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PSYCHIATRIC POWER

For a long time, medicine, psychiatry, penal justice, and criminology remained—and in large part still remain—within the limits of a manifestation of truth inside the norms of knowledge and a production of truth in the form of the test, the second of these always tending to hide beneath and getting its justification from the first. The current crisis in these “disciplines” does not simply call into question their limits or uncertainties in the sphere of knowledge; it calls knowledge into question, the form of knowledge, the “subject-object” norm; it questions the relations between our society’s economic and political structures and knowledge (not in its true and untrue contents but in its “power-knowledge” functions). A historico-political crisis, then.

Consider, first, the example of medicine, with the space connected to it, namely, the hospital. The hospital was still an ambiguous place quite late, a place of investigation for a hidden truth and of testing for a truth to be produced.

A direct action upon illness: not just enable it to reveal its truth to the physician’s gaze but to produce that truth. The hospital, a place where the true illness blossoms forth. It was assumed, in fact, that the sick person left at liberty—in his “milieu,” in his family, in his circle of friends, with his regimen, his habits, his prejudices, his illusions—could not help but be affected by a complex, mixed, and tangled disease, a kind of unnatural illness that was both the blend of several diseases and the impediment preventing the true disease from being produced in the authenticity of its nature. So the hospital’s role was, by clearing away that parasitic vegetation, those aberrant forms, not

only to bring to light the disease as it was but to produce it finally in its heretofore-enclosed and blocked truth. Its peculiar nature, its essential characteristics, its specific development would be able at last, through the effect of hospitalization, to become a reality.

The eighteenth-century hospital was supposed to create the conditions that would allow the truth of the sickness to break out. Thus, it was a place of observation and demonstration, but also of purification and testing. It constituted a sort of complex setup designed both to bring out and actually to produce the illness: a botanical place for the contemplation of species, a still-alchemical place for the elaboration of pathological substances.

It is this dual function that was taken charge of for a long time yet by the great hospital structures established in the nineteenth century. And, for a century (1760–1860), the theory and practice of hospitalization, and generally speaking, the conception of illness, were dominated by this ambiguity: should the hospital, a reception structure for illness, be a space of knowledge or a place of testing?

Hence a whole series of problems that traversed the thought and practice of physicians. Here are a few of them:

1. Therapy consists in suppressing sickness, in reducing it to nonexistence; but if this therapy is to be rational, if it is to be based on truth, must it not allow the disease to develop? When must one intervene, and in what way? Must one intervene at all? Must one act so that the disease develops or so that it stops? To diminish it or to guide it to its term?

2. There are diseases and alterations of diseases. Pure and impure, simple and complex diseases. Is there not ultimately just one disease, of which all the others would be the more or less distantly derived forms, or must irreducible categories be granted? (The debate between Broussais and his adversaries concerning the notion of irritation. The problem of essential fevers.)

3. What is a normal disease? What is a disease that follows its course? A disease that leads to death, or one that heals spontaneously once its development is completed? These are the terms in which Bichat reflected on the position of disease between life and death.

We are aware of the prodigious simplification that Pasteurian biology brought to all these problems. By determining the agent of the sickness and by pinpointing it as a single organism, it enabled the hospital to become a place of observation, of diagnosis, of clinical and experi-

mental identification, but also of immediate intervention, of counter-attack against the microbial invasion.

As to the testing function, one sees that it may disappear. The place where the disease is produced will be the laboratory, the test tube; but there, the disease does not develop in a crisis; its process is reduced to an amplified mechanism; it is brought down to a verifiable and controllable phenomenon. For the patient, the hospital milieu no longer must be the place that favors a decisive event; it simply enables a reduction, a transfer, an amplification, a verification; the test is transformed into a proof in the technical structure of the laboratory and in the physician's report.

If one were to write an "ethno-epistemology" of the medical personage, it would be necessary to say that the Pasteurian revolution deprived him of his role—an ancient one no doubt—in the ritual production and testing of the disease. And the disappearance of that role was dramatized, of course, by the fact that Pasteur did not merely show that the physician did not have to be the producer of the disease "in its truth," but even that, through ignorance of the truth, he had made himself, thousands of times, its propagator and reproducer: the hospital physician going from bed to bed was one of the main agents of contagion. Pasteur delivered a formidable narcissistic wound to physicians, something for which they took a long time to forgive him: those hands that must glide over the patient's body, palpate it, examine it, those hands that must uncover the disease, bring it forth, Pasteur pointed to as carriers of disease. Up to that moment, the hospital space and the physician's body had had the role of producing the "critical" truth of disease; now the physician's body and the overcrowded hospital appeared as producers of disease's reality.

By asepticizing the physician and the hospital, one gave them a new innocence, from which they drew new powers, and a new status in men's imagination. But that is another story.

These few notations may help us to understand the position of the madman and the psychiatrist in the space of the asylum.

There is doubtless a historical correlation between two facts: before the eighteenth century, madness was not systematically interned; and it was considered essentially as a form of error or illusion. At the beginning of the Classical age, madness was still seen as belonging to the world's chimeras; it could live in the midst of them and it did not

to be separated from them until it took extreme or dangerous forms. Under these conditions, it is understandable that the privileged place where madness could and must shine forth in its truth could not be the artificial space of the hospital. The therapeutic places that were recognized were in nature, first of all, since nature was the visible form of truth; it held the power to dissipate error, to make the chimera melt away. So the prescriptions given by doctors were apt to be travel, rest, walking, retirement, breaking with the artificial and vain world of the city. Esquirol will remember this when, in planning a psychiatric hospital, he will recommend that each courtyard open expansively onto a garden view. The other therapeutic place put to use was the theater, nature's opposite: the patient's own madness was acted out for him on the stage; it was lent a momentary fictive reality; one pretended, with the help of props and disguises, as if it were true, but in such a way that, caught in this trap, the delusion would finally reveal itself to the very eyes of its victim. This technique had not completely disappeared, either, in the nineteenth century; Esquirol, for example, would recommend that proceedings be instituted against melancholics to stimulate their taste for fighting back.

The practice of internment at the beginning of the nineteenth century coincides with the moment when madness is perceived less in relation to delusion than in relation to regular, normal behavior; when it appears no longer as disturbed judgment but as a disorder in one's way of acting, of willing, of experiencing passions, of making decisions, and of being free; in short, when it is no longer inscribed on the axis truth-error-consciousness but on the axis passion-will-freedom—the moment of Hoffbauer and Esquirol. "There are madmen whose delirium is scarcely visible; there are none whose passions, whose moral affections are not confused, perverted, or reduced to nothing. . . . The lessening of the delirium is a sure sign of recovery only when the madmen return to their first affections."¹ What is the process of recovery in fact? The movement by which the delusion is dissipated and the truth is newly brought to light? Not at all; rather, "the return of the moral affections within their proper bounds, the desire to see one's friends, one's children, again, the tears of sensibility, the need to pour out one's heart, to be in the midst of one's family again, to resume one's habits."²

What might be the role of the asylum, then, in this new orientation toward regular behaviors? Of course, first it will have the function that was attributed to hospitals at the end of the eighteenth century:

make it possible to uncover the truth of the mental illness, brush aside everything in the patient's milieu that may mask it, muddle it, give it aberrant forms, or sustain it and give it a new impetus. But even more than a place of unveiling, the hospital for which Esquirol supplied the model is a scene of confrontation: madness, a disturbed will, a perverted passion, must encounter there a sound will and orthodox passions. Their confrontation, their unavoidable (and in fact desirable) collision will produce two effects: the diseased will, which could very well remain beyond grasp so long as it did not express itself in any delirium, will produce illness in broad daylight through the resistance it offers against the healthy will of the physician; moreover, the struggle that is engaged as a result should lead, if it is properly conducted, to the victory of the sound will, to the submission, the renunciation of the troubled will. A process of opposition, then, of struggle and domination. "We must apply a perturbing method, to break the spasm by means of the spasm. . . . We must subjugate the whole character of some patients, subdue their transports, break their pride, while we must stimulate and encourage the others."³

In this way, the quite curious function of the nineteenth-century psychiatric hospital was set into place; a place of diagnosis and classification, a botanical rectangle where the species of diseases are distributed over courtyards whose layout brings to mind a vast kitchen garden; but also an enclosed space for a confrontation, the scene of a contest, an institutional field where it is a question of victory and submission. The great asylum physician—whether it is Leuret, Charcot, or Kraepelin—is both the one who can tell the truth of the disease through the knowledge [*savoir*] he has of it and the one who can produce the disease in its truth and subdue it in its reality, through the power that his will exerts on the patient himself. All the techniques or procedures employed in asylums of the nineteenth century—isolation, private or public interrogations, punishment techniques such as cold showers, moral talks (encouragements or reprimands), strict discipline, compulsory work, rewards, preferential relations between the physician and his patients, relations of vassalage, of possession, of domesticity, even of servitude between patient and physician, at times—all this was designed to make the medical personage the "master of madness": the one who makes it appear in its truth (when it conceals itself, when it remains hidden and silent) and the one who dominates it, pacifies it, absorbs it after astutely unleashing it.

Let us say, then, in a schematic way, that in the Pasteurian hospital the “truth-producing” function of the disease continues to fade; the physician as truth-producer disappears into a knowledge structure. On the other hand, in the hospital of Esquirol or Charcot the “truth-production” function hypertrophies, intensifies around the figure of the physician. And this occurs in a process revolving around the inflated power of the physician. Charcot, the miracle worker of hysteria, is undoubtedly the figure most highly symbolic of this type of functioning.

Now, this heightening occurs at a time when medical power finds its guarantees and its justifications in the privilege of expertise [*connaissance*]; the doctor is qualified, the doctor knows the diseases and the patients, he possesses a scientific knowledge that is of the same type as that of the chemist or the biologist, and that is what authorizes him to intervene and decide. So the power that the asylum gives to the psychiatrist will have to justify itself (and mask itself at the same time as a primordial superpower) by producing phenomena that can be integrated into medical science. One understands why the technique of hypnosis and suggestion, the problem of simulation, and diagnosis differentiating between organic disease and psychological disease were, for so many years (from 1860 to 1890 at least), at the center of psychiatric theory and practice. The point of perfection, of a too-miraculous perfection, was reached when patients in the service of Charcot began to reproduce, at the behest of medical power-knowledge, a symptomatology normed on epilepsy—that is, capable of being deciphered, known, and recognized in terms of an organic disease.

A crucial episode where the two functions of the hospital (testing and truth production, on the one hand; recording and understanding of phenomena, on the other) are redistributed and superimposed. Henceforth, the physician’s power enables him to produce the reality of mental illness characterized by the ability to reproduce phenomena completely accessible to knowledge. The hysteric was the perfect patient since she *provided material for knowledge* [*donnait à connaître*]: she herself would retranscribe the effects of medical power into the forms that the physician could describe according to a scientifically acceptable discourse. As for the power relation that made this whole operation possible, how could it have been detected in its decisive role, since—supreme virtue of hysteria, unparalleled docility, veritable epistemological sanctity—the patients themselves took charge of it and accepted responsibility for it: it appeared in the symptomatology as a morbid

suggestibility. Everything would spread out henceforth in the limpidness of knowledge cleansed of all power, between the knowing subject and the known object.

A hypothesis: the crisis was opened, and the still imperceptible age of *antipsychiatry* began, when people developed the suspicion, then the certainty, that Charcot actually produced the hysterical fit he described. There one has the rough equivalent of the discovery made by Pasteur that the physician transmitted the diseases he was supposed to combat.

It seems to me, in any case, that all the big jolts that have shaken psychiatry since the end of the nineteenth century have essentially questioned the power of the physician—his power and the effect that he produced on the patient, more than his knowledge and the truth he told concerning the illness. Let us say more exactly that, from Bernheim to Laing or Basaglia, in question was the way in which the physician’s power was involved in the truth of what he said and, conversely, the way in which the truth could be manufactured and compromised by his power. Cooper has said: “At the heart of our problem is violence.”⁴ And Basaglia: “The characteristic of these institutions (schools, factories, hospitals) is a clear-cut separation between those who hold the power and those who don’t.”⁵ All the great reforms, not only of psychiatric power but of psychiatric thought, are focused on this power relation: they constitute so many attempts to displace it, mask it, eliminate it, nullify it. The whole of modern psychiatry is fundamentally pervaded by antipsychiatry, if one understands by this everything that calls back into question the role of the psychiatrist formerly charged with *producing the truth of illness in the hospital space*.

One might speak, then, of the antipsychiatries that have traversed the history of modern psychiatry. Yet perhaps it would be better to distinguish carefully between two processes that are completely distinct from the historical, epistemological, and political point of view.

First, there was the “*depsychiatrization*” movement. It is what appears immediately after Charcot. And it is then not so much a question of neutralizing the physician’s power as of displacing it on behalf of a more exact knowledge, of giving it a different point of application and new measures. Depsychiatrize mental medicine in order to restore to its true effectiveness a medical power that Charcot’s shamelessness (or ignorance) had wrongly caused to produce illnesses, hence false illnesses.

1. A first form of depsychiatrization begins with Basinski, in whom it finds its critical hero. Instead of trying to produce the truth of illness theatrically, it would be better to try to reduce it to its strict reality, which is often nothing more than the capacity for letting itself be dramatized—pithiatism. Henceforth, not only will the relation of domination by the doctor over the patient lose none of its rigor, but its rigor will be directed toward *reducing* the illness to its strict minimum: the signs necessary and sufficient for it to be diagnosable as a mental illness, and the techniques absolutely necessary in order for these manifestations to disappear.

The object is to Pasteurize the psychiatric hospital, as it were, to obtain the same simplification effect for the asylum that Pasteur had forced upon the hospitals: link diagnosis and therapy, knowledge of the nature of the illness and the suppression of its manifestations, directly to one another. The moment of testing, when the illness appears in its truth and is fully expressed, no longer must figure in the medical process; the hospital can become a silent place where the form of medical power is maintained in its strictest aspect, but without its having to encounter or confront madness itself. Let us call this “aseptic” and “asymptomatic” form of depsychiatrization “zero-production psychiatry.” Psychosurgery and pharmacological psychiatry are its most notable forms.

2. Another form of depsychiatrization, the exact opposite of the preceding one. Here it is a matter of making the production of madness in its truth as intense as possible, but in such a way that the power relations between doctor and patient are invested exactly in that production; they remain adequate to it and do not allow themselves to be overrun by it, and they keep control of it.

The first condition for this maintenance of “depsychiatrized” medical power is the discrediting of all the effects peculiar to the space of the asylum. Above all, one must avoid the trap into which Charcot’s thaumaturgy fell: one must make sure that hospital allegiance does not mock medical authority and that, in this place of collusions and obscure collective knowledge [*savoirs*], the physician’s sovereign science does not get caught up in mechanisms that it may have unintentionally produced. Hence a rule of private consultation; hence a rule of free contract between physician and patient; hence a rule of limitation of all the effects the relationship at the discourse level alone (“I only ask one thing of you, which is to speak, but to tell me effectively everything that

crosses your mind”); hence a rule of discursive freedom (“You won’t be able to boast about fooling your doctor any more, since you will no longer be answering questions put to you; you will say what occurs to you, without even needing to ask me what I think about it, and should you try to fool me by breaking this rule, I will not really be fooled; you will be caught in your own trap, because you will have interfered with the production of truth, and added several sessions to the total you owe me”); hence a rule of the couch that grants reality only to the results produced in that privileged place and during that single hour when the doctor’s power is exercised—a power that cannot be drawn into any countereffect, since it is completely withdrawn into silence, and invisibility.

Psychoanalysis can be deciphered historically as the other great form of depsychiatrization that was provoked by Charcot’s traumatism: a withdrawal outside the asylum space in order to obliterate the effects of psychiatric superpower; but a reconstitution of medical power as truth-producer, in a space arranged so that that production would always remain perfectly adapted to that power. The notion of transference, as a process essential to the treatment, is a way of conceptualizing this adequation in the form of knowledge [*connaissance*]; the payment of money, the monetary counterpart of transference, is a way of preventing the production of truth from becoming a counterpower that traps, annuls, overturns the power of the physician.

These two great forms of depsychiatrization—both of which are power-conserving, the first because it annuls the production of truth, the second because it tries to ensure an exact fit between truth production and medical power—become the target of antipsychiatry. Rather than a withdrawal outside the asylum space, it is a question of its systematic destruction through an internal effort; and it is a matter of transferring to the patient himself the power to produce his madness and the truth of his madness, instead of trying to reduce it to zero. This being the case, one can understand, I believe, what is at issue in antipsychiatry, which is not at all the truth value of psychiatry in terms of knowledge (of diagnostic correctness or therapeutic effectiveness).

At the heart of antipsychiatry, the struggle with, in, and against the institution. When the great asylum structures were put into place at the beginning of the nineteenth century, they were justified by a marvelous harmony between the requirements of the social order (which demanded to be protected against the disorder of madmen) and the

needs of therapeutics (which called for the isolation of patients).⁶ In justifying the isolation of madmen, Esquirol gave five main reasons for the practice: (1) to ensure their safety and that of their families; (2) to free them from outside influences; (3) to overcome their personal resistances; (4) to subject them to a medical regimen; (5) to impose new intellectual and moral habits on them. Obviously, everything is a matter of power; subdue the power of the madman, neutralize the external powers that may be brought to bear on him; establish a power of therapy and rectification—of “orthopedics”—over him. Now, it is clearly the institution—as a place, a form of distribution, and a mechanism of these power relations—that antipsychiatry attacks. Beneath the rationale of an internment that would make it possible, in a purified place, to determine what’s what and to intervene when, where, and however necessary, it gives rise to the relations of domination that characterize the institutional setup: “The sheer power of the doctor increases,” says Basaglia, observing the effects of Esquirol’s prescriptions in the twentieth century, “and the power of the patient diminishes at the same vertiginous rate; the patient, from the mere fact that he is interned, becomes a citizen without rights, delivered over to the arbitrariness of the doctor and the orderlies, who can do what they please with him without any possibility of appeal.”⁷ It seems to me that one could situate the different forms of antipsychiatry according to their strategies with respect to these institutional power games: escape from them in the form of a two-party contract freely agreed to by both sides (Szasz⁸); arrange a privileged place where they must be suspended or rooted out if they manage to reconstitute themselves (Kingsley Hall⁹); identify them one by one and gradually destroy them inside an institution of the classic type (Cooper, at Villa 21¹⁰); connect them to other power relations outside the asylum which may have already brought about the segregation of an individual as a mental patient (Gorizia¹¹). Power relations constituted the a priori of psychiatric practice. They conditioned the operation of the mental institution; they distributed relationships between individuals within it; they governed the forms of medical intervention. The characteristic reversal of antipsychiatry consists in placing them, on the contrary, at the center of the problematic field and in questioning them in a primary way.

Now, what was essentially involved in these power relations was the absolute right of nonmadness over madness. A right transcribed into terms of competence brought to bear on an ignorance, of good sense

(access to reality) correcting errors (delusions, hallucinations, fantasies), of normality imposing itself on disorder and deviance. It is this threefold power that constituted madness as an object of possible knowledge for a medical science, that constituted it as an illness, at the very moment when the “subject” stricken with this illness found himself disqualified as insane—which is to say, stripped of any power and any knowledge concerning his illness: “We know enough about your suffering and your special condition (things that you have no inkling of) to recognize that it is a disease; but we are familiar enough with this disease to know that you can’t exercise any right over it or with respect to it. Our science enables us to call your madness a disease, and consequently we doctors are qualified to intervene and diagnose a madness in you that prevents you from being a patient like others: so you will be a mental patient.” This game involving a power relation that gives rise to a knowledge, which in return founds the rights of the power in question, characterizes “classical” psychiatry. It is this circle that antipsychiatry undertakes to undo: giving the individual the right to take his madness to the limit, to see it through, in an experience to which others may contribute, but never in the name of a power that would be conferred on them by their reason or their normality; detaching the behaviors, the suffering, the desires from the medical status that had been conferred on them, freeing them from a diagnosis and a symptomatology that had not simply a value of classification but also one of decision and decree; invalidating, finally, the great retranscription of madness into mental illness which had been initiated in the seventeenth century and completed in the nineteenth.

The demedicalization of madness is correlative with that fundamental questioning of power in antipsychiatric practice. A fact that allows us to gauge the latter’s opposition to “depsychiatrization,” which appears to characterize psychoanalysis as well as psychopharmacology: both seem to derive from an overmedicalization of madness. And now, at last, the problem is posed of the eventual freeing of madness from that singular form of power-knowledge which is expertise [*connaissance*]. Is it possible that the truth production of madness might be carried out in forms that are not those of the knowledge relation? A fictitious problem, it will be said, a question that has its place only in utopia. In actual fact, it is posed concretely every day in connection with the role of the doctor—of the official subject of knowledge—in the depsychiatrization movement.

The seminar was devoted alternately to two topics: the history of the hospital institution and hospital architecture in the eighteenth century; and the study of medico-legal appraisal in psychiatric cases since 1820.

NOTES

- 1 J. E. D. Esquirol, *De la Folie* (1816), §1: "Symptômes de la folie," in *Des Maladies mentales considérées sous les rapports médical, hygiénique, et médico-légal* (Paris: Baillière, 1838), vol. 1, p. 16 (repub. Paris: Frénésie, 1989).
- 2 Ibid.
- 3 Esquirol, *De la Folie*, §5: "Traitement de la folie," pp. 132-33.
- 4 D. Cooper, *Psychiatry and Antipsychiatry* (London: Tavistock, 1967), p. 17; *Psychiatrie et antipsychiatrie*, trans. M. Braudeau (Paris: Seuil, 1970), ch. 1: "Violence et psychiatrie," p. 33.
- 5 F. Basaglia, ed., *L'Instituzione negata: rapporto da un ospedale psichiatrico* (Turin: Nuovo politecnico, 1968); *Les Institutions de la violence*, in F. Basaglia, ed., *L'Institution en négation: rapport sur l'hôpital psychiatrique de Gorizia*, trans. L. Bonalumi (Paris: Seuil, 1970), p. 105.
- 6 See the pages of Robert Castel on this subject, in *Le Psychanalysme* (Paris: Maspero, 1973), pp. 150-53.
- 7 Basaglia, *L'Institution en négation*, p. 111.
- 8 Thomas Stephen Szasz, American psychiatrist and psychoanalyst born in Budapest in 1920. Professor of psychiatry at Syracuse University, he was the only American psychiatrist to join the "antipsychiatric" movement that developed in the sixties. His work carries out a critique of psychiatric institutions based on a liberal humanistic conception of the subject and human rights. See his collection of articles titled *Ideology and Insanity* (London: Calder and Boyars, 1970); *Idéologie et folie: Essais sur la négation des valeurs humaines dans la psychiatrie d'aujourd'hui*, trans. P. Sullivan (Paris: P.U.F., 1976); *The Myth of Mental Illness* (New York: Harper and Row, 1961); *Le Mythe de la maladie mentale*, trans. D. Berger (Paris: Payot, 1975).
- 9 Kingsley Hall is one of the three reception centers created in the sixties. Located in a working-class neighborhood of London's East End, it is known through the account given by Mary Barnes, who spent five years there, and her therapist, Joe Berke, in the book *Mary Barnes, un voyage autour de la folie*, trans. M. Davidovici (Paris: Seuil, 1973) [Mary Barnes and Joseph Berke, *Two Accounts of a Journey Through Madness* (London: MacGibbon and Kee, 1971)].
- 10 The experience of Villa 21, begun in January 1962 in a psychiatric hospital in northwest London, inaugurated the series of communal psychiatric projects, Kingsley Hall being one of the best known. David Cooper, the director until 1966, writes about it in his *Psychiatry and Antipsychiatry*.
- 11 Italian public psychiatric hospital located in northern Trieste. Its institutional transformation was undertaken by Franco Basaglia and his team starting in 1963. *L'Institution en négation* describes this anti-institutional struggle that set an example. Basaglia resigned as director of Gorizia in 1968 in order to develop his experience in Trieste.