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Madness, the family and psychiatry

Abstract
It is argued that an important factor behind the lack of direction in current policies towards serious mental illness has been the failure to critique properly the highly entwined relationship between the discourses of psychiatry and 'the family'. Interviews carried out with an ethnically diverse group of Londoners, who had a relative diagnosed as suffering from serious mental illness, suggest that while the families have an allegiance to a medical model, they are also actively and critically appropriating psychiatric discourse. Closer examination suggests that concerns about sexuality and people's apparent ability to engage successfully with intimate relationships are prominent among the criteria that family members use to judge sanity. A certain amount of historical explication is necessary to put these observations into context, since there has been so little critical analysis of the role that families play in psychiatry. A number of points can be made from the known histories of asylums and psychiatry that suggest that families and familial ideologies were significantly involved in defining ideas of insanity during both the rise and demise of asylum. On the one hand, idealizations of familial and emotional life came to be seen as connected to the causes and treatments of sanity. On the other hand, families were themselves actively involved in the construction of the asylums since they were choosing to commit relatives they deemed to be mad. These historical observations can help illuminate material from contemporary interviews with families. It is argued that our contemporary understandings of mental illnesses are immanent to ideas of family and emotional life.

Key words: asylum, community care, mental illness

Introduction

The policy of Community Care, as it relates to serious mental illness, is widely regarded as being in crisis (Payne, 1999). A number of well-publicized cases has helped build the impression that those whose lives might have been lived in the asylums are a potential danger to themselves or to others (Mujjen, 1996; Ritchie et al., 1994). The perception of a problem in this area is emphasized by legislation over the past few years referring to Community Supervision and Supervision Registers (DoH, 1993, 1994; Eastman, 1997; Parkin, 1996; Vaughan, 1998) and the introduction of the Care Programme Approach (DoH, 1995) aimed at managing people who are perceived as suffering with long-term mental health problems.

Coherent critique of the current situation seems absent. On the one hand, there are voices complaining of 'community neglect' (Scull, 1984) and calling for the closure programmes to be halted and more psychiatric beds to be created (see, for example, Weller, 1985; and the various campaigns, mounted by SANE, described by Ramon, 1991). On the other hand, alarms have been raised about the threat posed to civil liberties by increasingly coercive powers being handed to psychiatrists and other mental health professionals (Baker, 1997), or objections made to the recreation of repressive institutions in the community (Sullivan, 1998).

This article will argue that an important dimension of this uncertainty is the failure to grapple with the convoluted relationship between modern perceptions of mental illness and the family. It has been amply demonstrated that families are the crucial lynchpin of community care (Alcock, 1996; Bulmer, 1987; Cowen, 1999), with feminist critiques pointing out the gendered nature of the caring burden (Finch and Groves, 1984; Land, 1987; Ungerson, 1990; Wilson, 1977). Within the arena of mental illness, however, there are serious obstacles to the inclusion of families within the policy designs. One clear source of difficulties has been the many psychological and psychiatric models used by mental health professionals throughout, particularly the latter half of, the 20th century, which have tended to blame families (Hatfield and Lefley, 1987). I want to argue that there has been a failure to assess critically psychiatry's relationship to families. For too long 'families' have been treated as simply an object of psychiatric discourse – as a causal agent. It will be argued that

families are currently and have been historically *actively* involved in constructing psychiatric definitions of sanity and insanity.

A series of interviews with relatives of people with histories of serious mental illness was carried out. It will be argued that the interviews suggest that families themselves are currently actively involved in the identification and definition of madness. Particularly prominent among the criteria being used by relatives for assessing sanity is the ability to operate successfully within the emotional world of the family. A certain amount of historical explication is, however, firstly necessary in order to grasp the significance of these observations. It is necessary because, although a great deal of critical work on psychiatry has been historical, taking Foucault's *Madness and Civilisation* (1967) as its cue, it has had too narrow a focus. The tone of the influence that this work has had can be summed up by the often used quotation (see, for example, Parker et al., 1995: 113; Wallcraft, 1996: 186) from the preface:

> In the serene world of mental illness, modern man no longer communicates with the madman . . . . As for a common language, there is no such thing any longer; the constitution of madness as mental illness, at the end of the eighteenth century, affords evidence of a broken dialogue, posits the separation as already effected, and thrusts into the oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence. (Foucault, 1967: xii–xiii)

According to critics following this path, the mentally ill were thus victims of Enlightenment progress that had no place for the irrational world of madness. Those deemed mad came to be devalued as less than human, as their experiences and sufferings were transformed into diseases and disorders. This perspective has lead to a sympathetic environment for the service user's voice to be heard (Lawson, 1991; Reed and Reynolds, 1996; Rogers et al., 1993). Indeed, as a rationalization of the shabby, squalid and overfilled asylums that proliferated during the 19th century, such a sketch seems to have considerable explanatory power (Barham, 1992).

It will be argued that this is, however, a misleading sketch because it ignores the convoluted relationship between developments in discourses about the social significance of emotions, of family life

and psychiatry. Foucault himself came to be critical of his earlier work, believing that he had ignored the more productive constitutive aspects of psychiatry, and that

> . . . there are a series of historical relations between madness and sexuality which are important and of which I was certainly unaware when I wrote *Madness and Civilisation* . . . . [I]n the nineteenth century, an absolutely fundamental phenomenon made its appearance: the interweaving, the intrication of two great technologies of power: one which fabricated sexuality and the other which segregated madness. (Foucault, 1977 in Gordon, 1980: 184–5)

This article is concerned with examining this 'intrication'. The important argument here is that the apparent segregation of madness was not a symptom of the attempt to banish irrationality, but was a signal of the recognition that irrationality – the world of the emotions – was a crucial component of the social order. Psychiatry may be better understood not in terms of its exclusionary functions, but instead through understanding its involvement in the positive construction of new forms of governance that depend less upon rules being exerted from above and more on the application of power through more horizontal, social relationships (Gordon, 1980; Rose, 1996). Strong feelings, if properly contained and directed, provided an important means of locating and shaping social relationships. Discourses of family (encompassing gender relations), psychiatry and sexuality are linked by the role they play in the propagation and control of emotion.

Of course, any discussion of the 'family' raises the problem of how it can be adequately defined (see Anderson, 1994; Finch, 1989; Gillis, 1985; Macfarlane, 1986; Stone, 1977; Wolfram, 1987 for discussions of historical changes; and Silva and Smart, 1999 for analyses of the contemporary situation). The difficulty is that 'the family' is many things. As Donzelot (1980: xxv) warned, the family should be seen 'not as a point of departure, as a manifest reality, but as a moving resultant, an uncertain form whose intelligibility can only come from studying the system of relations it maintains with the socio-political level'. The notion of family encompasses ideas about human relationships and emotions, biological facts of relationships, legal obligations and economic relationships. I am much in sympathy with Gubrium and Holstein's point that the family is not 'a distinct entity', but is rather 'a way of interpreting, representing, and ordering social

relations' (Gubrium and Holstein, 1987: 776). Gender is, of course, a prominent aspect of that ordering, as is the arrangement of people's emotional lives and relationships. Indeed, it will firstly be argued here that the idea of family as a means of ordering sexual and emotional relationships has been an important one that has informed the models of mental illness that have been underpinning the major policy developments in mental health. Secondly, however, it needs to be understood that the family has not just been a passive template of such governmental concerns, but families themselves have been active participants in the formulations of, and responses to, mental illness during the asylum-building era.

Families and emotionality: the psychological family

The assumption that the key to mental illness lay in family life was discernible at an early stage in the history of psychiatry. Indeed, the birth of modern 'psychiatry', occurring around the end of the 18th century, has been associated with a shift in the perception of madness away from being seen as the absence of reason towards being seen as disorders of emotions (Doerner, 1981; Skultans, 1979). Attention has been drawn to the interest in sexuality as a cause of insanity that was apparent in references to masturbation psychosis (Foucault, 1979; Skultans, 1979) and women's maladies (Chesler, 1972; Skultans, 1979) during the 18th and 19th centuries. The assumed significance of family life was also evident in the influential idea of the 'Moral Treatment' of insanity. Various writers, despite having very different philosophical stances, agree that Moral Treatment represented a significant transformation in practice towards the insane, and was an important spur and justification of the growth of asylums during the 18th and 19th centuries (Foucault, 1967; Grob, 1983; Jones, 1972; Scull, 1979). Emblematic events were the instigation of the York Retreat by Samuel Tuke in 1796 and Pinel's unchaining of patients in 1793 at the Bicêtre. The central assumption of Moral Treatment was that, if people were treated with decency and respect and were placed in a well-ordered environment, they would be more likely to recover their sanity – ideally that environment would be of a familial style. Daniel Tuke, the grandson of the founder of the influential York Retreat, finished off a summation of the important aspects of the York Retreat in 1882 by noting '. . . that from which the first has been regarded as a most important feature of the institution, is its

homishness – the desire to make it a family as much as under the peculiar circumstances of the case is possible' (quoted in Skultans, 1975: 154–5). Donnelly (1983: 46) argues that, although the Tukes were remarkable in so directly associating the idea of 'family' with the asylum, 'moral pressures, exerted with a force close to the intensity of a parent's bond to a child, were the fundamental motor of the new plan of "management" in asylums and its most telling symptom'. The creation of dedicated, state monitored asylums would allow for Moral Treatment to accomplish its cure (after the fashion of the York Retreat and similar private establishments).

The 20th century was witness to a significant flowering of psychological perspectives on family life which had begun during the 19th century (Rose, 1989). The models adopted by professionals who worked with families increasingly assumed that family life was the fulcrum of people's emotional lives. Psychoanalytic thought is a particularly clear example of the assumption that early family experiences are the key to mental health. This presumption underpinned the work of those who can be termed the early family therapists, who emerged from several research centres in the USA in the postwar period (see reviews by, for example, Barker, 1986; Nicholls and Schwartz, 1991). Their models were an amalgam of psychoanalysis, cybernetics and behaviourism, and had the common goal of hunting for the roots of schizophrenia in the behaviour and communication styles of the immediate family, particularly the parents (Barker, 1986; Foley, 1974; Goldenberg and Goldenberg, 1991; Hoffman, 1981). Here, the linkage between ideals of family behaviour and sanity became entirely explicit. At this point in time, the apparent coherence of this linkage between madness and family life was so unquestioned – despite the lack of evidence (Hirsch and Leff, 1975) – that even those adopting an 'anti-psychiatric' viewpoint wholly absorbed the assumptions. For example, R. D. Laing (Laing, 1959; Laing and Esterson, 1964), the chief guru of anti-psychiatry in Britain (Sedgwick, 1982), was significantly influenced by this work that pinned the blame on families (for example, Ackerman, 1958; Lidz, 1963).

Active families: the patrons of the asylum

It is important to recognize that families were not simply passive objects of professional attention. There is strong evidence that families

themselves were 'policing' the borderline between sanity and madness, and were encouraging the growth of asylums by placing their relatives there. Perhaps this is not surprising since, as Donzelot (1980) so persuasively argued, the family was little use, when considered as an agent of governance, if it were simply a passive instrument only capable of acting on instructions from government and its tutelary networks. Instead, it needed to be an active and autonomous agent that required as little support as possible in order to function. This more active facet of the family can be seen very clearly in the story of the development of the asylums.

Charlotte MacKenzie (1992), through her study of the development of the private Ticehurst Asylum in England, documents in detail the intimate involvement of family members in the decision to admit to the asylum, in the monitoring of treatment and the decision to discharge. Nancy Tomes (1994) argues, from her detailed study of the 18th and 19th century history of Pennsylvania Hospital for the Insane, that families should be considered as 'patrons of the asylums', so active were they in encouraging its development. Walton (1985) focuses on the development of the Lancaster Public Asylum from 1840–70, arguing that the inmates were not part of a rogue band of 'inconvenient people' who were swept up by the authorities, but were brought by 'desperate families' who were asking for help.[1]

Other studies have not dwelt on the families' perspectives, but have noted their involvement in commitments to a number of English asylums (Arieno, 1989), the North Wales Lunatic Asylum (Hirst and Michael, 1999), Irish asylums (Finnane, 1996; Prior, 1996), and North American asylums (Grob, 1983; Jimenez, 1987). Castel (1988) details the rights of families to have relatives detained in pre- and post-revolutionary France.

Families talk about madness

I have argued that our ideas about 'family' and mental illness have long been connected, and that families themselves, through their patronage of the asylums, helped shape policies towards mental illness. This section shifts to the present and begins to examine the role that contemporary families might be playing in shaping our ideas about mental illness.

Despite the fact that successful implementation of Community Care policy would very likely be dependent upon families' involvement, the dearth of studies that have examined the families' perspectives is striking (Creer, 1975; Hatfield and Lefley, 1987; Perring et al., 1990; Strong, 1997). This gap provided the rationale for an in-depth study of the experiences of people who had a relative diagnosed as suffering from either schizophrenia or manic depressive psychosis and had a history of considerable contact with psychiatric services. Interviews with 34 families were carried out by the author (see Jones 1997, 2002). Family members were contacted if there was a name and address available, usually found in the next of kin section of people's psychiatric notes. The definition of family was simple and pragmatic; it was whoever could be contacted. In reality, this meant that the people interviewed were close blood relations (usually parents and siblings, with some spouses and one set of cousins). These were open-ended, qualitative interviews designed to allow the families to describe their experiences and perceptions of mental illness as much as possible in their own words. Typical interviews were between one and two hours long. A number of people were interviewed on several occasions and some were visited regularly over a period of two years. A number of issues about the psychological impact on families (in terms of bereavement, anger and shame) are described elsewhere (Jones, 2002). The initial motivation for this research was a concern that families' perspectives have not been heard at all in critical conversations about the future of mental health services, which stands in contrast to the growing impact of the voices of service users themselves (for example, Lawson, 1991).

The following discussion is divided into two sections: the first considers how actively and critically families can use psychiatric discourse; the second section examines the way that concerns about sexuality and family relationships were helping to inform people's ideas about mental illness.

1. The active and critical appropriation of psychiatric discourse

The sample families largely reflected the ethnic and cultural diversity of the urban area of north London where the study took place (half the sample, for example, were Afro-Caribbean – see King et al., 1994). This diversity made the observation that the interviewees invariably

saw their relatives' difficulties in terms of illnesses – rather similar to mainstream psychiatric perspectives – more notable. This could be cited as evidence that families have simply been recruited to the medical model they find around them (as suggested by Perelberg, 1983 through her study of families involved in the admission of people to a psychiatric ward). As should become clear, this interpretation would be too simplistic. The following extract, for example, points to how active families can be in pressing for a medical diagnosis and of how poor relationships between families and professionals often are (and the low esteem in which professionals are held). In this passage, Sam Mason[2] describes he and his family's frequent arguments with psychiatrists in getting them to accept that his brother was suffering from a mental illness. The psychiatrists' reluctance to apply psychiatric labels seemed (ironically) to Sam to be 'mad'. Sam was Afro-Caribbean and, thus, it might be argued that experiences of discrimination could have contributed to his feeling of alienation here (Littlewood and Lipsedge, 1989). What points to this being a deeper issue here is, first, the fact that white families interviewed expressed very similar sentiments and, second, Sam is the one who demanded that his brother's difficulties be seen in terms of a 'western' medical model. Sam and his family were very actively building and bolstering the concept of 'mental illness'. It is important to note that Sam also felt this to be an instrumental issue; the professionals are reluctant to give the diagnosis as this would result in access to resources:

> SM: I don't think they [psychiatrists and GPs] understand it to be honest, I don't think they really understand mental illness, because when I'm talking to some of the psychiatrists, they are mad, really [laughing]! They really are, they are crazy. Because you'll be telling them, you'll be . . . you'll be the member of the family and you'll be saying 'This person is doing this and this person is not doing this, they're not thinking in this way', and they'll be saying 'There's nothing wrong, they've just got a slight behavioural problem!' or [laughing] . . .
>
> DJ: Why do you think they said that?
>
> SM: Because they are mad [laughing]! . . . No, I don't know how much society really wants to care for these people, and sometimes I think that they 'Yeh fob them off to the family, let the family deal with them'. If they do say there is something wrong then they may feel

> that they have to do something about it and that may cost time and money, or whatever. And the system is not geared for that, so the professional people do say . . . his doctor, said he had 'a slight behavioural problem' and this is after years of going in and out of hospital, after years of that doctor seeing him and giving that diagnosis that he was schizophrenic . . . he's going it wasn't a behavioural problem then he said something like 'he's extrovert' [laughing], this is before the last admission into hospital! So I'm led to the conclusion that they are crazy, they're absolutely crazy!

This finding that families could be very active in 'pushing' a medical model is in keeping with work in medical sociology that suggests that diagnoses are products of wider influences than merely the decision making of doctors (Mishler, 1981). There was also evidence, however, of a *critical* appropriation of psychiatric ideas. Some relatives were very aware and seemed knowledgeable about the psychiatric terms that were being employed. They questioned the meaning and validity of the terms, however. Towards the end of the interview with Fred Bryant, I experienced some difficulty when I brought up the subject of 'illness'. His son John had been involved in prostitution a couple of years before and Mr Bryant seemed to associate the word 'illness' with AIDS. This association with the word illness is striking because otherwise Mr Bryant had a medical view of his son's mental health difficulties. I introduced the word 'schizophrenia' (which I usually avoided) in order to try and clear up any misunderstandings. It seemed that Mr Bryant was very familiar with the term, even quite knowledgeable about it. The reason for him not mentioning it before appeared to be that it was simply a term that he accorded little meaning; it was just a name, 'a handle' for which he had little use:

> DJ: Have they talked about John having an illness?
> FB: Who?
> DJ: People at the hospital.
> FB: Talked about John having an illness? What do you mean by an illness?
> DJ: Well, have they named any illness?
> FB: No . . . I've asked them . . . . Do they think he's got AIDS?
> DJ: No an illness like schizophrenia, or . . .
> FB: Yeah they say he's got schizophrenia. I thought you meant he's got AIDS, I don't know, that would be possible. But I think they have

> blood tests there . . . . But if there's anything they should tell me if there's anything wrong with him . . . . But I mean this schizophrenia, I read loads of books, it's just a name in't it? All different psychiatrists have got different opinions about it. What is it? It's just a name, just a handle isn't it?

The families interviewed were clearly sharing discourses about mental illness with psychiatry. They were, however, actively and critically using this discourse.[3] Families themselves seem to be dynamic players in promulgating the world of mental illness.

Of course, as previously mentioned, there is an alternative interpretation of the relatives' use of illness discourse. Perhaps they have simply introjected professional models that they have been presented with (Perelberg, 1983). This section has demonstrated the following points that suggest the situation is certainly more complicated than this. First, it was clear that relationships and communication between families and professionals were often very poor. Family members often felt that professionals were distinctly hostile towards them, a finding consistent with many previous observations (Cournoyer and Johnson, 1991; Creer, 1975; Holden and Lewine, 1982; Mills, 1962; Shepherd et al., 1994; Strong 1997). Given the models (notably the family therapy model) that have been influential on professional practice, this suspicion of hostility might be well-founded. Second, it was apparent that the families, like their 19th century predecessors who used the asylums (MacKenzie, 1992; Tomes, 1994), were very active in appropriating medical discourse. They often reported spending a lot of time persuading health professionals (particularly medical staff who are more likely to be the gatekeepers to resources) to give a diagnosis of mental illness. The reluctance of medical staff to give psychiatric diagnoses has been observed for some time (Field, 1976). Third, there was often real scepticism towards specific psychiatric diagnostic categories and treatments. Words such as schizophrenia were rarely spontaneously used by relatives. Some further questioning often revealed that they knew this label had been applied but were sceptical about the precision of the term, or they held what was clearly a popular view of the meaning (that is, schizophrenia as 'split personality'). Doubts about the efficacy of available treatments were also widely expressed.

All this does suggest that families were not simply repeating psychiatric discourse. At the very least it implies that the construction

of insanity as being an illness is now generally available in the wider culture. This view is entirely consonant with work in medical sociology that suggests that medical diagnoses emerge from negotiation between medical professionals' patients and their families (Mishler, 1981).

The next section provides further support for the notion that the families' ideas were not simply imported from professional discourses. There were interesting ruptures between theories held by families and conventional psychiatric models of the cause of mental illness. The most notable of these is that families sometimes believed that sexual boundaries and relationships were both significant causes of madness and protectors of sanity.

2. Sexuality, family aspirations and sanity

Prominent among these relatives' concerns, when talking about their family members' mental health problems, was anxiety about emotional behaviour, with the boundaries around madness often constructed around how people were seemingly unable to fulfil familial and sexual roles. A significant ambivalence around strong romantic attachments emerges. It was evident that, on the one hand, the positive and active engagement in emotional relationships was a mark of sanity and normality. On the other hand, falling in love and the risk of a broken heart were seen as likely triggers of mental illness. There were also fears that mental illness rendered their relative vulnerable to sexual exploitation. This stands in contrast to the commonly made observation that the general public can feel threatened by the aberrant sexual behaviour of people with mental illness (for example, Jodelet, 1991). This points to an important idea; that mental illness represents a problem not because it threatens to break sexual boundaries and contaminate 'normal' people, but because it does not acknowledge the expectations and rules of romantic sexual attachments. There was evidence that people really felt that a significant problem that their relative had was that they were not able to engage in romantic/familial relationships. The realization of this often involved considerable disappointment and loss. This is perhaps evidence, as some prominent commentators have suggested (Giddens, 1991; Silva and Smart, 1999), of a shift in the expectations of familial relationships. While the ideal of the 18th and 19th century family that informed ideas of Moral Treatment tended towards those of

discipline and control within relatively prescribed roles, the latter half of the 20th century began to see more emphasis on the positive construction of relationships.

Broken hearts

A conspicuous theory that family members sometimes held was the thought that their relative had become ill in response to having been rejected in love. This, for example, is Bruce Dear's brother being asked what he thought had caused his brother's mental health problems:

> DJ: What do you think caused it?
>
> MrD: I think he must have been in love with someone, but she left him, and he went crazy . . . he's never said anything. but I think that's what happened. That's what has happened to most people who are like that.

There does not seem to have been any evidence for this, but is instead somehow self-evident that falling in love was a destabilizing experience. This is a theory of schizophrenia that does not appear in contemporary psychiatric textbooks (for example, McKenna, 1994).[4] While links between sexuality and mental health are made in psychoanalytic theory, of course (Freud, 1915; Raynor, 1991), these have remained very marginal to discussions about psychosis within mainstream psychiatry (Clare, 1976; McKenna, 1997). This is, therefore, an interesting discontinuity between psychiatric and lay discourses about mental illness.

Anxiety about sexual boundaries and mental illness has been observed in other studies. Perelberg (1983), through her ethnographic study of the family events surrounding the admission of patients to an acute psychiatric ward, argues that parents made recourse to the idea of mental illness when certain familial boundaries were broken, particularly around authority, privacy and sexuality. Jodelet (1991) made a similarly ethnographic study of the difficulties encountered in the integration of a group of psychiatric patients in the 'ordinary' rural community of Ainay-le-Chateau in France. She concludes her study by focusing on the fears that the resident population had about transgressions of sexual boundaries through taking psychiatric patients into their families. She constructs a psychodynamic formulation to argue that unconscious fears of contamination through sexual contact were a major obstacle to full integration.

To the families interviewed by this author, the concern with sexual boundaries was indeed evidenced by the prominence – in the initial recognition of mental illness – given to the perception that sexual boundaries had been ruptured. While several families found overtly sexual behaviour particularly difficult to cope with, there was, however, more often a concern with the *vulnerability* of their relative; a fear that their relative would be taken advantage of sexually themselves. This is important inasmuch as it suggests that Jodelet's (1991) interpretations of people's fear of contamination through contact with insanity needs to be considered further. On the face of it, my observations might suggest the opposite; these families were worried about their own ill relative becoming contaminated by the outside community. Perhaps this emphasizes how the central anxiety is with the observance of the boundaries themselves, rather than necessarily with contamination by what lies on one particular side. Conceivably, the reactions of the citizens of Ainay-le-Chateau, studied by Jodelet, are not symptomatic of their fear of insanity itself, but of the way insanity, by definition, does not recognize boundaries and rules about sexual behaviour.

In support of this premise is the observation that relatives' hopes for the ill person were often framed in family terms; that they should have a family of their own or at least a girlfriend/boyfriend. To be successfully involved in familial and romantic relationships would appear to be, at the very least, a highly meaningful symbol of normality and sanity. Jacob Doors is a father of a young woman (in her late 20s) who has a long history of living in and out of psychiatric hospitals with a diagnosis of schizophrenia. Here he responds to a question about his hopes for her future. He explained that in the past he used to hope that his daughter would meet a nice man who would look after, and marry, her (1, 2). However, he has now come to the conclusion that his daughter's state somehow, crucially, precludes such a relationship (3).

DJ: What do you think will end up happening to her?

JD: Ohhh this is one of these things I don't like to face actually. Realistically . . . when I was younger, a few years ago. Of course she's very attractive looking, and delicate, nice voice, I thought she might attract a man (1), possibly someone older than her, someone of gentle philosophical nature, sort of person who smokes a pipe and wears a velvet jacket. I thought it might attract her attention, and get

> married to her and look after her (2), that's what I thought, like David Copperfield and his child-wife. She is, however, quite a snappy, difficult person and think she'd reject David Copperfield and er . . . [edit] . . . . So er . . . unless she fell in love with someone who fell in love with her . . . and looking at it logically I don't think April or someone in her state, I'm talking for all patients: none can fall in love, on a long-term basis. I think love and commitment and all the feeling, they need to come from someone who is sane, if they are not sane they can only love themselves (3). That's my view for what it's worth, I might be wrong, I hope I am wrong. I don't think so. I don't see. In order to love people you have got to understand people and feel for them, do things for them. If you are tormented by your own problems, there's no way you can understand or feel for another person. And anybody that would perhaps spend time with you and try to be kind with you . . . it might by some sort of peculiar perversion might make you turn on them, I don't know why it should be but I just believe it to be the case. I don't know, I think it would make for tormented relationships one way or the other.

This man explicitly associates insanity with the inability to love and to sustain intimate relationships. In linking romantic love, marriageability and madness, I suggest that this father is expressing important truths about contemporary social definitions of sanity and madness which throw light on contemporary dilemmas that psychiatry currently faces. Madness has come to be seen as a failure to actively engage in the emotional world – most poignantly represented by the family. To be able to operate successfully within the sphere of family life has become the crucial marker of sanity. This extract above might be explained in terms of cultural assumptions about women (Chesler, 1972); the next example suggests, however, that men are being subject to similar standards. Perhaps this is evidence of a shift in the model of the family being used away from the more prescribed, disciplinarian model of 19th century Moral Treatment. Silva and Smart (1999: 7), in reviewing contemporary studies of family life, suggest that the patriarchal model is no longer dominant, that the family has 'come to signify the subjective meaning of intimate connections rather than formal, objective blood or marriage ties'. Giddens (1992: 42) refers to the feminization of the family in describing the shift from the patriarchal family towards one more

maternally centred and based on the values of emotion and affection.

A good example of the reverence being applied to relational abilities comes from an interview with Jason Manula about his brother. Jason expressed fears that his brother, who had a long history of contact with psychiatric services, would be taken advantage of by prostitutes when he was ill. In contrast, when he described his brother when he is well, he focused particularly on his ability to sustain a relationship with a girlfriend, to behave well towards her and to be 'a good communicator'. This is perhaps the flipside (to use Jason's phrase) of the concern with sexual vulnerability; to be successfully involved within a long-term relationship is seen as highly desirable:

> DJ: You said he has been quite well for the last couple of years, what has he been like then?
>
> JM: My brother is a very different person when he's well, he's calm, quiet, loving, considerate, helpful you name it. It's the flipside of the coin . . . he's very different when he's well, he's a good communicator, he's fun to be with . . . um . . . and he's responsible very responsible . . . when he's well, for example in the case of relationships he devotes himself to one girlfriend at the time and he'll give her his all. He'll share his last penny with her, he's that sort of person. So you can imagine to see that transformation, you know it's painful.

Loss of family expectations and distancing

While previous studies have highlighted the 'burden' suffered by families caring for someone suffering from mental illness (Creer, 1975; Platt, 1985; Winefield and Harvey, 1994), they have tended to focus on the practical aspects and overtly distressing events. What emerges from these interviews is the pain caused by the loss of familial expectations through the failure of those deemed mentally ill to engage with relational and emotional aspirations. This point is put forcefully by Penny O'Reilly who expresses very directly how she feels her brothers' difficulties have left her, in mid-adulthood, with a diminished (extended) family. The question I ask is how she felt her brothers' difficulties (both being diagnosed as suffering from schizophrenia) have affected her parents. The answer quickly comes around to herself and her awareness of how things might have been different. The loss is of the idyll of the extended family:

> PO: It's a fucking tragedy isn't it, let's face it! I mean . . . I can't . . . I can't think how different their life would have been if it hadn't

> happened [sigh, shrugs]. It would be totally different, wouldn't it? A totally different life. I mean you'd have two elder brothers most probably married with wives and children. It would be a different thing entirely. I'd have extra nieces and nephews, and two sister-in-laws and a much larger er . . . family [edit] . . . so you think of all the possibilities like that . . . .

To carry on and have a relationship with a family member who no longer fits with familial expectations and finds it difficult to engage in the emotional world can be a challenge. What came across very strongly from interviews with families where there seemed to have been the most successful reconciliation was that the relationship was markedly 'distanced' – spatially and psychologically.[5]

Mr Doors, who we have already met, talked about how he had tried to cope with his daughter at home for a number of years. He was also able to talk about the difficulty of knowing what sort of relationship was appropriate between him and a 27-year-old daughter who had not become adult in conventional terms. He speaks of a moment of realization that he was not going to be able to continue coping with her at home, when he became aware that his daughter did not take her medication unless he physically gave it to her. This was a degree of dependency that he could not really tolerate. He had to give up the idea that she suffered from the sort of illness that was going to be simply mended in hospital (1):

> JD: So it was then that I realized, it all came to me, that unless I was physically present she would not take the pills. So how . . . because I was entering the room set her in panic. So that was when I said 'I can't cope', it's me who's taking the pill, not April. I mean I've got to take them three times a day, in effect. If I don't do, then she doesn't, she will stop and she will revert to the state she was then. So then I made it plain – 'Well please yourself don't take them, I'm not doing it anymore' – and then as she deteriorated again then she went . . . I said 'I can't cope'.
>
> DJ: You realized she needed full-time care?
>
> JD: Yes, yes it took some time to work that out. Because before when she went to hospital for quite a while it was like going to hospital – as if you've got something physically wrong with you – you get mended and you come back home (1). I then realized it wasn't on, I certainly couldn't cope unless I made it a full-time job. If I did

> nothing else but making sure she took those pills. Seems rather pointless as an existence, for her, for anybody . . . .

Concluding discussion

It is being argued here that although psychiatry, throughout its 200-year history, has been subject to considerable criticism (Miller, 1986; Pilgrim and Rogers, 1993), these critiques have often been misdirected. Two well-aired criticisms of psychiatry can be identified. The first is that of 'medicalization'. The accusation is that psychiatry has been responsible for the sequestration of aspects of human life within a medical ambit (Goffman, 1961; Szasz, 1970). These aspects might be better understood as being unhappiness, perhaps due to social conditions (Lawson, 1991; Wallcraft, 1996). The second (in many ways related) criticism is that psychiatric discourse is exclusionary, that it is responsible for the marginalization of aspects of human behaviour and experience that do not fit within a certain narrow template of rational conduct.

The argument made here, through the gathering of historical data and contemporary interview material, is that the growth of psychiatry represented not the exclusion of irrationality, but was – alongside the creation of the modern family – part of a movement that ushered its further incorporation into the social body. Despite 'the West's' own rhetoric that stresses rationality (Bendelow and Williams, 1998), a case can be made that certain features of human life which can be deemed irrational – the worlds of the emotions – are now at the heart of western cultural practice (Doerner, 1981; Foucault, 1979; Giddens, 1992; Wouters, 1992). Critiques of psychiatry that have focused on its exclusionary functions, notably the marginalization of irrationality, have neglected the more productive involvement of psychiatry (Gordon, 1980; Rose, 1996). Critics need to be more conscious of how complex and embedded notions of madness and sanity are within discourses of emotionality and family life. It is unfortunate that individual families have undoubtedly ended up being blamed through the failure to analyse the relationships between psychiatric and familial discourses. The family is not a passive object of psychiatric discourse either, however. Families are also active agents in shaping the practices and boundaries that surround mental illness.

If we are to understand the difficulties that will face those suffering from severe mental health problems, we need to look beyond those specific policies directed at mental illness. It has been argued here that there are strong links between family practices, ideologies and ideas about mental illness. As discussed in the introduction, families were active in supporting the growth of asylums; it is perhaps likely that they will help shape the post-asylum world. Two issues stand out strongly from the interviews with families. First, they were strong proponents of a medical perspective on their relatives' distress. This suggests that the medicalization of mental distress will not disappear even as the asylums and associated institutions are swept away. Second, the judgement that their relatives were unable to engage with close emotional relationships was prominent among their concerns. The loss of those familial hopes and relationships was difficult to deal with and implies that a certain amount of distance in their relationships was necessary.

On a more general level, we might look, for example, at wider changes in family practice and wonder how they will impact on those suffering from serious mental health problems. Some commentaries on the rise of divorce, the increase in cohabitation and children born out of wedlock have suggested that this signals the weakening of familial relationships – meaning bad news for potential recipients of family care (Phillipson, 1992; Poponoe, 1993). Recent analyses of contemporary family life strongly reject this picture (Silva and Smart, 1999). They argue that family relationships now spill well beyond the walls of households. This might be good news for those who find close relationships a strain (Taylor, 1991). On the other hand, it is also being suggested that family relationships are becoming less dependent upon prescription and tradition and more dependent upon the active construction of individuals. Perhaps there is evidence of real change here. Chesler (1972), for example, emphasized the patriarchal nature of the family model that underlay the old asylums: 'mental asylums are families bureaucratized: the degradation and disenfranchisement of self, experienced by the biologically owned child (patient, woman) takes place in the anonymous and therefore guiltless embrace of strange fathers and mothers' (Chesler, 1972: 34). Perhaps we are witnessing a shift to a less patriarchal, more 'feminized' family (Giddens, 1992). Modern individuals, as Giddens (1991) has prominently suggested, must actively construct their own biographies and

relationships (see also Beck and Beck-Gerhsheim, 1995). The interview material suggests that these are becoming real issues. Perhaps work needs to be carried out to examine the extent to which these new requirements to create and maintain our own biographies, to choose and shape our family relationships, might impact on the lives of those people who are seen as suffering from serious mental health problems. More work would certainly have to be done on how people in that position view family relationships, since they would be very much part of the equation. Given the immanence of our ideas about sanity, emotional and familial life, it may well be that to understand the forces that will shape future responses to mental illnesses, we have to consider changes in familial practices as much as those policies directed explicitly towards mental illnesses.

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Notes

1. Indeed, some better-off families were so proactive in this that there was concern about the power that families might wield over the fates of their relative. Throughout the 18th century, relatives could have a family member admitted to an asylum so long as they paid the charges. Discussions of the 1763 Parliamentary Select Committee reveal the anxiety concerning unscrupulous families putting sane relatives in asylums (Skultans, 1979). By the 19th century, anxiety had grown about possible abuses by families, such that doctors were required to formally support an application for internment (Twigg, 1994).
2. All names have been changed and identities disguised.
3. O'Malley (1996) has referred to such phenomena as 'indigenous governance'.
4. Although the significance accorded to emotional relationships and mental health can be seen to be historically well-embedded, as suggested by MacDonald's (1981) work with the notebooks of a 17th-century physician. Shakespeare's line from *As You Like It* hints at the popularity of the view: 'Love is merely madness: and, I tell you, deserves as well a dark house and a whip as madness do; and the reason why they

are not so punished as cured is, that the lunacy is so ordinary that the whippers are in love too' (Act 3, Scene 2).

5. This would help explain the frequent observation of how few people with serious mental health problems do live with their families (Brown et al., 1966; Rogers et al., 1993).

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