ARTICLE

Foucault understood critical psychiatry

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SUMMARY

Critical trends in psychiatry are abundant today. Their impact on how psychiatry is currently practised is considerable. Yet what deserves close examination is the extent to which these modes of critique (anti-psychiatry, liberation movements, activism, existential, narrative or hermeneutic approaches, theories of values, psychoanalysis) inherently belong to or have become part of the very system that they criticise. Despite their political, social or scientific influence, which is undeniable, their critical power is often limited by their inability to radically challenge the deeper anthropological and philosophical presuppositions on which mainstream psychiatry rests. It can be argued that Foucault offers such a challenge. Implementing his historico-philosophical method, Foucault is sceptical of the anti-psychiatric quest for non-oppressive modes of psychiatric power and the humanist and postmodern efforts to moralise or relativise psychiatric truth. All these modes of critique rest on preconceived notions of nature, power and truth and have been integrated by the pluralism of the psychiatric universe. Yet Foucault's critique seeks precisely the opposite: to explore a new anthropological conception of insanity that has the power to challenge the legal, moral or reductionist constraints under which medical truth currently operates.

LEARNING OBJECTIVES

After reading this article you will be able to:

- outline the basic tenets of Foucault's historico-philosophical approach to psychiatry
- understand Foucault's anthropological model and its relation to current thinking
- analyse the significant critical trends in psychiatry, assessing their scope and possible limitations.

KEYWORDS

Critical psychiatry; Foucault; enlightenment; theory of values; anthropology.

Psychiatry was born as a discipline during the Enlightenment. According to official historians, this event occurred because the period put an end to a long history of ignorance, prejudice and religious superstition, enabling mental doctors to reach a sufficient level of lucidity to insert insanity into the realm of rational medical observation. According to the same narrative, Foucault's work is anti-psychiatry and anti-Enlightenment, claiming that the birth of psychiatry was the direct result of an oppressive rationalist and moral imperative to exclude and conquer unreason. Yet what Foucault wants to underline is precisely that this double side of rationalism, this 'blackmail of the Enlightenment' as he calls it, is invalid (Foucault 1997, p. 123). Foucault sees a more complex relationship of the Enlightenment with itself. The Enlightenment may have been marked by the triumph of rationalism, but it was also an age of critique. Alongside the emancipating project of a rationalist movement, the late 18th century saw the emergence of anthropology, a critical reflection on the finitude of man and on the limitations of his reason. It was a vast philosophical, epistemological and ontological self-reflective attitude that permeated institutional practices, acquired scientific status in medical research and became a philosophical system in thinkers such as Kant. In today's naturalism, positivism and humanism, the anthropological attitude has become marginalised, but Foucault's historico-philosophical analysis highlights its secret presence beneath the calm of objectivity of science and its radicality as a tool of critique of current psychiatric theory and practice.

Anthropology

What is anthropology and why did it become so central in the period of the Enlightenment? Anthropology is not a particular science studying cultures exterior to the West. It is a philosophical structure attempting to answer the simple (and complex) question: What is man? Up to the 18th century, all philosophers had tried to tackle that same question, therefore anthropology had always been tied to the question of philosophy itself. Yet, in the 18th century, especially with Kant, the way this problem was posed changed radically. It became for the first time a problem of human finitude (Foucault 1998, p. 250). Up until Kant, every reflection on man was secondary to the thought of the infinite. It was considered that knowledge of the infinite, that is, truths derived from mathematics, physics, metaphysics or religious doctrines,

could provide the fundamental laws of human behaviour, thought and perception. With Kant, there is nothing but finitude. The infinite is no longer given and man constructs his own history, his own consciousness and identity through the powers of his reason and it is reason that sets the boundaries of what man can perceive and comprehend about himself and the world.

The central theme of Kant's anthropology is the pragmatic nature of pure reason (Foucault 2008). Reason is *pragmatic* because it is a vital, material force, embedded in human practices. It constitutes the logic of social relations, expressing the diverse interests, intentions and wills of subjects who, as 'citizens of the world' (Foucault 2008, p. 42), compete for their role in the general management of society – the way of governing, the distribution of justice, education, health. But reason is also *pure* because it is not reducible to the human interests that it expresses; it also coordinates the encounter of interests, it functions as the filter of truth through which interests confront and communicate with each other. Thus, from a pragmatic viewpoint, reason is not relative to human passions or values, nor an *a priori* set of axiomatic principles imposed by impersonal, anonymous agencies. It is an active faculty which groups and individuals use in order to address each other with truth demands (i.e. mutual requests for the production of forms of knowledge that can legitimately be inserted into a universally accepted division of truth and falsity). It is In the context of this geographically and historically conditioned division, that subjects in a given society can recognise each other as participants in a common truth that renders them capable of representing reality in a shared and meaningful way.

Pure reason is not only the dynamic, material principle of human practices, but also their limit. Reason judges the validity of statements and the legitimacy of truth claims. It safeguards against arbitrariness and division. It not only judges the correct use of syllogisms, but also observes the instances when certain assertions acquire absolute value, disrupting the free circulation of truth and the participation of subjects in universal reason. This occurs, for example, when laws acquire a transcendental authority to be followed blindly or when scientific, religious or philosophical truths become dogmatic propositions. In more extreme cases, it occurs when reason itself is impaired, failing to contain the understanding within its empirical domain, giving rise to transcendental illusions, fantasies and passions – this for Kant is the state of madness.

Anthropology and the birth of psychiatry

Let us now consider the birth of psychiatry from the anthropological perspective. In the late 18th century the logic of social relations was disciplinary: the social objective of the time was to ensure order and public hygiene by rationalising behaviours. The administrative goal was to establish a norm defined through rational criteria in order to train bodies, educate or correct individuals, monitor daily activities (Foucault 2006a, p. 50–55). Soon concern arose about those individuals who could not be trained in schools and transgressed the social pact. Society was then faced with the question: What is the rationality, what are the interests of those individuals who become temporary despots by defying the law and escaping the norm? There was no abstract authority responsible for tackling this problem. There were specific agents (family, parents, magistrates, the police) who sought concrete and immediate answers. Truth demands began to circulate. The family demanded expert knowledge on family members who behaved normally but became disruptive on specific occasions (pathological jealousy, misrecognition of family members); administrators requested assistance regarding law-abiding citizens who terrorised society with no apparent ideological or political motive; magistrates could not apply the law to peaceful individuals who committed extraordinary but motiveless crimes, in perfect lucidity and intact moral consciousness (sound syllogisms, full awareness of legal consequences) (Foucault 2003, pp. 121–122).

Soon, this series of administrative, familial and juridical truth demands reached medicine. Doctors were asked to make a diagnosis: what was the common element that these extreme cases shared and that created an impasse to social training and legal punishment? That element was delusion. These were individuals unsuspected by society, who harboured ideas expressed in ways inaccessible to the untrained eye. They were not wild beasts, governed by their passions, blind to their own interests. On the contrary, they strongly asserted their interests, passions and instincts; but these instincts were coordinated by a delusion. These individuals were ready to hold onto this delusion dispassionately and with rational calculation, despite the risk of involuntary incarceration, punishment or even death. Their ailment was not simply moral or humoral, but mainly epistemological. They constituted a singular case of subjectivity at the limits of reason and truth. That is why they became the prototype of a new conception of madness that was inserted into a new symptomatology and nosography. It had the following characteristics.

(a) The mad subject is captive to his own truth. In Kantian terms, the insane person exercises the pragmatic dimension of reason in a solitary manner, producing an absolute, private truth outside the common horizon of reason where claims and beliefs are put to the test.

(b) As an expression of a private truth, delusion is the hallmark of madness (Foucault 2003, p. 130). But delusion, as these exemplary cases indicate, is not a global phenomenon; it is a local disturbance with a particular delirious object or thematic, leaving the other areas of the personality intact.
(c) Because of this new, disturbed and localised relationship with truth, the subject breaks with all prior causality. The subject no longer resembles his own past (childhood, past habits and beliefs) or the immoral or illegal acts that he commits. In insanity, there is an absolute rupture with the patient's own nature and prior subjectivity (Foucault 2003, pp. 302–303).
(d) In madness, there is an exaggeration of passions and instincts organised around the powerful affirmation of a deluded idea. The subject finds a unifying principle in his solitary, indisputable truth. This truth gives meaning to his life and value to his actions. It therefore inflates the ego, which is why the subject supports it and asserts it with unshakable force. The patient may be captive to his truth, but he is also an ultrapowerful individual (Foucault 2006a, pp. 27–28).
(e) An isolated, medically controlled milieu is required to observe but also to manage and subdue the patient's powerful, sudden and unpredictable emergence of delusion (Esquirol's principle of isolation, Falret's principle of the two wills – Box 1) (Foucault 2006a, pp. 103, 147). Hence the organic role of the asylum in the therapy and guidance of the mad.

From anthropology to positivism

By the middle of the 19th century the logic of social relations changed. This time the value of security prevailed. There was a general demand for prevention, protection of life and prophylaxis. This demand concerned not only the correct application of the law or the discipline of individuals, but also the protection of the population and the detailed description of natural processes (Foucault 2007, p. 47). Man was no longer studied as an individual with his singular relationship with truth, which, if disturbed, produced madness. He was now part of a species governed by a set of natural laws whose violation would lead to mental illness, a measurable and controllable entity.

This new social truth demand, which was simultaneously a reality demand, also constituted an internal challenge for psychiatry. Psychiatry had to move away from the anthropological problematic of subjectivity and truth which was quasi-philosophical. Alienism was too preoccupied with unpredictable breaks and discontinuities and too much involved in philosophical notions such as reason, illusion and truth. As a medical science, psychiatry should be able to produce positive knowledge of causal chains and mechanisms in order to increase its demonstrative and predictive power, which was also a new administrative and legal requirement. It therefore overproduced knowledge and reversed the terms of the debate, giving rise to the following assertions.

(a) Delusion is not the cornerstone of insanity. It is not a regional phenomenon outside the bounds of reason, but a cognitive distortion expressing a global dysfunctional state the brain (Baillarger, Griesinger), which, by its causality, explains the appearance of the individual as its victim and bearer (Foucault 2003, p. 313).
(b) There is a continuity between the deluded subject and its premorbid subjectivity. It is up to the clinician to demonstrate this continuity, using the universal laws of human development, evolution and maturity. Mental illness is a dysfunctional natural process, not a subjective outbreak (Foucault 2003, p. 303).
(c) Insanity is not a state of exaggeration and pronounced traits, but a state of deficiencies and lack. Underneath the powerful manifestation of delusions and hallucinations lies automatism, lack of free will and a process of either arrested development or degeneration, transmitted across generations (Morel, Valentin Magnan, Hughlings Jackson, Kraepelin's dementia praecox, Bleuler's four As – Box 2).

From this point onward, psychiatry acquired a naturalist and positivist language which, through new forms of knowledge – neurology, neurochemistry, genetics and statistics – promised the inclusion of madness into a network of increased scientific sophistication, liberal and humanist structures, and security. The asylum should now become

BOX 1 Alienists

Starting in the early 19th century, psychiatrists were referred to as 'alienists'. It was the alienist's job to study, understand, care for and assist patients in overcoming their 'mental alienation', understood as the suffering and symptomatology of the psychiatric patient stemming from being excessively alienated from society and out of touch with their true selves (self-alienation).

Phillipe Pinel (1745–1826) liberated the insane from their shackles.

Jean-Étienne Dominique Esquirol (1772–1840) charted a new nosographic table. His principle of isolation consisted in isolating the mad in order to ensure the personal safety of the patients, to free them from outside influences, to overcome their personal resistances and to impose new intellectual and moral habits on them.

Jules Falret (1824–1902) described bipolar disorder and *folie à deux*. His principle of two wills was based on the notion that in every madness there is always an assertion of omnipotence; therefore the disturbed will and perverted passion of the patient must come up against the sound will and orthodox passions of the physician.

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BOX 2 Psychosis, schizophrenia and the four As

In 1896, Emil Kraepelin (1856–1926) defined psychosis as a degenerative process leading to premature dementia.

Eugen Bleuler (1857–1939), who coined the term schizophrenia in 1919, described its primary symptoms, known as four As: associational disturbances, affective disturbance, ambivalence, autism.

useless and deinstitutionalisation became the end goal of psychiatric establishments.

Foucault's anthropological model – a case of Enlightenment critique

After examining these two major phases of psychiatric evolution, a crucial anthropological question arises: Is insanity an original state of the mind or an inevitable consequence of a disturbed natural causality? Should we discard the term 'madness' as a precarious, quasi-philosophical archaism in order to replace it with 'mental illness', a valid medical notion susceptible to empirical investigation? The lesson that Foucault draws from the early, anthropological stage of psychiatry is that that this dilemma is superfluous. These terms are not antithetical, they just refer to two distinct levels, two different and mutually dependent aspects of man. Man has an essence, but he is also a subject; he is part of a species, but he is also an individual. The alienists did not deny the humoral aetiology of mental disorder, but emphasised its unique individual expression. As a part of nature, man has a suffering body, which may confuse the mind. It is a body that degenerates and dies. But as a subject, man is not a passive receptor of information causally connected to his body; he relates the experience of his bodily inclinations to a truth that he has constructed through his own history, his shared reason and language, and his will. As a subject, man is a free, social agent, actively engaged in the production of his own truths and illusions, and in madness this autonomy and freedom are pathologically intensified and monstrously accentuated, because the subject translates his sensory stimuli into private, self-sufficient, incommunicable truths.

Psychiatric positivism shifted the centre of gravity to the study of nature. However, it did not merely objectify the subject. It altered the terms of its relationship with nature. For positivism, subject and nature are no longer in a dynamic relationship of truth and bodily reality, but in a static, causal connection of freedom and necessity, actuality and potentiality. Nature is the domain of objective processes and potentialities, and mental illness is their deficient development. The subject's health is measured by its freedom to compensate for these deficiencies in order to fulfil its biological and psychological capacities. Thus, the subject is regarded as an autonomous, transcendental agent with a legally protected right to growth, but at the same time his autonomy is limited by the laws and causal processes to which he must conform and to the potentialities which he is supposed to fulfil. In positivism, there is a paradoxical complementarity between the free subject and *homo natura* (Nietzsche's human being as a creature of nature (Nietzsche, 1989, pp. 159–162)), between the humanism of existential freedom and human rights and the knowledge of the structure and design of the human species (Foucault 1997, pp. 121–124).

For Foucault, it is this coupling of humanism and positivism, which he calls anthropologism, that merits critique (Foucault 1997, p. 229). It rests on a juridical and rationalist 'Enlightenment' conception of man. It is based on a legal and moral definition of the subject and a biological definition of nature, resulting in an anthropological split. Positivism implies an anthropological *minimalism* in which man as part of nature is the blind instrument of physical and psychological laws, the object of causal determinations. Humanism (Box 3), on the other hand, suggests an anthropological *maximalism* in which man as subject is autonomous, completely free of causal determinations, endowed with inalienable rights that must be protected from the interests of power. This anthropological division, apart from its internal antinomies, carries moral and metaphysical overtones that generate significant epistemological problems for psychiatry, which I address in the next two sections.

A science of abnormalities: positivism

In its early years, psychiatric diagnosis was not strictly differential, as in the rest of medicine, but had a dual aspect: the absolute diagnosis between madness and non-madness (Foucault 2006a, pp. 266–267). The proto-psychiatrists were looking for a core of delusion behind every disordered passion and bizarre behaviour, because delusion meant alienation, an experience sharply distinct from all other mental conditions. Alienation meant radical estrangement from the common practice of reason, but also from the self. Delusion is primarily self-delusion. Its two pillars are the two aspects of the will, analysed by Nietzsche and taken up and reworked by Foucault: the will to truth and the will to power. First, Hallucinations and fantasies capture the subject's will to truth (i.e. his natural desire for familiarity with the world and the self) operating as simulacra of familiarity, deceiving, and flattering the

BOX 3 Humanism

Humanism is a philosophical stance that emphasises the value and agency of human beings, individually and collectively. It is an approach to life based on reason and common humanity, recognising that moral values (mainly freedom and progress) are properly founded on human nature and experience alone.

There are several types of humanism, scientific or anti-scientific, religious or anti-religious, existentialist, psychoanalytic and Marxist. For Foucault, despite their diverse thematic, what these versions of humanism share is a set of value judgements and certain ready-made conceptions of man borrowed from religion, science and politics. This is why they merit scepticism and must be carefully distinguished from anthropology, whose objective is precisely the exploration of man's conception of himself and the epistemological and ontological ground of human values.

subject. Then, the seduced will to truth tuns into will to power (i.e. the desire for appropriation, possession and assimilation). This is the onset of delusion–familiarity turns into identity and doubt into absolute certainty. The subject consents unconditionally to the veracity of false appearances and begins to interpret the world in a self-referential manner (Foucault, 2006a, pp. 147–148).

Positive medicine later overturned this situation: behind every delirium, psychiatrists began to look for causal determinants in the axis of the voluntary and the involuntary, aberrant instincts and genetic abnormalities. Every delusion came to be seen as a secondary phenomenon, a misinterpretation of reality, caused by perceptual automatisms. The active involvement of the will in the production of delirium was abandoned and was replaced by notions such as 'drive', 'motivation' and 'frontal lobe executive' (Berrios 1995). This was an event with major ramifications: psychiatry managed to pass from diagnostic isomorphism to aetiological equivalence with organic medicine, because not just delusion but any idea has a neurological background and an underlying neurochemical imbalance. But this equivalence also created a continuum between psychoses, neuroses and types of behaviour previously accorded only a moral, disciplinary or judicial status. All possible involuntary, irregular, eccentric and dysfunctional behaviours came under the jurisdiction of psychiatry (Foucault 2003, pp. 160–163). Alienation and absolute diagnosis were left behind, but now abnormality became the object of psychiatric knowledge, exploding the diagnostic field uncontrollably (today, one needs only to look at DSM-5, where more and more aspects of human behaviour receive a medical comment (Porter 2002), and the notion of the 'spectrum' officially enters the scene).

A value-laden science: humanism

The anthropological view of man considered autonomy as the fundamental property of the individual. But this autonomy was examined in epistemological terms. A patient does not become deluded because he is a slave to passions or victim to involuntary impulses. On the contrary, it is delusion that controls the interplay between will, authority and reason. The mad subject is not innocent or guilty, master or slave. He is seduced. The patient is unwittingly caught up in the spontaneous emergence of images and scenarios, but at the same time he affirms their authenticity with an unshakable certainty, which he experiences as absolute freedom. Captivity to passions exists side by side with sovereign convictions; both are consequences of the patient's profound self-deception. In 'moral treatment', which the proto-psychiatrists called 'direction', the doctor did not train the passions by teaching moral values (family, religion, community), but confronted the patient's will to power, which had to be renounced if the patient were to recognise the illusion to which he was passionately attached (Foucault 2006a, p. 339).

In the humanist conception of the positive, autonomous and self-fashioned self, the mentally ill person is considered a slave to passions or a victim to social or biological forces beyond his control. Therefore, he must become master in his own house, he must exercise his sovereign will over his passions. In this case, first, there is a split and confusion between the moral and the medical. If the passions must be renounced, then the distinction between moral therapy and medical treatment becomes blurred. Second, the doctor feels that he must empower the patient. In this case, he may fuel illness and illusion. Third, discipline, obedience, exclusion and paternalism (Box 4) lose their epistemological connotations and become negative moral values. At the same time, the positive values of security, deinstitutionalisation and rights globalise a new, paradoxical form of paternalism, this time in a voluntary, extra-asylum space, in which patients who evoke victimhood are encouraged to exercise their autonomy, while maintaining their sick role.

BOX 4 Paternalism

An action performed with the intent of promoting another's good but occurring against the other's will or without the other's consent. In psychiatry, coercive hospital admission or coercive treatment of psychiatric patients are justified by their potential of benefiting the patients themselves.

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Critical psychiatry and its trends

I will now discuss some of the major critical trends of psychiatry that have claimed an affinity with or even inspiration from Foucault's theories. I will focus on the way these critics have attempted to dismantle psychiatric anthropologism (humanism/positivism), illustrating, however, that they have limited the scope of their critique by siding with either one or both of its terms. Some critics have opted for humanism, considering the subject as totally irreducible to any biological definition (negative anthropologism); others side with positivism, seeking to liberate the subject through the elimination of the deviations of nature (positive anthropologism). Others accept the ambiguity and see in it an occasion for creative synthesis (value theory, post-psychiatry). As I proceed in outlining the basic tenets of each trend, I will contrast them with Foucault's anthropological world view, to show how the anthropological method is more radical and far-reaching.

Anti-psychiatry

It is well-known that the anti-psychiatry movement has not been uniform. There are several types of anti-psychiatry representing heterogeneous philosophies, ideologies and objectives. Yet they share a common premise, which oscillates between a positive and a negative anthropologism. Thus:

(a) *Mental illness exists but it is always misrepresented.* In the anti-psychiatry camp, positive anthropologists are ready to admit the existence of mental illness but claim that its exclusion is based on falsified or ideological representations. Either a transhistorical power of sovereignty, or the totalitarian tendencies of state control or the irrational rationality of capitalism force the psychiatrist to exercise his oppressive social role of arbitrarily incarcerating dangerous individuals, using false and invalid labels. This view presupposes that sovereignty is a permanent and inherent property of power and that ideology is the sole enemy of truth.

(b) *Mental illness does not exist.* Negative anti-psychiatry anthropologists exalt the role of individuality and humanism, denying the existence of the reality of mental illness (Szasz 1977). They therefore exclude *a priori* the body from the formation of subjectivity and its relation to truth. They consider the individual as a disembodied entity endowed with rights.

(c) *Madness: does it exist?* Existential humanists hold that the 'insane' proclaim deeper, more insightful truths about the human condition, about society, being and the world, truths that the rational mind cannot tolerate and therefore excludes (Laing 1967). As Foucault shows, however, this conception of mad truth belongs to the pre-Enlightenment period. The anthropologists of the 18th century were more sceptical, considering the possibility that the subject proclaiming these truths may be in a state of self-deception (Foucault 2006b). This version of negative anthropologism adopts a judicial conception of the Enlightenment, defending the right of the individual to falsity.

The theory of values

Since the 1990s a group of psychiatrists have drawn attention to the role of values in psychiatric practice. Through strict logical analysis they have illustrated that psychiatry's anthropological split follows logically from the inherent conflict and interpenetration between facts and values. Positivism, they argue, is permeated by the social, cultural and political context in which it operates, therefore it cannot lay claim to objectivity and neutrality. Every diagnostic concept, all decision-making and all research into the facts of mental disorder are guided by the criterion of utility, by a moral judgement of good and bad, even by the choice between the ugly and the beautiful. Humanism, on the other hand, is a set of value judgements (freedom, rights, functionality) that cannot draw its validity from the facts of nature. Drawing on the analytic tradition and the philosophy of Hume, value theorists aptly declare that 'you cannot derive an ought from an is', meaning that we cannot logically deduce from any fact of nature that a patient will desire freedom or slavery, will value health instead of illness (Fulford 1990, pp. 27–56). On the contrary, value theorists continue, it is the patient's negative subjective evaluation of his own condition (illness) that precedes any investigation into the objective facts of physical (or psychological) ailment (disease) (Fulford 2006).

Facts versus values or truth versus reality?

It is immediately obvious that such a position is not far from Foucault's analyses. Psychiatry, Foucault has shown, was born from factors external to it because it had to respond to a specific extra-scientific demand, a political, administrative and juridical will to govern in terms of discipline, that is, the moral value of training individuals and enforcing public hygiene. Yet, as I have tried to show, this moral demand reached doctors through the filter of truth. Medicine did not provide the legally and morally codifiable and scientifically measurable criteria of the norm. On the contrary, alienism defined madness as the focal point where legal power, moral codes or psychological laws reach their limits of truth. Insanity did escape the social norm, but not because it challenged the values (functionality, productivity, morality) on

which this norm was based. It was because it failed to participate in the common, pragmatic field of truth production, promoting its own, private truth as absolute, that it eluded morality and rationalisation. It is the division between truth and falsity that defines the norm (what Foucault calls 'ethics' (Foucault 2005, p. 317)), not the other way around.

When psychiatry was inserted into the context of security, that is, a set of moral values promoting legal and biological protection, moral values *did* begin to penetrate diagnostic judgements, because the exceptional case of absolute truth ceased to be the criterion of insanity; it was replaced by the notion of abnormality, the disorder of conduct, functionality, the voluntary/involuntary axis. In this context, value theory is right to question the values governing medical discourse, but it cannot claim that it is a transhistorical phenomenon.

Moral values or the value of truth?

The anthropological model does not leave out values altogether. There is a general and constant battle around truth, and the birth of sciences and institutions rests on the circulation of truth demands. Subjects are truth seekers, meaning that their will, their desires and interests are involved in the search for truth. But this will to truth implies the value of truth itself, not the fact that moral values permeate truth. Truth becomes value laden when it becomes a tool of utility, of direct representation and manipulation of reality. In its entanglement in human relations and in its moments of expression, truth takes the form of a risky dialogue, an open-ended challenge, in which moral values may find justification or face reversals.

Post-psychiatry

Post-psychiatry is another critical trend, which has incorporated certain views of the influential intellectual movement of postmodernism of the late 20th century (Lyotard 1984). In keeping with the postmodern spirit, post-psychiatry is a movement sceptical of universal truth claims, dogmatism, grand narratives and timeless anthropological constants. It considers truth as theory laden and value laden, it views the human subject as a social construct and science as one language game among others (Lewis 2006). As a mode of psychiatric critique, post-psychiatry synthesises the critical trends discussed earlier: although it does not reject scientific research into the reality of mental illness, it mistrusts naturalism, positivism and all claims to neutrality. It supports humanism and deinstitutionalisation, it advocates the right of mental patients to raise their voice against the hegemonic discourse of mainstream psychiatry.

Post-psychiatry maintains that insanity is only a historical construct, the product of an interpretation made by a subject occupying the status of rationality. This interpretation can have no restraining force on patients insofar as it has no universal truth value. The goal of the post-psychiatrist is to free patients from the constraints of absolute medical truth claims and to allow them to speak for themselves, to give their own meaning to their condition so as to negotiate their existential position with society, without feeling disadvantaged or stigmatised. Thus, post-psychiatry implements a sceptical and hermeneutic approach and is right to see in it an affinity with Foucault, among other critical, existential or 'postmodern' theorists (Bracken 2005).

Relativism

The danger, however, is that this scepticism can lead to a relativism and an abstract pluralism that are already part of the psychiatric universe (Brookbanks 2014). Current psychiatry is aware that its knowledge is incomplete, which is why it relies on simulation models of aetiology and atheoretical texts of description (DSM, ICD). In the globalising universe in which it operates, postmodern psychiatry does show concern for difference, striving to accommodate diverse cultural, ethnic and religious backgrounds. It has institutionalised community and crisis intervention services where patients can voice their difference and negotiate their problems.

Difference versus otherness

What concerns Foucault's critique is not the liquidity of difference and hermeneutics, but the solidity of truth and otherness. Madness is not different because of its unusual, eccentric or abnormal meaning. It is 'other' because the mad person experiences an enigmatic 'interruption of meaning' in his everyday life (Carrette 1999, p. 88). The insane person is fascinated by this interruption, which he experiences as a revelation of an all-encompassing truth, an ineluctable fate that gives meaning to his whole life. Attempting to provide a meaningful context to the deluded idea, especially in the acute phase of its expression, is futile. On the contrary, what is required is a limit-hermeneutics (Foucault 1991), which will demonstrate to the patient that it is his revelatory truth that dictates and organises meaningful connections.

Exclusion or inclusion?

Post-psychiatry advocates a dialogue with the insane based on their inclusion into a vast network of meaningful exchanges. This is indeed a goal consistent with the anthropological pragmatics of reason and the mutual construction of meaning between subjects, but it requires one specification:

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if it is based on an abstract exchange of meaning between transcendental consciousnesses, it risks establishing a monologue on the part of the rational subject controlling the distribution of meaning. As Foucault's anthropological analysis shows, however, subjects and meaning can never be presupposed; they are *effects* of a game of truth challenges, questions and answers between singular, radically other, agents. On the other hand, it is not necessary to go so far as 'to weaken the notion of authority in the field of mental health altogether' (Bracken 2010, p. 227) in order to ensure free dialogue; on the contrary, a solid and rational (but not arbitrary) authority which sets for itself the task of dispelling cases of pathological self-deception is indispensable for universal participation in truth exchange. Finally, the uncontrolled inclusion of otherness has brought about the overmedicalisation of everyday life and has enhanced a consumerist attitude of 'mental health service users'. It has generated new forms of dependence. It is interesting that Foucault himself, the activist against practices of exclusion, warned against the dangers of inclusion and assimilation: 'there are instances when it is necessary to resist the phenomenon of integration' (Foucault 2000, p. 367).

Psychoanalysis

Since the advent of positivism in psychiatry, psychoanalysis has been the most radical anthropological movement. Taking as its starting point the groundbreaking split that hysteria introduced in the 19th century between diagnostic truth and pathological reality (clear neurological symptoms with no anatomical localisation), psychoanalysis reinstated the question of madness in the confrontational relationship between truth, desire and reality (Foucault 2006a, pp. 297–323). It presented itself as a type of medical and psychological practice, which foregrounded the inner tensions of clinical psychopathology and criticised the efforts of medicine to pathologise madness.

Positivism or humanism?

Throughout its complex history, psychoanalysis has adopted both humanist and positivist overtones. As a humanist psychological discourse, it has aspired to liberate libidinal forces from the repression of social exclusion and biologism. It has joined forces with revolutionary movements (Rusquellas 2008, pp. 257–274) and has been a source of philosophical, political and literary critique of theories and institutions. At the same time, inspired by Freud's efforts to reduce the workings of the unconscious to drives and instincts, psychoanalysis has become the protagonist in the expanding system of positivism and normalisation. As Foucault points out: 'if it has played a critical role, at another level, psychoanalysis plays harmoniously with psychiatry' (Foucault 1989, p. 198).

Science or counter-science?

As a science and a rational discourse, psychoanalysis is a quasi-philosophical expression of biologism and experimental psychology, transferring the power of the asylum institution to the figure of the analyst. But psychoanalysis was born as a counter-science, as a discourse on human finitude (Foucault 2002). As Lacan has most emphatically shown, psychoanalysis introduced the notion of the subject not as a stable transcendental agent but as the product of social truth demands (the signifier) and the unconscious as man's most secret truth beyond the limits of representation and at the borders of human experience (Lacan 1981, p. 198). Psychoanalysis has remained at bottom a (neo)alienist theory, forcing psychiatry to reconsider the autonomy of the subject, whose reason contains a kernel of unreason and whose nature contains conflicting interests and contradictory instincts. It is a complex anthropology that upsets the rationalist pretensions of psychiatry and the transparency of its views on man. As Foucault asserts, 'without psychoanalysis, our criticism of psychiatry, even from a historical perspective, would not have been possible' (Foucault 1989, p. 198).

Conclusions

Since the 19th century, psychiatry has perceived naturalism and positivism as the logical continuation of its Enlightenment origins. It has borrowed concepts from evolutionary theory (arrested development/degeneration), seeking to grasp man as a species, in order to be able to speak the most universal, natural language of mental illness. As a result, psychiatric discourse has codified bodily and mental functions in negative terms (neurochemical imbalance, automatisms), reducing them to a spectrum of elementary disorders (errors, abnormalities, deviations). This level of abstraction has caused a regression to the pre-Enlightenment period in reverse: from the era of humoral pathology and the indiscriminate 'Great Confinement' of deviants (Foucault 2006b, pp. 44–78) to the globalised preventive correction of abnormalities and today's promise of the 'Great Deinstitutionalisation'. This same level of abstraction also lacks a coherent definition of individuality. It is not clear who the subject, the concrete bearer of mental illness, is, and to what extent this subject is autonomous with regard to its somatic reality or represents the mere expression of psychosomatic determinism.

MCQ answers
1 b 2 a 3 b 4 d 5 e

For Foucault, if it is worth reconsidering the Enlightenment and the early anthropological practice of alienism to which it gave birth, it is precisely because individuality and its relationship with power and truth reached the 'surface of visible transformations' during this period (Foucault 1997, p. 47). For the alienists of the early 19th century, it is the individual who becomes the organising principle of mental disorder. The individual's body, his will and his relationship with truth, constitute the conditions of the *actual* existence of mental disorder, which precedes any investigation into the conditions of the *possibility* of illness (neurochemical imbalance, automatisms). No biological disturbance, however severe or diffuse, can cause insanity, until it crosses the critical threshold of subjective illusion, until it produces representations that acquire absolute truth value. This is why the purpose of the early 19th-century asylum was not to explore the somatic aetiology of representations or the overwhelming automatism of passions and instincts. It sought the pragmatic (in the Kantian sense of the term) evidence of their delusional transformation by a seduced will to truth – when the patient powerfully or even violently asserted his convictions despite logical refutation and when he showed total disregard for fundamental instincts in favour of single idea. It was only after that observable moment of actualisation that the seductive properties of representations could be subjected to phenomenological and aetiological analysis. The clinic precedes the laboratory, diagnosis precedes aetiology.

Today, the anthropological outlook of alienism, although still present in aspects of everyday clinical practice, has become marginalised and seems in many respects archaic. Yet its critical value is considerable. Unlike most medico-philosophical currents of the 20th century, whose criticism has not escaped abstraction or carries metaphysical or normative overtones (ontological, axiological, cultural), anthropology is a material, holistic, ethico-epistemological and humanist view of man, setting boundaries to the normalising and dematerialising effects of current psychiatric discourse and practice. It is ethico-epistemological because it tackles corporeality and human volition as the constitutive elements of cognition, fundamental for the most extreme forms of illusion and irrational experience. It is humanist because it stresses the suffering subject's fundamental freedom amid the existence of blind, impersonal forces. This freedom, however, is not a possession of the subject by right, it is not its abstract existential quality. It is a risky, reciprocal process of quest, testing and constant verification of experience – it is linked to the exercise of truth.

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MCQs

Select the single best option for each question stem

1 Anthropology:
- a is a science studying cultures exterior to the West
- b is a philosophical structure concerned with human finitude
- c is the precursor of naturalism
- d is an extension of pragmatism
- e is the dominant medico-philosophical approach in psychiatry today.

2 Early psychiatry (alienism):
- a considered delusion to be the core of madness
- b considered delusion to be a case of false cognition
- c treated madness as a disturbed relationship of the subject with reality
- d promoted deinstitutionalisation
- e excluded the mad because they were ignorant of deeper psychopathological mechanisms.

3 Foucault criticises positivism for:
- a rejecting humanism
- b introducing moral values into psychiatric epistemology
- c rejecting the judicial and rationalist version of Enlightenment anthropology
- d medicalising madness
- e violating the patients' autonomy.

4 Foucault influenced the major critical trends of psychiatry in the 20th century because:
- a he advocated a cultural relativism with regard to the definition of madness
- b he maintained that mental illness does not exist
- c he criticised psychiatry for its low epistemological level
- d he disputed the neutrality of psychiatric discourse
- e he stressed the oppressive role of psychiatrists.

5 Foucault's anthropological critique:
- a disputes the organic basis of madness
- b holds that psychiatric discourse is unscientific, insofar as social factors transform its meaning and form
- c condemns the exclusion of the insane
- d considers psychiatric power inherently oppressive and psychiatric truth intrinsically ideological
- e is a critique of pure reason; it seeks to purify truth from the moral and legal forces that subjugate it.