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Inviting Relational Responsivity

Nick Drury 2017

ABSTRACT

This paper reviews Foucault's account of the social construction or "fabrication" of the 'autonomous self' for the purposes of political governance over the past millennia in Western Culture. The emergence of the 'psy complex' over the past two centuries, as an aspect or expression of political governance, is deconstructed to show how unnecessary explicit rules and superstitions are generated to account for interpersonal relationships. Once we recognise that we are relationally responsive by nature these fictions dissolve. This has practical implications when we compare Pinel's 'medical model' of psychiatry, where "autonomous" practitioners attempt to leverage or engineer change in "autonomous" patients, with Tuke's ethical engagement with brethren, where the engagement itself induces change. The paper concludes with a suggestion for the 'psy complex' to reposition itself in political governance processes in order to facilitate greater relational responsivity or further steps to an ecology of mind.

KEY WORDS: Foucault, Levinas, Pinel, Tuke, relational responsivity, psychotherapy ethics

The Foucauldian analysis offered in this paper follows the usual protocols, which includes a critical history showing the development of contemporary thought and practice on a particular topic, in order to not only disturb conventional understandings but to create space for alternative ways of dealing with that topic (Dean, 1994;

Dreyfus & Rabinow, 1983). The focus here is on the different understandings of 'the moral treatment' as understood and developed by Pinel (1806) and Tuke (1813), which not only led to the 'fathering' and positioning of the 'psy' disciplines, but provide the basis of our current mental health clinical endeavours.

In his early work (1964, 1973) Foucault questioned whether the 'psy' disciplines in particular (or the social sciences in general) are 'sciences'; in that (unlike the hard sciences) the grounds they are built upon cannot assume that such 'things' as 'madness' and 'sanity' are objectively knowable or discoverable things (i.e. tightly definable). He claimed that such 'things' are given much of their reality status by the very practices that made these 'sciences' possible. Prior to the emergence of the 'psy disciplines' our discourse on madness appears to have been, in some ways, much richer and fluid. For example Locke (1700) noted that "the disorderly jumbling of ideas together" is to a greater or lesser degree common to us all; and those we deem mad "do not appear to have lost the faculty of reasoning entirely". So a Foucauldian analysis takes the view that 'truths' are largely socially constructed by the *episteme*, or world-view they arise within.

A Foucauldian analysis also understands that 'truths' are intimately bound to power, as power is largely enacted through what we believe to be true (Foucault, 1980). Power/knowledge (Foucault saw them as so bound, the words cannot be separated) not only constrains us, but also produces us. Understanding how this occurs is useful here as it enables us to see how an alternative understanding of the 'moral treatment' might lead to the social construction of a different world. Foucault offered a 'triangle of power' to facilitate an understanding of power politics, which in many ways shows

how the ‘psy’ disciplines emerged centre-stage. His triangle of power is made up of sovereign power, disciplinary power, and biopower. Although a little light on the inspirational aspects of *sovereign power*, Foucault’s description of sovereignty is our traditional idea whereby the ruler controls by laws enacted through fear and punishment. However a society where people govern themselves is much easier to control than one mostly through law; so Foucault identifies how *disciplinary power* became more prominent and clearly visible during industrialization. Largely begun in monasteries, followed by the drills of the barracks and classrooms, it is where people are “invited” by “carrot and stick”, to discipline their own behaviour so that it aligns with ‘norms’ that are set by either sovereign power or biopower (Lilja & Vinthagen, 2014). Foucault (1978) identified the prison, post the Enlightenment, as exemplifying disciplinary power well. As the prisoners come increasingly under the ‘gaze’ of the guards, the prisoners’ behaviour is increasingly affected by their beliefs as to what the guards are looking for. Now *biopower* is a set of truth discourses, usually about the ‘health’ of society (including economics) circulating within a society (Foucault 2008). (White and Epston’s ‘Narrative Therapy’ (1989) stems from an understanding of this.) Foucault (2006) showed how the psy-complex arose to play a central role in the development of biopower over the past two centuries; by appealing to the rising popularity of scientific discourse as it put into public circulation sets of ‘norms’ that people can measure (diagnose) and discipline themselves against. As noted above, there is a certain amount of fluidity to these ‘norms’ or ‘truths’ in that they are created (constructed) by the very process of their identification; then shored up by statistical analysis. Variations in biopower’s form show themselves when a change in biopower occurs, such as when we moved from the post-depression Keynesian welfare state to Thatcher-Reagan’s neoliberalism: a different set of statistics, values and norms

became dominant (Dilts, 2011; Read, 2009). The self "fabricated" when we shifted from Keynesianism to neoliberalism was far less secure and far more entrepreneurial (Bröckling, 2016; Lazzarato, 2009). Cabanas (2016) calls these neoliberal individuals 'psytizens', driven by positive psychology's "happiness industry".

'A Cartesian Moment'

If the 'self' is largely "fabricated" in the "cruel ingenious cage[s]" of disciplinary processes (Foucault, 1978), then psychologists may well be interested to know of Foucault's ideas on "the art of not being governed quite so much" (1997). Such an understanding provides us with some guidance on our potential to resist current power-knowledge structures and forge new ones (Butler, 2002).

Foucault's (2005) work in this regard began by showing us how a disembodied Cartesian mind was constructed (fabricated) about a thousand years ago, when the Church first promulgated the idea that rationality or reason on its own could allow us access to the truth about ourselves. Foucault called this a "Cartesian moment" even though it precedes Descartes by hundreds of years; and so Descartes himself becomes someone articulating this idea. Strange as it may sound to us today, prior to this moment, "one could not be impure, immoral, and know the truth" (1984, p.372). This is because the 'truth' sought about oneself, for the Greeks, was 'wisdom', and wisdom was seen as a matter of perceptual-performance knowledge, rather than a conceptual knowledge. More a matter of 'recognition', like when you look in a mirror or hear a recording of your voice, rather than ideas about oneself. What we

said (our conceptual knowledge) was just an expression of this. This wisdom, or recognition of oneself, could be cultivated or deepened through a special kind of care of the self, which the Greeks called '*epimeleia heautou*'. Our performance changed as a result of recognizing subtler aspects of ourselves; and this kind of self-discipline was brought to the fore especially whilst engaging in "I-thou" relationships of care of others (Buber, 1937). For the Greek and Roman senators, this was "the wife", "the boy" and "the citizens" one governed (Foucault, 1986). This kind of self-discipline doesn't require the stick and carrot, it is not a struggle against oneself. We witness it amongst many women (not all), who on discovering they are pregnant, find little difficulty to stop smoking or drinking. It encourages an "I-thou" relationship with self as well as others; whereas Descartes encourages an "I-it" relationship with others and self. '*Epimeleia heautou*' begins with a recognition that our relational responsivity generates responsibility.

Thus for Foucault, this "Cartesian moment" was a re-write of the Delphic Oracle's 'know thyself' (*gnōthi seauton*). As Lane (2008) put it when he recognised he was a relationally responsive being: "….I began to let go of the images and concepts of me, …the notion of me as some separate and historical being died – and a human being was born" (p. 3). That we are innately relationally responsive is apparent when we imagine encountering a three-year-old lying on the road bleeding. We are instinctually 'called' to respond. This is central to the philosophy of Buber, Wittgenstein, Merleau-ponty and others. In this regard Levinas (1998) calls his philosophy an "ethics-first" philosophy, as my first response to another is a reflexive ethical one; which occurs before I think. Now Foucault's argument is that the theologians lost faith that *epimeleia heautou*

would generate self-discipline, and so began requiring their flock to (conceptually) know they were sinners by reflecting in the mirror of the ten commandments, 'confess' their sins, and take guidance from the church. A thousand years later and the confessional has been taken over by the 'psy' disciplines, and people are disciplining themselves largely by our 'truths', and are out of touch with their human nature (Foucault, 2011).

'Psy' Disciplines pre-history

Foucault (1964) reports that from about 1650 onwards, as Europe industrialised and self-organised, those deemed non-productive (or 'unreasonable') were interred in various institutions, e.g. workhouses, poor houses, houses of correction. He called this the period of 'the great confinement', leading to one in a 100 Parisians to be confined by the early1700s. However, as the Enlightenment philosophy developed, madness became increasingly separated out amongst those so confined, and the view that it was a form of degenerative bestiality constructed. So much so, that by the late eighteenth century, the poor, the delinquents, the debtors, and their growing army of human rights advocates, were demanding and obtaining segregation from the mad. By that time, Bethlem, specializing in madness, competed successfully with the Tower of London (which had lions) and Bartholmew Fair in the tourist industry; for here, humanity's bestial nature, which lay beneath the façade of reason, was on display (Porter, 1991). Charging a penny a visit, Foucault (1964) calculated 96,000 visits a year to Bethlem, where, like in other institutes, the mad were trained to perform with "a few flicks of the whip".

The therapies that were in existence tended to largely follow suit in their cruelty and harshness, as they aimed at taming this bestial nature through whippings, beatings, isolation and keeping them shackled. This cruelty abruptly changed in form, according to Foucault (1964; 2006), when an epistemological rupture occurred late in the eighteenth century. The human rights sentiments of the Enlightenment (which saw the French and American revolutions and the abolition of chattel slavery) swept the Western world. However, Foucault (1964) claims that the physical cruelty just gave way to psychological cruelty; beatings to threats. Importantly, Locke's (1700) (and others') observation that there is a sliver of reason in the madman was seized upon, and the idea that a cure (or more importantly for industrial society, a return to productivity) might be affected, gained attention. So the received view today is that Dr Pinel, with a sentiment of enlightened compassion in his heart, entered the Bicêtre Hospital in Paris in 1792 and struck the chains binding the lunatics to the floor of their dungeons; who in turn, expressed their gratitude to Pinel by embarking on a path to cure. This was the commencement of the 'moral treatment' and "this is what passes for the initial, founding scene of psychiatry" (Foucault, 2006, p.19).

Of course the actual story is a little different. The chains were struck from the mad by the superintendent of the Asylum de Bicêtre, Jean Baptiste Pussin, three years after Pinel had moved on to the Salpêtrière. Pinel (1806) acknowledges learning 'the moral treatment' largely from his observations of Pussin and his wife Marguerite Jubline, whom he subsequently moved to the Salpêtrière to be his superintendents there. He also learnt from the writings of Francis Willis (who had treated King George III in England) as well as numerous other "charlatans" or "empyrics" (or 'lay concierge') practicing in Europe. Medical

specialization was rare then, and specialist surgeons, without any theoretical knowledge who had learnt from practice, and were thus disdained by the official medical community (hence 'charlatans' or 'empyrics') hawked their services, for example as "hernia stone-cutters". They were often more successful because of their specialization. It wasn't until the shift from the humoral theory to the specific disease model at the turn of the nineteenth century (Foucault, 1973) that medical specialists were called into existence, where "every organ has its priest". Pinel, as one of these new medical specialists, brought a philosophical rationale that appealed to the medical and scientific community to the 'moral treatment' learnt from Pussin and others. Similarly, William Tuke, the other major 'father' of the 'moral treatment' (whose work was written up by his grandson Samuel), learnt a great deal of his version from his superintendents at the Quaker's Retreat in York (George Jepson and his wife Katherine Allen). By contrast, Tuke brought a moral philosophy to account for the Quaker's treatment, but unfortunately this has been largely overshadowed by Pinel's more 'scientific' one (Charland, 2007).

Tuke and Pinel: essential differences

In 1796, William Tuke led some Quakers in York, upset that one of their own had died as a result of harsh treatment in the York Asylum, to establish the York Retreat. They took the view that these people were their ***equals*** or 'brethren' (at first treating only Quakers) in need of love and kindness. In a loving environment, their God-given propensity to recover their reason would manifest or their 'inner light' would flourish (Digby, 1985; Tuke, 1813). Treatment

elsewhere "was, too frequently, calculated to depress and degrade, rather than awaken the slumbering reason" (Tuke, 1813, p. 18.) Although their successes were perhaps over-stated, they had a steady stream of visitors wanting to repeat what they had done in other parts of the world. Many of their emulators also rejected, as they had, medical or psychiatric leadership (Whitaker, 2015).

However, Pinel (and the psychiatrists who succeeded him) had a far greater influence on the era of asylum building (and the development of the 'psy' disciplines), which followed in the wake of reports on the success of moral treatment. Even though Pinel eschewed the medical treatments for madness that were in vogue (e.g., blood-letting and drugs), he offered the medical community a rationale that appealed to them (Berrios, 1985; Digby, 1985; Grange, 1961). Unlike Tuke, there is no indication, from the very beginning, that Pinel and the psychiatrists saw their patients as equals. This difference may well have been decisive in the subsequent development of psychiatry and therapeutic psychology (and to the fate of those deemed insane). Pinel's approach was far more 'technical' or 'manipulative'; "I-it" rather than "I-thou".

As mentioned above, this was a time when the medical 'gaze' was shifting from the balance of humours paradigm to the specific disease paradigm. A shift from "what's wrong with you?" to "where does it hurt?" (Foucault, 1973). A trade in cadavers developed so students could see the diseased organs. Pinel was one of the leaders of this movement, and perhaps played an equally if not more important role in that shift, which brought doctors from around the world to Paris to learn. The first vaccination in Paris was given at Pinel's clinic. This led

to a more 'engineering' approach to illness; having identified the disease through a comprehensive assessment, the task then, was to apply biological leverage to ameliorate it. When we read the case studies of Pinel, if we didn't know better, we might well think that these are missing chapters from Jay Haley's classic text on strategic therapy, *Uncommon Therapy* (1993). For example, Pinel and colleagues at the Bicêtre set up a fake (unbeknown to the patient) trial of a tailor deluded that he should be guillotined for disloyalty. When the "Court" acquitted him, saying he was a loyal citizen, he made a recovery. However, he later relapsed when a disclosure of the ploy was made (Pinel, 1806, pp. 224-8).

Although Foucault, in his early work (1964), denounced both Tuke and Pinel as engaging in a duplicitous exercise in social coercion (a replacement of physical manacles with "mind forg'd manacles" of guilt), he also acknowledged that the "spirit and values [of each] are so different" (p.270). In his later work (2006), his attacks on Tuke are more reserved. A close reading of Tuke (1813) shows that although restraint was sometimes a necessary evil at the Retreat, coercion was eschewed as a method of treatment. This cannot be said of the Bicêtre. "Subjugating and subduing the lunatic …[was] .. the most powerful" remedy says Pinel (quoted in Goldstein, 1987, p. 87). (Whereas, Tuke (1813) says the maxim of subjugating is "now in great measure exploded" (p. 141)). Further, what Pinel considered the most striking feature of the moral treatment was their theatricality: 'pious frauds' that take advantage of the patient's gullibility for their own benefit (as we see in the case above with the tailor). Pussin and his assistants, for example, are described shaking chains noisily as they approach cells. At the same time, a visitor to the York Retreat noted the soul searching

amongst the managers on how to get rid of the "harsh ungrateful sound" of the bolts on doors (Tuke, 1813, p. 142).

A further point of difference lies in the importance Tuke gave to 'esteem' as the curing factor, which does not show up at all amongst Pinel's four principles of moral treatment (Goldstein, 1987). In order to raise the esteem of the 'friend' at the Quaker Retreat, the superintendent might introduce a topic of conversation this 'friend' had some expertise on. For example, "one of the worst patients [was] … a grazier, … [and gave] … very sensible directions for the treatment of a sick cow" (p.100). "The patient feeling himself of some consequence, is induced to support it by the exertion of his reason, and by restraining those dispositions, which if indulged, would lessen the respectful treatment he receives; or lowers his character in the eyes of his companions and attendants" (p.101). Charland (2007) and Digby (1985) suggest that it is the expression of benevolence towards others (and animals) that lies at the core of Tuke's treatment. We shall return to the subject of Tuke's 'morality' later, suffice it to say intimidation and threat were not part of it.

Pinel's Political Prescription for the 'Psy Disciplines'

Although appearing grateful to Pussin for showing him how to apply the moral treatment, Pinel was quite condescending towards him, for like his patients, he was considered no equal and "was inalterably the intellectual inferior" (Goldstein, 1987, p. 77). Pinel was developing his *médecine philosophique* (philosophical medicine) on *alienation mentale* (a straying away from reason), that

would allow the emerging new science of psychiatry to find a home in this newly developing disease paradigm of medicine. Previously, medicine (and the 'life sciences') were not seen as sciences so much as an art or applied technology (Porter, 1995). Pinel's *médecine philosophique* (for both disease medicine and psychiatry) found roots in John Locke's (1700) liberal philosophy, which provided the impetus to study 'the mind' as 'a mechanical machine' just as the body could be (Sloan, 1995). Locke began with a claim that 'the mind' begins as a *tabula rasa* (blank slate) and so all its' contents came from either sensations or reflections on sensations. Locke's diatribe against innatism is, of course, directly opposed to, or ignorant of the Delphic Oracle recognition that we are relationally responsive (responsible) beings. As such, Locke has us relating to others mechanically ("I-it") and dismisses any sentiments we may have towards another as inconvenient learnings (to our objective gaze) that we can safely ignore. Locke's political philosophy took a social contract form; as independent minds we had contracted with each other to live in an orderly manner with each other. Morality is a set of derived reasons in this philosophy and has no innate basis. It is ironic and deeply disturbing that mental health and the 'psy disciplines' are built on "I-it" rather than "I-thou" relationships.

From Locke, Pinel turned to the eighteenth century French philosopher-priest Condillac who suggested that memory required language to retrieve old perceptions; but imagination had a more 'bestial' component to it (was more visceral), allowing past perceptions to be revived more vividly and sensuously. This of course is the semantic/somatic memory (or explicit/implicit, or nondeclarative/declarative) distinction that makes up much of our trauma literature today (e.g. van der Kolk, 2014). (Condillac may have developed this

from Gassendi and Thomas Willis, both living in the seventeenth century and seeing 'madness' as a conflict between the rational soul and the animal soul.) Condillac suggested, for example, a sudden encounter with a precipice, especially if one was already vulnerable due to an upset of some sort, might evoke the imagination to generate sensations associated with sudden death. Although Pinel had satisfied himself through post-mortems that there were no actual physical lesions on the brain, he warmed to the idea that the imagination was the faculty "most liable to profound lesions" (Goldstein, 1987, p.92). Condillac had reasoned that in times of vulnerability, we struggle to distinguish between real and imaginary objects. (On the basis of this, Condillac advised young women not to read novels!)

However, it also provided a rationale for Pinel's version of the 'moral treatment'; to "shake the imagination strongly" to allow a more powerful and congenial passion to partner with reason. This way, the more pathological passion-reason link would be counterbalanced by a stronger and more "natural" passion-reason link; that of course the more 'morally advanced' doctor has knowledge of. This "natural self" idea was from Rousseau, and in this post-revolutionary era, there was much attraction to Rousseau's idea that isolating an individual from one's usual social environs with an appropriate tutor might allow one to be restored to one's "true nature". A corrupt society had thwarted one's 'natural' social passions for honours, dignities, wealth and fame; and here was a pathway, and rationale for recovery. Pinel also urged his readers to familiarize themselves with the Stoic ethics, as this is what was to be instilled in the patient.

Armed with this *médecine philosophique* Pinel then classified patients into five groups: the incurable 'ideots' and 'demented' (both of whom he had found to have abnormal brains), and then, the melancholics, the maniacs with delirium, and the maniacs without delirium (none of which had abnormal brains). This provided the rationale for the design of the hospital so that the various groups could be kept separate from each other. (However, in reality, patients very quickly became divided up by curable/incurable, calm/agitated, obedient/insubordinate, working/not working, etc., (Foucault, 2006, p.180; Greene, 1889)). The 'servants' for the asylum could be selected from the convalescents, but the superintendent(s) should, as Fodéré from the Marseille Asylum suggested, be of "noble and manly physique … dark hair … and lively eyes, … a proud bearing" (Foucault, 2006, p. 4). This was because the cure was dependent on the superintendent's ability "to awaken in [the lunatic] respect and obedience" or execute what Foucault (2006) called 'moral' or 'mental orthopedics'.

However there was also another level of prescription for medicine in Pinel's *médecine philosophique*, and this was in intensifying their power through public health or population hygiene. Foucault (1973) identifies an incident in southern France in 1776 when a government official ordered the killing of suspect animals in an agricultural epidemic. This had obvious short-term economic downturns for the region, but was the beginning of a 'policing' role for health. (Elsewhere, Foucault traces the idea of strengthening the state by ordering and manipulating the population, slaughtering some of them if necessary, back to Machiavelli (Martin, et al., 1988). This is known as biopolitics (Rabinow & Rose, 2006), and consists of moving resources so that some forms of life are fostered and others allowed to die.) So in 1776, institutions of justice (the courts) began dialogue with institutions of truth (science) (Foucault,

1973). Old medical guilds fell away as new ones, more willing to gather statistical health information or 'police' populations, through a network of doctors took their place. This was interrupted by the 1789 Revolution in France when various guilds (greengrocers, cobblers, etc.,) were swept away, as the equality of all citizens was declared. For a brief period, anyone could call themselves a doctor, but very quickly the proviso of a state exam was instigated. So a new guild, state based, was established to set the exam. As the Napoleonic regime arose early in the nineteenth century, Pinel, as a result of a number of useful associations, found himself head of a hospital and professor of medicine and set about re-establishing population health monitoring.

Foucault (2003; 2005; 2006; 2008) sees this move to policing public health, especially for psychiatry as expert witnesses in the courts, as an important milestone in the development of bio-power. In fact Foucault (2003) sees psychiatry's role as detector of public danger, a judicial role, as primary, and its medical role secondary. The psychiatrist (or his assistants, such as psychologists, who emerged later) were now to be brought into the courts (and later the factory, the classroom and the barracks) to regulate the population there too. As we have seen, Pinel's 'moral treatment' is not so much a medical treatment as a disciplinary system; so this move to bio-power had the added benefit of increasing the leverage of the psychiatrist in the asylum and clinic, as his social authority was now increased. Bynum (1964) shows that a British parliamentary investigation into the treatment of the mad, early in the nineteenth century, was characterized by intense lobbying by medical men to be in control of psychiatry and the asylums, which the lay reformers like Tuke "seemed content to allow". Although there is no necessity for the 'moral treatment' as developed by

Pinel to be under medical leadership, the rationale provided and close association with medicine in public hygiene and the judiciary established the dominance of psychiatry (Greene, 1889). A dominance it has not been willing to surrender, despite compelling evidence of its ineffectiveness, and indeed harm, as a health discipline (Drury, 2014; Whitaker, 2015).

Asylums, the Therapeutic State and Eugenics

Pinel (1806) says that Willis (of George III fame) cures "nine lunatics out of ten" (p.55) and he himself had a 93 percent cure rate at the Salpêtriére (when 'ideots', 'demented' and 'madwomen of long-standing' were excluded from the study) (Goldstein, 1987, p. 103). This was consistent with other claims in the first half of the nineteenth century of "sixty, seventy, eighty, even ninety per cent cures" (Scull, 1991, p.155). Perhaps more realistic was the report from New York's private Bloomingdale Asylum claiming two-thirds discharged were either 'cured' or 'much improved' between 1821 and 1844 (Johnson, 1990). Whatever the actual early cure rates were, they reflect the optimism as state centred Asylum building took off from about 1820 through to about 1950. Despite the recommendations by both Pinel and Tuke that small is best, the asylums not only grew in number but also in size, with some US institutions holding more than 10,000 'inmates' (Greene, 1889; Scull, 1991). By the early twentieth century, it was clear that the asylums were not just for the insane, but for those with neurological disorders, demented elderly and the intellectually disabled (Grob, 1994; Scull, 1989). The number of 'certified lunatics' grew at rates far exceeding population growth; and in the twentieth century the number of first admissions

aged over sixty increased fourfold. This was partially due to psychiatry's foray into public hygiene (biopolitics), allowing an expansionary view as to what it could treat and return to productivity to emerge (Scull, 1989; 1991). Those it couldn't return to productivity, were best served by the 'benevolence' of the asylum.

By the later part of the nineteenth century, it was becoming obvious that the 'cult of curability' was generating 'gaming'. Some, for example, would discharge patients as 'cured' to alms-houses or workhouses, only to re-admit them as new patients a week or two later (Blanche, 1999; Bynum, 1964). (A similar criticism can be levelled at outcome measures today that only report on episodes of care. This masks the 'frequent flyers' who have developed iatrogenic problems and show up in the four- or five-fold increased rate of welfare beneficiaries due to mental health reasons (Whitaker, 2016).) The French alienist Morel complained that doctors' "entire time is occupied writing monthly notes for the 900 patients that have to be treated" (Dowbiggin, 1991, p.17). So as the asylums grew, intimacy was lost, bureaucracy increased and therapy failed in these well-oiled machines "for the collection of dead souls in a network of cemeteries for the still breathing" (Scull, 1991, p. 161). By the second half of the nineteenth century, this failure to deliver produced a 'crisis of legitmacy' for psychiatry (Rosenberg, 1975).

Biopolitics or forensic psychiatry provided psychiatrists with a way to meet this challenge. Earlier in the nineteenth century, medicine claimed that 'monstrous' forms of humanity (e.g. giants and midgets) were "the product of a disturbance

in the action of natural laws", and thus 'monsters' who performed crimes without clear reason are similarly disturbed (Foucault, 2003). Looking at the records of some English asylums Ray (1981) showed that 'hereditary causation' (and the implication of non-curability) went from four percent of admissions in 1870, to 40 percent in 1890. So now, madness became increasingly viewed as the irreversible product of mental degeneration that was hereditary; and psychiatry was in fact doing this more important task of protecting the public by way of its' diagnostic acumen, especially "as in just those cases in which the signs of insanity seem slight to an ordinary observer that the greatest danger exists" (Greene, 1889, p. 498). Psychiatry was providing the courts with clarity on the question of insight (Marková, 2005). The truly mad had no insight and most couldn't be cured. As psychiatry was now claiming to diagnose a genetic deficiency, it is little wonder that eugenics appeared to be the solution. So psychiatry took a central role in the rise of the eugenic movement, a movement supposedly to control the fertility of the lower classes whose constitutional defects were transmitting criminality, epilepsy, insanity and alcoholism; and then sterility to their offspring, thereby 'polluting' the human gene pool. Eugenics cast a deep shadow over the twentieth century and still exists today (Pilgrim, 2008). It is now well documented that British and American eugenicists openly discussed the use of 'lethal chambers' to kill 'defectives' up until 1942, praising Germany's endeavours (Black, 2003, Joseph, 2005; Pilgrim 2008; Sofair & Kaldjian, 2000; Whitaker, 2015).

With the shift of the psychiatric gaze to genetics, the seeds were sown for the emergence of biological psychiatry as a dominant discourse in the 1970s. This

was a shift of focus from the environmental stone causing a 'lesion' in the "window" of the mind, to the problem of why the glass was so thin in the first place, and what we can do to repair and thicken the glass. In this paradigm, the trauma was largely lost sight of. The twentieth century however, is perhaps most notable for the establishment of the 'therapeutic state' where everyone became a 'patient' (Szasz, 1984). From forensic psychiatry in the first half of the nineteenth century, psychiatry moved into "the borderlands of insanity" (Wynter, 1875) where the 'neurasthenic' (chronic fatigue syndrome?), the hysteric, the alcoholic and the criminal 'resided'; which brought Charcot, Freud and others to the fore. The First World War saw psychiatry treating 'shell-shock'. Prior to World War II, two-thirds of American psychiatrists worked in asylums, but by 1956, 83% worked outside them (Grob, 1994). Psychologists went from measuring intelligence and personality at World War I to providing clinical services post World War II; where they were joined by social workers, family therapists, occupational therapists, etc., as the army of 'psy' disciplines grew. Foucault (2008) describes how 'panopticism' (the self-surveillance of people in the mirror of 'normalizing judgements' that strengthens their sense of 'autonomous individualism') increased throughout the twentieth century, which in turn, increased the demand for even more 'psy' services. Hacking (2007) calls this cycle of progressive infirmity 'looping'. One result is the hundreds of different schools of psychotherapy, all formulating and applying leverage to the 'lesion' in different ways.

Despite this massive expansion of Pinel's 'moral treatment' and *médecine philosophique* rationale into all corners of society (and other cultures (Watters,

2010)), there is little evidence that cure or recovery rates, especially for Serious Mental Illnesses (SMIs) have improved much at all or that the world is better off (Hillman & Ventura, 1993). In fact there is a growing body of evidence that mental health and addiction services are generating malignant and treatment-unresponsive disorders, especially through the use of neuroleptic and antidepressant medication, that is showing up as a four- or five-fold increase in mental health sickness and invalid beneficiaries over the past 30 or 40 years (Viola & Moncrieff, 2016; Whitaker, 2016). Moreover, the Cartesian disembodied 'self', 'fabricated' as increasingly autonomous by this biopower provides a foundation for neoliberalism, which is generating massive wealth disparities and ecological disaster.

Tuke's Moral Treatment.

The most successful treatment of psychosis in the published literature for the past twenty years has been the Open Dialogue work of Seikkula and colleagues in Northern Finland (Seikkula & Arnkil, 2014). With very little use of anti-psychotics, two- and five-year follow-ups are showing that 80+% are in full-time work or study and are symptom and medication free. In a number of papers, Seikkula and colleagues lament that when endeavoring to teach their 'Open Dialogue' approach (which "I feel uneasy to name as a therapeutic *method*" (Seikkula, 2011, p.191), it is difficult to get professionals to drop their trained habits of imposing plans or structure on the therapeutic session and just be with the client in dialogue (Arnkil & Seikkula, 2015; Katz, Shotter & Seikkula, 2004; Seikkula, 2016). In other words, Seikkula is encouraging professionals to drop the human engineering or technical leverage approach developed by Pinel and his successors, 'the medical model', in favour of a

more relationally responsive way of just being with clients (Kykyri, et al., 2016). A shift from "I-it" relationships to "I-thou".

As we saw, Foucault acknowledged that the "spirit and values" of Tuke's 'moral treatment' were "so different" from Pinel's. For a start, he treated his residents as equals, was not trying to leverage them into change (despite Foucault's comments to the contrary) and thought that their self-esteem was the key to successful outcomes. As we uncover Tuke's philosophical foundations, we begin to notice similarities to Seikkula's 'Open Dialogue'. Some light is shed on this by the Scottish Enlightenment philosophers, especially Frances Hutcheson (1660-1739), who had a strong influence on the Quakers, both coming together in the abolition movement against slavery (Charland, 2007; Jackson & Kozel, 2015; Scott, 1900). Hutcheson's thesis was that there was "some instinct, antecedent to all reason from interest, which influences us to the love of others" (1725, p. 112); or in a word a "moral instinct", which he frequently referred to as 'benevolence to others'. From the mid-eighteenth century, the Quakers' 'inner light' became increasingly associated with Hutcheson's moral instinct (Landsman, 1997; McKanan, 2002). This 'inner light' is something we, and even children and animals see, as someone being attentive and responsive to us. There is a certain 'light' in their eyes. If they are being 'nice' to us in order to elicit answers to some checklist of their own self-interest questions, we sense it (sooner or later). It is worth noting that Hutcheson was motivated in part, to counter some economists of his time who thought society was built on self-interest calculations and didn't recognise authenticity as an attraction for us (Adam Smith was a pupil of Hutcheson). Authenticity elicits benevolence. Although there might be a conjunction of interests amongst merchants at times, there was no necessary affection

or benevolence, unlike in most families; and Hutcheson saw that a more beautiful society emerged when we harmonized, or channeled our self-interest towards this natural ordering process of beneficence (Teichgraeber, 1986). We recognise in Hutcheson, albeit in a less nuanced form, the idea found amongst twentieth century philosophers as disparate as Buber (1937), Wittgenstein (1958), Levinas (1998) and Merleau-ponty (1945); that the other calls forth an ethical authenticity from me, or what Foucault (2001) in the last years of his life called '*parrhēsia'* ('fearless speech'). Recently Chuang (2015) has argued that the 'benevolence' Hutcheson saw elicited by authenticity can be seen as the Hindu doctrine of 'desireless action', in that when I am "called" by, for example, the bleeding three-year-old on the road, I act without desire.

So in both Seikkula and Tuke there appears to be a similar suggestion that we give up our professional role obligations to change the client via some treatment plan; and instead, make ourselves totally present in a "not-knowing" or non-intentional way (Anderson & Goolishian, 1993). As Seikkula once put it, this "means giving up the idea of primarily having control over things and, instead, jumping into the same river or rapids with our clients and trying to survive by taking each others hands" (Katz, et al, 2004, p.38). Allowing the therapeutic conversation to take on a life of its' own (Seikkula, 2011; Shotter, 2012). This immediately cuts out of the practice a great deal of unnecessary explicit planning, as we move from what Wittgenstein (1958) called 'obeying rules' (which requires rules to be explicit) to 'rule following' (where regularities are implicit and unspoken) (Shotter, 1996).

How does that help with psychosis? The phenomenological Ipseity-disturbance model of psychosis (Sass & Parnas, 2003) suggests that psychosis can be understood as the 'self' being "asleep" in much the same way as my arm might be if laid on for a long time. I can see it moving, but it doesn't feel like my arm at such times. I might then, start to entertain all sorts of bizarre ideas as to whose arm it is, or who is controlling it etc. Levinas' (1998) idea that the 'self' is 'awakened' or called into existence by the presence of other is relevant here; my presence invites his or her presence. And this appears to be what Tuke had seen. In this regard, Jeb Brown (2016), the director of ACORN, the US company managing the largest database of therapists in the US using outcome management tools, has noticed that clients with SMIs (Serious Mental Illnesses) were more like to rate the alliance as less than perfect, and changes in the alliance scores matched outcomes more strongly than with any other adult group.

A relationally responsive world?

As we have seen, Foucault's historicity of the past thousand years showed the fabrication and growing dominance of an autonomous self that became central to biopower or management of the modern industrial state. Politically, the state's goal is to strengthen itself, and thus it fabricates a 'self' that works towards that endeavour; but this 'self' has not been 'relationally responsive' (Dean, 2010: Foucault, 2009). It has lost touch with the instinct to attend the bleeding child on the road. Foucault was particularly critical of the fathers of neoliberalism (Friedman, Hayek) for failing to recognise that *homo entrepreneur* is neither the

basis nor pinnacle of human nature, and how some might become critical of an endless pursuit of wealth (Dilts, 2011). He saw that neoliberalism incites entrepreneurialism to a point of crisis, generating global Ponzi schemes (Kiersey, 2009). We are all too aware of the growing wealth disparity and accelerating anthropocene of neoliberalism (McMichael, 2014). However during this millennial period, there has been a discourse amongst the subaltern that we are increasingly recognising as providing a more accurate description of human nature. This discourse does not suggest as Locke did, that we have no innate tendencies and are striving for autonomous freedom; but that we are relationally responsive to each other. This is what the Delphic Oracle would have us recognise. When we looked at the successful recovery from madness, we saw that this was a door, for "*The road from mental illness to mental health is not to create from a shattered ego a fortress ego, but to regain one's obligations, one's responsibilities to and for the other"* (Cohen, 2002, p. 48).

Cartesian individualism found expression in psychology as cognitivism; where it generated no end of superstitions as it puzzled how we communicate and understand each other. As separate minds, their puzzle was, how do we get information from one mind to another? Many cognitivists are attracted to the idea that the human biocomputer has an app called the 'Language of Thought' (LOT) that operates on the syntax of language interpreting sounds or representations into meaning. However, from a relationally responsive perspective, we see that we engage in attention sharing activities of various forms (which we see in newborns), which Wittgenstein (1958) called 'language games', and thus, no interpreting device is needed. Cognitivism speculated that

we need some sort of Theory of Mind (ToM) to understand each other, as if we are amateur anthropologists. This assumption dissolves once we realise that our responsivity to each other is so astute that we all too frequently do 'mind-read' each other well, and it is the basis of our intersubjectivity (Leudar & Costall, 2009). We 'sense' where each other is going with this (Overgaard, 2007). As Wittgenstein put it: *"(I)t is correct to say 'I know what you are thinking', and wrong to say 'I know what I am thinking'. (A whole cloud of philosophy condensed into a drop of grammar)"* (Wittgenstein, 1958, p.222e). When I have given myself to the conversation I am not looking at myself, and have no idea what I am thinking, but hopefully showing you by how I talk and what I say.

Similarly, a great number of problems that we sought to tackle clinically over the past 150 years may well have iatrogenic features as a result of our love affair with separate individuated minds; or a failure to recognise our innate relational responsivity. Recall Foucault's description of the self-discipline of *epimeleia heautou*' which was described above as being like some pregnant women giving up smoking and drinking with relative ease. Now, look at the Bruce Alexander's 'Rat Park' studies (2008). Previous researchers had found that if rats in individuated cages were given the choice between taking water from a bottle laced with heroin (or cocaine) or just plain water, they would choose the drug-laced water; and very rapidly develop an addiction that was sometimes fatal. Of course, this became fuel for the 'war on drugs', which was rooted in late nineteenth century eugenics, especially, towards minority groups (Black, 2003). Alexander's radical idea was to construct 'rat park' – a far more natural environment where rats could run around together and which had lots of toys,

sex, and variety. Now, in 'rat park', rats didn't go for the drug laced water; and even those given a habit before coming in soon gave up the drug water. Alexander points out that it was feared that there would be epidemic problems with the number of US vets returning from the Vietnam war, where they had been using large amounts of heroin; but most just gave up on returning home. Similarly, patients given access to Patient-Controlled Analgesia (PCA) machines seldom develop problematic addictions.

Shortly before his assassination, Martin Luther King's "creative maladjustment" speech to the American Psychological Association was in galley proofs for the *Journal of Social Issues*. In that speech, he urged us to see our clients as the "coalmine canaries" to an unjust and sick society, rather than sick in themselves (Robbins & Friedman, 2014). Alexander is making a similar claim with regards addiction problems: they may be better thought of as relational responsivity problems. As is now well-known, the therapeutic alliance has been shown to be the single most important factor the therapist has any impact on (Wampold, 2015). It has been shown that when the "active ingredient" to most psychotherapies is omitted, it has little effect on treatment outcome (Wampold, 2015). Long exposure to the medical "leverage" model of treatment blinds many therapists from seeing that the active ingredient is relational responsivity; which, I'm suggesting, we also invite in our client and society.

Concluding Remarks

Both Wittgenstein and Levinas, philosophers strongly attracted to a relational perspective of human nature, were fond of quoting Dostoevsky's character Father Zossima, who states: "everyone of us is responsible for everyone else in every way, and I most of all" (Dostoevsky, 1958, p.339).

The recognition of our innate responsivity has a profound implication for biopower. We have seen that the 'psy complex' is situated in the governance of health, as much as anything, due to historical 'accidents'. There it is fabricating selves that are out of touch with human nature, because health has become a science discourse over the past two centuries. Relational responsivity as the basis of our nature indicates that the 'psy complex' needs to shift from health to welfare. The 'science of the individual' would now become secondary to 'the ethics of care'. It is no longer appropriate to approach others primarily as objects for scientific scrutiny; 'aboutness' knowledge is not clinically necessary for dissolving 'psy' problems (de Shazer, 1991, p.xiii). The clinical problems we tackle are primarily relational ones. Such is a path back to our nature, or as Bateson (1972) put it, 'steps to an ecology of mind'.

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