simpletons and dreamers and malcontents should have been construed as mental defectives. However, it is quite misleading to define them only negatively by their military failings, for this is to concede overmuch to the rectitude of the general staff at the expense of acknowledging that these 'failures' also exemplify an alternative stance or vantage point within life, a competing sensibility on might say, in which, regardless of their limited articulacy and homespun horizons, they come over as possessing a certain kind of unalloyed integrity, hanging on to their own imagining . . . One does not mean to dispose of mental deficiency as a social problem to say that some of these simpletons and 'defectives' do seem to have a point' (p. 78)*

 A third is to explore the life-experiences and 'moral careers' of these distressed servicemen, and sometimes also of their families, through the interwar period especially, but in some instances later, even into the 1960s. And, fourth, but not least, I meant to expose how diagnostic categories such as Dementia Praecox, regardless of how 'objective' the claims about them may be, are inevitably invested with, and caught up in, political meanings and demands. Indeed, at bottom this is a book about the moral politics of psychiatric diagnosis and appraisal. Here I revisit, with renewed intensity, territory that I had already touched on in chapter 1 of *Schizophrenia and Human Value*, 'The Making of the Chronic Schizophrenic', and in a section in chapter 4 of *Closing the Asylum*, 'The Professional Dialogue with the Pauper Lunatic'. Under the special circumstances of the war, I argue, political biases that formerly were latent or hidden were brought to the fore.

In the years leading up to the Great War, Britain appeared to be on the cusp of radical change. In writing about this period I was influenced and helped by the synoptic account of the historian Jose Harris, *Private Lives, Public Spirit: Britain 1870-1914,* particularly in her emphasis on paradox and plurality, the currents and counter-currents in British society, the diversity and contradictory quality of social reality in this period, and also by her insights relating to emergent concepts of citizenship and social equality. As Harris states in one of the most insightful and helpful remarks for any student of this period: '*one reason why accounts of social life in this period vary so widely is the immense diversity of objective reality itself*'. British society '*was not (despite the fashionable jargon of the Edwardian era) a coherent “organism”, still less a “corporation”, a “system” or a “machine”.*

 New-fangled ideas about citizens' rights were in the ascendant, some progress had been made in eroding what had been an exclusively property-based franchise, and there was a rising ground swell of resistance to the faltering pace of health and welfare reform. If all this was indicative of an emerging culture of social citizenship, there was one sphere in which the old hierarchies and divisions still very much prevailed. When it came to psychological suffering and ravaged minds, there was no semblance of equality, either in professional attitudes or in treatment regimes. For the great majority of the population in Britain in the early part of the twentieth century, to become the bearer of a mental illness diagnosis, and to be removed to a lunatic asylum, was to be thrust into a position in life as ignominious as it was awesome. The barrier drawn in Britain before the Great War between mainstream society and the outcast in lunatic asylums was every bit as severe and rigorous as that between citizens and slaves in the later Roman Empire.

 The years 1914-18, in which more than 5.7 million men passed through the British Army, were to deliver a severe jolt to this disdainful class-based state of psychiatric mortmain, producing the conditions in which a disenfranchised community could start to exert a claim on the body politic and make some headway in remedying a basic injustice. The sway of traditional military values as the supreme tribunal before which a serviceman who had failed to make a real soldier of himself was derided as an 'inferior individual' was at least arrested. The First World War produced a notable counter-blast of 'civilianness' in which the dominion of militarized social relations over disadvantaged groups such as the psychiatric casualties of war was significantly restricted.

 The study of war has attracted the interest of historians not merely for its harmful consequences but also for the experiments in social solidarity, a sudden and explosive intensification of social relationships, that it frequently forces into existence. In Parts I and II, I examine the special conditions, in class composition (the visibility of the 'respectable classes' in the ranks), as much as in political culture (above all, these were 'civilians in uniform' for whom strength of patriotic feeling did not staunch a strong sense of what was due to them as citizens), that already in the opening months of the war produced a class alliance to protest against the removal of mentally disordered servicemen to asylums. As a consequence, the authorities found themselves propelled on a line of concession and reform that was to have enormous consequences and repercussions, during the war, and above all after, and at great cost to the state, starting with the creation of a range of specialized war mental hospitals.

 Against the official position that 'incurability' was a fate or destiny which the unfortunate sufferer had inevitably disclosed, was ranged the passionate lay belief, supported by an emerging scientific counter-current, that lives were being needlessly wasted. In the angry apologetics of ex-servicemen's advocates, the certified lunatic was less a natural object than the adventitious product of a misdirected politics. And in a war hospital such as Napsbury we discover the paradox of a domain under military control that became the site for a form of therapeutic carnival in which conventional norms were suspended and the narratives of ordinary servicemen challenged the divisive class psychologies advanced by contemporaries such as W. H. Rivers.

 Justice was the term that figured most prominently in the contemporary wartime debate, setting the scene for a consensus in which solidarity with the community of serving citizens was able to trump traditional military values as the operating standard. A person's value was not made to hinge on his efficiency as a soldier; it was enough that he had left his customary sphere and been received into the military enterprise. Under these special circumstances there came about a kind of psychiatric decommissioning in which alienists and other mental experts handed in their weapons and relinquished their positions on the high ground of moral certainty; condemnatory voices were temporarily stilled and replaced by a tone of hesitancy in the face of the anguish that confronted them. One may think of this as inaugurating an epiphanic moment in the history of madness in which, for a season, the usual suspects of hereditary insanity, such as dementia praecox, were accorded an honourable place as war psychoses.

 The Great War psychotic is the product of a remoralization of lunacy when psychiatrists, along with other branches of officialdom, were being forced to retreat, and implicitly to accept that their traditional repertoires had mostly been in the service of less inclusive social visions. The majority of insane ex-servicemen were made eligible for war disability pensions and the definitions and determinations of the war psychotic were, largely, taken out of military and place under civilian, control. Ex-servicemen with psychiatric disabilities were assigned to a special category named Service Patients where they received pensions and, supposedly, though they were not always forthcoming, special facilities. There was a good deal of equivocation and filibustering over this category not least because the authorities were anxious about the consequences of making a population of mad soldiers publicly visible.

 Much has been made of an integral divide in Britain between mute working-class soldiers and agitated but still voluble upper-class officers, between the traumatic hysterias of the rank and file and the anxiety neuroses and neurasthenias of the officer class. Some respected cultural historians have taken this distinction at face value, treating it not so much as representation of how members of one class imagined, or believed they differed, from another class but as a broadly truthful account of a real state of affairs. In actuality, what we discover here, I claim, is a predisposition to code working class reality. The signs and symptoms common to the officer class were no less evident among the other ranks but frequently they were submerged, disavowed and trivialized by the attitudes and interpretations that were imposed on them. Though the integral divide between 'upper' and 'lower' is reflected in certain basic structures and institutions, still the reality as the anthropologist and psychiatrist Arthur Kleinman has remarked turns out to be 'more and more porous, fuzzy and complexly human'.

 A supposedly 'progressive' military doctor such as W. H. Rivers was still operating within the consensus, enjoying some Freudian cake while upholding traditional class and gender values, and subscribing to a hierarchical psychology in which a superior value was placed on officers over common soldiers and psychiatric assessments were inextricably interwoven with moral and social divisions. '*How utterly different Rivers's neurasthenic officer is from the common soldier*', remarks the anthropologist Allan Young, proposing that the contrast derives less from real differences in symptoms than from contrasting valuations of officers and common soldiers. Not infrequently psychiatric diagnosis played second fiddle to a moral diagnosis. Even in a seemingly progressive professional idiom in which the traumatic hysterias were analyzed as a protest of the inferior, and mutism was cast as an outcome of repressed aggression, there were was a persisting, and largely unexamined, ambiguity around the meaning of 'inferiority' as between an existential predicament (the feelings of the depressed soldier), an objective class or status position (the 'oppressed') and a moral judgment (the doctor's outlook on the depressed soldier and his class).

 Perhaps the most striking feature of the distressed servicemen brought into the psychiatric wing of the Napsbury War Hospital is a comprehensive and consuming sense of failure. These were mostly humiliated and insulted characters, suffering from 'delusions of unworthiness' in the official idiom, who had been brought down by a culture of Great Expectations in which recruits lived in constant fear of being reprimanded, punished or even shot for constantly falling pathetically short of the manly and valorous ideals that beckoned them onward. The conditions of life on the Western Front gave short shrift to any residual belief a man might have had that he was authoring the action of his own life, or that he had some control over his destiny, and demonstrated to him that at best he had a bit part in a fathomless, and largely incomprehensible, drama which, especially if he were exhausted and run down, easily defied classification and turned into an absurdist nightmare,

 The currents running in social and political life before and during the war were reflected also in ideas. Out of the biological awakening of the mid-nineteenth century, a subversive principle had emerged, an affiliate in the scientific domain of the nascent solidarities in the social which played on a fascination with connectivity, and with destabilizing traditional demarcations, leading Charles Darwin to conclude that multitude of life-forms past and present were all interconnected. '*We are all netted together*', he jotted in his notebook in 1838. This was the kind of inspiration that urged the anatomist G. Elliot Smith and the psychologist T. H. Pear to produce *Shell-Shock and Its Lessons,* a small volume that was quickly to achieve iconic status in the new psychological landscape that emerged out of the war, and which by 1917 was already into its second edition.

 Smith and Pear were in the vanguard of a group of psychological observers who were starting to fashion psychological theories that were more inclusive than the divisive and condemnatory rhetoric of psychiatric orthodoxy. In defining shell shock, Smith and Pear cast the dragnet wide to outline a wide-arching perspective affirming the emotional origins of mental disturbances. “It i*s not in the intellectual but in the emotional sphere'*, they write, 't*hat we must look for terms to describe these conditions*'. The wholehearted engagement with emotional reality was potentially a subversive undertaking in itself, in as much as it exposed a common ground into which all servicemen were thrown, regardless of rank or station, opening windows into the subjectivities of ordinary soldiers. In Part III, “*Revolting” Psychology*, I explore different facets of this new psychological landscape in the writings of contemporaries such as Millais Culpin and D. W. Winnicott.

 Not surprisingly, curmudgeonly officials later denounced the sway of public feeling over the formation of policy over psychiatric casualties. '*Misguided public opinion had raised the psychoneuroses to the dignity of a new war disease'*, sneered the official medical historian of the war, and in our time historians of a military persuasion such as Ben Shephard have been no less irascible, berating public opinion for trespassing on the competence of generals and their medical votaries. Yet if this was not a great revolution in mental health culture, sweeping away all old prejudices, by no means was it entirely trivial either. Even though by the 1920s Britain was again a divided society in which governments looked with ill favour on the progeny of war socialism, even so they were not snuffed out entirely: notions of citizens' rights became more etched on popular consciousness, lending support to a politics of social solidarity that was eventually to issue in the European welfare state and the repudiation (in principle, at least, if not altogether in actuality) of the disdainful class- and race-based psychiatry that held its own until well into the twentieth century.

 Between the wars, war disability pensions unquestionably provided a survival kit in the barren environment of mass unemployment for as many as 5,000 war psychosis pensioners in the community, aside from those committed to mental hospitals. Buffeted though they were, claimants had nonetheless gained a foothold in society from which they could not be dislodged. Up to a point, this study may be held to record the history of a double enlistment: of soldiers into the army, obviously enough, but equally of soldier lunatics into the polity. The focus in this book is mainly on the British context but there are resonances here with debates about the political culture of mental health in other national contexts within and between the two world wars, and about madness and modernity more broadly, that I intend to explore in more detail in a future contribution.