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Contemporary Criticism and Defenses of Psychiatry’s Moral-Medical Types in Light of Foucault’s Lectures on the Abnormal

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In critical social science, the analysis of psychiatry, psychology, special education, and other “psy-sciences” is incredibly important, because these disciplines and the practices relating to them are considered to play an important role in the subjugation, regulation, and transformation of subjects. What is and what should be the strategy of critical approaches when it comes to the analysis of psychiatric, psychological, criminological, etc., categories and categorized subjects? On what grounds could psychiatry and psychiatric treatment be criticized?

One of the strategies, informed by an objectivist perspective, consists of pointing out the relationship between psychiatric treatment and moral judgment or normativity. From there, one can conclude that some usages of psychiatry are not genuinely scientific; therefore, the treatment of real mental illness should be kept separate from the regulation of “deviant” or otherwise “problematic” populations; in the case of the latter, “psy-sciences” should not play a role. To put it simply, social problems must not be medicalized or psychiatrized, and psychiatry should only deal with medical issues on the basis of its own, medically defined territory.

Shall we say then that the treatment of mental illness should be morally neutral, without any basis in other people’s, let alone governments’, institutions’, etc., exterior moral appreciation; that it should be non-judgmental in a moral sense? Certainly, criticisms of psychiatry have often highlighted the moral antecedents and/or components of diagnoses and treatment. By the
same token, these approaches also tried to cast doubt about the scientificity of psychiatry, asserting that it rather deals with moral and not medical types. If this claim is true, then psychiatry is enmeshed with normalizing intentions and institutions, the primary roles of which are social control, maintaining “public hygiene” and discipline, the encouragement of conformist and rule-following behavior by the stigmatization of “perversions” and “deviance,” and so on. These critical approaches include antipsychiatry, various interpretations in the realm of the history of science, but also analyses stemming from critical sociology and social constructionism.

However, it is far from certain that these types of analyses successfully support their criticism, for they often reference incoherent presuppositions and dubious epistemological criticism, which contrasts “good, scientific medical practice” to “bad, biased practices entangled with power relations.” In these criticisms, what really is at stake is the scientific status of psychiatry; and when psychiatry does not prove to be scientific enough, then it is considered a discipline serving only the power interests of dominant groups and institutions. Nevertheless, in these approaches it is not outright excluded (and more often it is even asserted) that there is potential for a kind of psychiatry that deals with genuine mental illness, independently of any exterior social or moral influence. In turn, defenses of psychiatry usually tried to refute the meaningful connectedness between psychiatry and morality by simply reaffirming the medical model.

However, it should be noted that it is not possible to distinguish between bodily and mental illnesses by only taking into consideration their respective relationships to normativity and normality—contrary to the intention for example, of Thomas Szasz’s antipsychiatry. It is well known at least since Georges Canguilhem’s *The Normal and the Pathological* that even physical illness cannot be defined in a neutral, statistical, and objective manner that relies only on exterior norms, because it is always necessarily linked to the individual’s own values and norms (just as in the case of mental illness): “. . . a statistically obtained average does not allow us to decide whether the individual before us is normal or not. We cannot start from it in order to discharge our medical duty toward the individual. When it comes to a supra-individual norm, it is impossible to determine the ‘sick being’ (*Kranksein*) as to content. But this is perfectly possible for an individual norm” (Canguilhem 1978, 105).

This view, without referring to Canguilhem, is also echoed by philosopher of psychiatry Eric Matthews (1995, 20), who asserts that “‘illness’ is
a value-laden concept, since ‘being ill’ is by definition being in an undesirable state. In that sense, there is no difference between undesirable bodily and mental conditions: they can both be considered as ‘illness’. . . . If we are to make a distinction between literal (bodily) and metaphorical (mental) illness, however, the crucial question is for whom the state is undesirable, or by whose standards.” Also, continues Matthews (1995, 20), in spite of the fact that objectivist views on medicine are quite misleading, they are still firmly anchored in present-day reflections: “modern conceptions of health and illness imply that health is a non-moral good, and so that illness is a ‘disorder’ in a non-moral sense”—a view against which Matthews forcefully argues.

From all this follows that if one, by adopting an objectivist perspective, takes psychiatry to be a strict medical science or, by taking a normative stance, a would-be medical science, then she surely repudiates any link with moral and social norms as spurious. Either she rejects any accusation of psychiatry as moral and intertwined with power relations in any way; or if she recognizes the existence of such links, she would still make suggestions to purify it, with the intention of making visible its supposedly true scientific nature. Since within this kind of framework critics and defenders of psychiatry adopt a common epistemological stance, their respective positions are not very far from each other.

However, recently other types of defenses have appeared, along with other types of criticisms. These defenses, in flagrant opposition with previous ones, try to argue for the non-contradiction between morality and rationality (Charland 2006, 2008, 2010; Zachar and Potter 2010; and in a very different vein Castel 2009, etc.). They also do not view this connectedness as problematic with regard to psychiatry’s scientific status. Some of these approaches (of which I will only deal with that of Louis Charland here) state that a rational norm for mental illness can be created, which, at the same time, is not and cannot be separated from the moral component; others may even advocate for the relevance of the moral treatment of personality disorders; and the topic of moral responsibility and forensic psychiatry re-emerges as well.

It should be noted that the claim of the inseparability of moral and rational aspects also characterizes some types of criticisms as well, but these are different from antipsychiatry or social constructionism. These are approaches that neither intend to sort out the elements of morality in psychiatric diagnoses and practice, nor do they strive to prove psychiatry’s irrational or unscientific character. Here, we should mention, in the first place, the genealogies of Michel Foucault and other authors inspired by him, like Nikolas Rose
or David McCallum. Therefore, the question should be posed: how can this non-separation be some times affirmative and at other times critical? To give a tentative answer to this question, it is worth re-examining the genealogy of forensic psychiatry provided by Foucault in his Collège de France lectures on the birth of “abnormality,” entitled *Abnormal* (Foucault 2003).

But let us consider first the traditional criticisms of psychiatry, which operate by highlighting the moral components of the diagnoses. The type of criticism exerted by the antipsychiatry of Thomas Szasz is the following: so-called mental illness is diagnosed on the basis of external behavior, including expressions of attitudes and beliefs. Szasz’s argument is the following: since the behavior is the patient’s own behavior, it cannot be considered as alien or undesirable to her. On the contrary, more probably it follows her norms, which might contradict the norms of society that the patient refuses to follow. Therefore, according to Szasz, psychiatry resembles much more the activity of policing and rectifying individuals considered abnormal, than a medical specialty: “the psychiatrist’s task is not to improve the patient’s condition in terms of the patient’s own standards of well-being, but to make the patient’s behavior and attitudes conform to social standards to which he or she is at best indifferent” (Matthews 1995, 21). In contrast, “a truly therapeutic attitude should be non-judgmental: that is, it should be able to set aside as irrelevant any value judgment about the patient’s condition other than those of the patient him- or herself” (Matthews 1995, 22).

Furthermore, according to Szasz, psychiatry operates with a naturalistic bias, as if it was a medical specialty, by mistaking the mind for the brain. However, psychiatry could never become a medical science, says Szasz, for it has to deal with meanings, signs, modes of conduct, interpretations, rule-following behavior, and has to take into account the essential liberty of human action—all that is underdetermined by possible bodily processes. However, sometimes even Szasz asserts that a non-medical scientific psychiatry could exist, if a science of personal conduct existed, on which it could be based. But at other times, this scientific nature as such becomes doubtful, as if psychiatry were not and could never be a science—for it is not a natural science and does not deal with illness, that is, with something objectively given.

Szasz’s main example for medicalized mental illness is hysteria and “hysterical conversion.” For this kind of symptom, bodily signs symbolize personal problems. Szasz claims that contrary to the psychiatric interpretation, hysteria is an idiom in which patients communicate their genuine psychological prob-
lems in a covert manner. Also, the actions performed under the description of hysteria may be explained by the existence of social norms: in some situations it is not possible to express one’s desires or to ask for help in an open way (Szasz 1974, 145–46). But will the symbolization of hysteria become “personal and idiosyncratic” only because it is not “anatomical and physiologic”? We will see that this is far from evident.

For Szasz, bodily illnesses are events producing indexical signs as symptoms, whereas hysteria and other phenomena called mental illness are actions producing iconic and conventional signs (Szasz 1974, 120–34). Now the critique of Szasz consists in highlighting the way psychiatry transforms iconic and conventional signs into indexical signs, thereby establishing a firm causal relationship between disease and symptom. But this is a deeply flawed practice, for in most cases of mental illness, symptoms are not pre-determined and partly depend on the choice of the individual, on her more or less free intention to express the psychological and social state in which she finds herself. Therefore, these symptoms are misperceived by psychiatry.

Szasz strictly contrasts pathological to moral, body to mind. For him, there are clear, definable limits to what we could legitimately call illness. According to critical psychiatrists Patrick Bracken and Philip Thomas, for Szasz, “problems with our bodily functions are properly understood to be pathological, but difficulties with our thoughts, feelings, relationships, and behaviors are of a different order. They are not pathological, not diseases or illnesses; they are best characterized as ‘moral’ issues or simply ‘problems in living’” (Bracken and Thomas 2010, 220). Szasz thinks that the only essential things that come forth in psychiatric treatment are the moral issues, which are pathologized and therefore misunderstood. The task for Szasz is to keep them separate from the power of psychiatry and disentangle them from external standards and judgment. This can only be assured by therapies exerted on a free and contractual basis, while psychiatry is the agent of the state inculcating biomedically naturalized moral standards.

The connectedness and desirable separation of moral and medical categories, although in a different manner, appears as well in the program of critical sociology and constructionist approaches, which intend to unmask how psychiatric treatment is intertwined with social influences, including moral subjugation and social control mechanisms. How is this constructionist criticism achieved? How do social constructionist approaches proceed when they analyze psychiatric, psychological, criminological categories, and categorized
subjects? They do not intend to examine the nature or the supposedly inherent characteristics of psychiatric patients that would emerge due to supposedly preexisting disadvantages, impairments, or illnesses. Rather, they are curious about how these definitions or categorizations are constructed. They bracket everything that is considered to be “objective” by psychiatric categorizations, and investigate how these very categorizations come about.

The main targets of constructionist approaches have been the objectivist and functionalist analyses of social and mental pathologies considered objective. In contrast, labeling theorists or constructionists are inclined to deal with institutions of social control. In their view, deviance and the perception of deviant groups, including the mentally ill, is created by reactions to certain conduct; therefore, they refrain from formulating anything with regard to their objective reality. However, the question arises, how can the deviant/mentally ill label be criticized? What could be the basis of the critique? There are several, although implicit or unconscious strategies employed to solve this problem.

Steve Woolgar and Dorothy Pawluch, in their article entitled “Ontological Gerrymandering” written in the eighties, revealed an inherent ambiguity in social constructionist explanations. According to the authors, social constructionist researchers “elaborate the imperative to study definitions of social problems rather than the imputed conditions themselves. To do so, they employ the assumption that in many cases definitions of social problems vary while conditions (defined) do not” (Woolgar and Pawluch 1985, 216). For sure, constructionists consider these definitions of problems as morally loaded, which, thereby, distorts the perception of the conditions. Therefore, by presupposing some “stable conditions,” they seem to tacitly reintroduce the reality of deviant behavior or mental illness, but before its definition as such, as a kind of preexisting reality, which could be distinguished from its morally anchored and arbitrary definition. Woolgar and Pawluch name this procedure “ontological gerrymandering.” This practice could be epitomized by the formula they borrow from a constructionist researcher: “The same ‘objective’ condition may be defined as a problem in one time period, not in another” (Gusfield 1981, 8, cited in Woolgar and Pawluch 1985, 216). This is a kind of ontological manipulation, which renders uncertain the status of definitions by referring to a so-called more real reality. For researchers generally implied that the label or definition, as a putative characteristic, does not have a basis in reality; “putative,” suggesting that it is not true or not grounded in reality. But the problem, which was never reflected upon, is the following: what is the nature of the reality to which they are supposed to be referring? For this so-
called reality has already been bracketed by the initial methodological considerations, and therefore has never been examined by sociologists.

Applying this kind of constructionist approach to psychiatry is attractive because it makes it easier to take a normative stance, namely by the tacit adoption of a realist criterion of truth through the presumption of an ever-existing reality (though structured in a specific way) that only has to be unveiled by science. However, according to constructionists, the discovery of this reality is only possible if scientific practices are not diverted by social influences. This line of thought is characteristic of Thomas Scheff, for example, who worked within the labeling paradigm. Scheff cites five case studies, where he finds “strong relationships . . . between such social characteristics as class, and commitment rates, with psychiatric conditions controlled for. These five studies support labeling theory since they indicate that social characteristics of the patients help determine the severity of the societal reaction, independent of psychiatric condition” (Scheff 1974, 449, italics are mine). Therefore, Scheff not only admits that there might be a genuine psychiatric condition, but relies on it as something objective in order to formulate his critique. In fact, in the strategies mentioned, criticism can be inserted by virtue of the separation of the conditions from their definitions, for these definitions seem to be merely the consequence of the historical and social changes in the context of the defining subjects, and not due in any way to the defined objects.

Other social constructionists adopt a different strategy, denying the existence of underlying objective phenomena as such under the constructed definition. They “rely on the theoretical principle that all societal reactions might be unwarranted” (Woolgar and Pawluch 1985, 223). However, in this way, they only fail to account for the very real effects of scientific categorizations, while still tacitly (and unconsciously) referring to the already bracketed objective reality. It is philosopher of science Ian Hacking who advanced a most perspicacious critique of social constructionist talk (Hacking 1999). The inherent ambiguity of social constructionism is that it implies that construction equals non-existence or not-genuine-existence, whereas researchers only point out that the emergence of the objects in question was not inevitable: they have been created in a historical and social process. The first problem Hacking identified is the way criticism is generated. What constructionists actually demonstrate is that it would have been possible that the objects in question did not come into existence. But then they misleadingly conclude that the objects do not actually exist, or that they only exist in the minds of those persons who construct the categories. It follows that the critique of
psychiatry could be formulated by pointing out the fictitious entities of its own creation. But of course, it is not the case that it would be contradictory to assert at the same time that the object is fabricated—it has come into existence at a certain moment, has a history—and that at this very moment it exists as something real. The process of construction does not imply at all that the object is non-existent (we could actually argue for the contrary; see, for example, Latour 2013).

Second, most of the time, social constructionists also misunderstand the things they regard as constructed. For while they usually talk about the construction of objects, in their analyses they only examine the construction of the categories and the definitions (Hacking 1999, 47). In discussions about the constructed nature of the categories, they fallaciously imply that the objects are constructed as well, along with the tacit assumption that they know how the real objects—contrasted with the “constructed” ones—look. If this is the case, then we are back to the previously analyzed problematic of “ontological gerrymandering.”

Third, and most importantly, it is not all about concepts. It is also about the emergence of those objects designated by the concepts. This means that construction should be taken seriously: the psychological sciences, in spite of, or maybe due to their moral character, have an ontological role. They influence and produce parts of reality by creating not only theoretical entities, but also real ones. If this is the case, the moment of construction cannot become the locus of the critique.

Woolgar and Pawluch, by the end of their article mentioned above, ask whether it is possible to describe phenomena independently of their ontological status. And, if there is no objective element, would criticism still be possible? Therefore, the question is if criticism can be exerted without having recourse to an explicit and exterior norm, without having to take a dubious epistemological stance. In this respect, I will examine Foucault’s genealogy of forensic psychiatry.

But before I do so, let me turn to some of the counter-tendencies in theoretical reflections on psychiatry, to those defenses that try to accommodate moral terms and morally defined categories with scientific formulations, thereby saving psychiatry from this type of criticism. If morals and the practice of psychiatry do not contradict each other, then psychiatry is rescued on the epistemological level—where this battle has actually been waged. In this respect, I will only cite the thoughts of the philosopher Louis Charland. According to
him in the DSM IV, Cluster B personality disorders (but not the others) are identified through explicit moral terms and notions such as “lying,” “lack of empathy,” or “conning others” (Charland 2006, 119). A condition defined in this way is evidently moral, but for him, this is unproblematic. He calls his first argument for the non-separability of moral and medical kinds the “argument of identification.” His second argument comes from treatment, which can be formulated like this: “there is an important difference between, say, ceasing to be depressed on the one hand and ceasing to be a liar on the other. The difference is that the first case can be seen as a cure while the second case is tantamount to a moral conversion” (Charland 2006, 122; see also Charland 2010). According to him, the “psychopathology of affectivity” is the branch of psychopathology devoted to the study of mental disorders implicating mental states associated with moods and emotions, which used to be called passions. He traces back this usage of affectivity to eighteenth-century conceptions of morality, evoking thoughts of Rousseau and Hume. Defending psychiatry’s scientific quality, he also turns to nineteenth-century moral treatment and Pinel, who, according to him, “believed that the new psychopathology of the passions had to include elements of value and especially morals along with psychological terms and notions generally.” Therefore:

For Pinel, “moral” often means what is mental and what, additionally, has to do with morals. But not always, since there are many instances where psychopathology is only concerned with states that are psychological and morals are not involved. Pinel saw no contradiction between acknowledging the psychological aspects of moral treatment (le moral) while at the same time insisting it had important ethical presuppositions (la morale). (Charland, 2008, 9, italics are mine)

Charland claims that medicine can contribute to ethics by showing how social and personal lapses in morality can often lead to mental illness. Charland disregards anything that could be considered as problematic in moral treatment and completely neglects the history of personality disorders. Furthermore, he asserts that according to Pinel’s documentation, his “treatments based on ‘moral’ principles and notions in the widest psychological sense were often extremely successful” (Charland 2008, 26).

Even though we could qualify Charland’s analysis as utterly naïve because it lacks historical reflection on the functions psychiatry could fulfill in different apparatuses of power, while positing some unchanged human moral
character that can become the object of a stable science of personality, it does point to some important insights regarding the potential critique of psychiatry. Namely, it highlights the blind spots of epistemological criticisms that rely on the attitude of “purification,” and intend to sort out legitimate (pertaining to “real” illness) and illegitimate (imbued with effects of power and morals) features of psychiatry.

Common refutations of, for example, the symptomatology of “antisocial personality disorder” would point out that starting from Prichard’s “moral insanity,” “theorists have always confused undesirable behaviors with mental aberration. The reason for the confusion between antisocial personality disorder and criminality is that there has never been a clear definition of insanity or mental disorder” (as the Sydney-based psychiatrist John Ellard put it, cited in McCallum 2004, 28). According to this claim, had there been a clear definition, this confusion would not have been possible, and the purity of “real” psychiatric diagnostics could have been preserved. David McCallum, analyzing these critical interpretations, points out that the problem formulated by them is the lack of distinction between insanity and wickedness. Also, this is precisely the point where criticism can be inserted; namely, the critique of this non-distinction. In fact, the strategy of these critical theoreticians is to assert that the fundamental distinction had been lost in the successive confusion of medicine with morals, the figures of which can be rendered as the following: Isaac Ray’s (1871) “moral mania,” Spitzka’s (1887) “moral imbecility,” Koch’s (1891) “psychopathic personality,” Cleckley’s (1941) “psychopath,” Bowlby’s (1949) “moral defective,” and finally the first Diagnostic and Statistic Manual’s “sociopathic personality disturbance” (1952). So “these (critical) . . . accounts assign a prior existence to different categories of mental illness and disorder independent of their historically specific means of calculation” (McCallum 2004, 29). Therefore, these criticisms accept the existence of unhistorical psychiatric entities, which would only need to be purified from contamination by power, social norms, and morals. Once again, we are back at the unfounded epistemological criticism called ontological gerrymandering.

We saw that for Szasz, what is at stake is the recovery of some original meaning, which was supposedly lost in psychiatric treatment. He does not intend to salvage the science of psychiatry, but rather the idiosyncratic self-expression of the individual. According to him, communication by hysteria proceeds by a somewhat autonomous series of signs that is not predetermined by some underlying illness. Yet psychiatrists wrongly interpret it, thereby distorting it. So, what is the relationship between this therapeutic activity and the
original intention of hysterical behavior? It seems that this is a relationship of permanent misunderstanding, where psychiatry fails to attribute the symptoms to the will of expression of the individual, and constructs an underlying substance instead, that is, an illness. There is no real interplay or communication between the psychiatrist’s interpretation and hysteria, and thereby no mutual influence: the psychiatrist is deaf to the real issue.

However, as we can learn it from Foucault, the problem is far from being resolved by the restoration of a kind of “hermeneutical relationship” that has allegedly been masked by the construction of (pseudo-)natural kinds, or essences. Szasz’s hermeneutical approach pretends that the subject-objects of the human sciences already bear a pre-existent meaning, which is to be sussed out. However, even if Szasz does not present this meaning as substantial, he does not take into account either the entanglement of power relations or the production of knowledge. The individual, the subject of psychiatry, constructs his own subjectivity with the help of pre-established interpretative schemes, even if he is not incorporated into a coercive institutional environment. Therefore, as Foucault implies, nothing could be the adequate interpreter of subjectivity, for subjectivity does not exist before interpretation, but interpretation can only take place among power relationships.

In Foucault, we find no a priori image of a “good science.” Science is examined as it is being made, and there is no explicit normative stance adopted capable of judging it. In his genealogy of the “abnormal” (Foucault 2003)—a thoroughly moral concept and object—psychiatry plays a huge part. According to Foucault, psychiatry took on a significant role in the realm of justice in relationship with some particular events, and especially with the appearance (in its psychiatric definition) of “homicidal monomania” (Foucault 2003, 119). This symptom characterizes a type of “moral monster” and the crime committed by him. In this case, the perpetrator of the crime, according to expert psychiatric assessments, is not insane; however, his act seems to be unmotivated. Outright madness is excluded, but the subject and his act still do not look rational because it is not possible to understand his reasons. Therefore, the criminal court has to look for motives in order to be able to make the act intelligible, which is now—from the beginning of the nineteenth century on—a precondition for punishment. These motives will be detected in the character of the perpetrator of the act, without which the criminal court would be helpless. According to Foucault, law has “a radically uncomfortable position” while dealing with a “motiveless act committed by a subject en-
dowed with reason.” If this is the case, the situation becomes difficult: “the exercise of punitive power can no longer justify itself, since we find no intrinsic intelligibility of the act through which the exercise of punitive power connects up with the crime. . . . Consequently, it can no longer judge; it is obliged to come to a halt and put questions to psychiatry” (Foucault 2003, 116–17).

Therefore, the legal norms will be applied by the mediation of extra-legal norms, which are, in this case, the psychiatric norms, and which, in turn, create the figure of the abnormal. In the juridical sentence as well as in medical assessments, the “abnormal” character will replace the perpetrator of the crime. Extra-legal norms obey a different type of rationality, but they can be integrated into the legal machinery, thereby creating the relationship between criminality and mental illness, whereas, before, these two were radically different: the mentally ill person, by definition, was not responsible for his acts. From now on, the sentence will be based on the morally qualified personality of the criminal, beyond his acts. It is applied to the criminal, who is not perceived as someone breaching the law or as a perpetrator of a crime, but as an “abnormal,” that is a morally-psychologically defined individual (the pathological nature of whom is attested by his “inclination” or even “instinct” to violate the norms). The objective of the sentence will not be limited to punishment, but will equally comprise correction—and undoubtedly, penal institutions will have an important role in the use of morally-informed therapeutic procedures. Psychiatry was invented and has always been practiced as a moral discipline; furthermore, as it emerged that its conditions of possibility were thoroughly moral, the intention of liberating or purifying it from morality simply does not make any sense.

However, the fact that psychiatry proceeds by constructions does not prove its anti-scientific character, because these constructions appear not only in the order of knowledge, but just as well in reality. Psychiatry creates the conditions under which its objects can appear as natural, as if those pre-existed its functioning. But of course, this means neither that these objects existed as such before the work of interpretation, nor that by dismissing the interpretation (the construction work) provided by psychiatry, individuals can regain their “real nature” and interpret themselves freely, without any constraints.

For these reasons, the critique’s point of attack should be the fact that psychiatry produces its subjects in a certain way, rather than its epistemological status. Psychiatry cannot be blamed for epistemological fallacies, because the connection between power and knowledge cannot be disentangled. Foucault accepts that psychiatric sciences can be scientific because, for him,
“scientific” is not a value-laden concept, while what counts as scientific is historically changing. He does not intend to criticize them by unveiling their so-called unscientificity: he does not have a normative epistemology. “. . . I believe that the problem does not consist in drawing the line between that in a discourse which falls under the category of scientificity or truth, and that which comes under some other category, but in seeing historically how effects of truth are produced within discourses which in themselves are neither true nor false” (Foucault 1980, 118). Therefore, it is not possible to investigate the nature of psychiatry as a science independently from the entities with which scientific classification deals. The functioning of the science cannot be separated from its objects on which it works—this is the sense of the interior relationship between power and knowledge. The epistemological type of critique had to turn a blind eye to this problem, for it was only able to examine constructions in the order of knowledge. In turn, it rigidly separated these constructions from the purportedly erroneously categorized “real” objects. Furthermore, it omitted the empirical examination of the latter, thereby creating an insurmountable contradiction.

In contrast, the question for Foucault is how mentally ill, handicapped, criminal, etc., populations come about as real entities, and how they are constantly transformed due to scientific classification and other scientific practices. Techniques of transformation exerted on patients can work (without necessarily being successful) because of the institutional treatment (the sentence and the modes of punishment based on the category of an abnormal sub-type), and also because individuals apply these norms to themselves, by which they form their own subjectivities. By the fact of her subjugation to norms, the subject creates new, unprecedented forms of behavior, including forms of resistance, and in turn, institutions will have to elaborate new forms and procedures in order to counter them. (In Hacking’s vocabulary, psychiatric patients can be described as “interactive kinds,” which makes them “moving targets” when it comes to the interpretation of their character and behavior (Hacking 1999 and 2007).

For Foucault, psychiatry, its categories and subjects, are either constructed or cannot exist, which does not mean that he endorses its particular methods, results, and, especially, consequences; on the contrary, they all should be criticized. The subjects (that is, the patients) dealt with in psychiatric practice have a particular kind of objectivity. This reality is thoroughly constructed, but this fact, in the absence of a clear norm of “objectivity,” does not reduce the scientific quality of psychiatry as a science. This is the reason
criticism cannot redirect the mode of truth construction in the terms of an objectivist science, but can only criticize the way in which these scientific objects, which are, in fact, subjects, emerge.

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