FOR A LONG TIME, medicine, psychiatry, penal justice, and criminology remained, and to a large extent remain still today, on the borders of a manifestation of truth in accordance with the norms of knowledge and of a production of truth in the form of the test, the latter always tending to hide behind and get its justification from the former. The current crisis of these "disciplines" does not merely call into question their limits or uncertainties within the field of knowledge, it calls into question knowledge itself, the form of knowledge, the "subject-object" norm; it puts in question the relationships between our society's economic and political structures and knowledge (not in its true or false contents, but in its power-knowledge functions). It is, then, a historico-political crisis.

Take, first of all, the example of medicine, along with the space connected to it, the hospital. Even quite late the hospital was still an ambiguous place, both a place for finding a hidden truth through observation and a place of testing for a truth to be produced.

In the hospital there is a direct action on the disease: the hospital does not only enable disease to reveal its truth to the doctor's gaze, it produces that truth. The hospital is a birthplace of the true disease. It was assumed, in fact, that left at liberty—in his "milieu," his family and his social circle, with his regimen, habits, prejudices, and illusions—the sick person would be affected by a complex, confused, and tangled disease, a sort of unnatural disease that was both the mixture of several diseases and the obstacle preventing the true disease from appearing in its authentic nature. In removing that parasitic vegetation, those aberrant

forms, the role of the hospital, therefore, was not only to make the disease visible just as it is, but also finally to produce it in its hitherto enclosed and fettered truth. Its distinctive nature, its essential characteristics, and its specific development would finally be able to become reality through the effect of hospitalization.

The eighteenth century hospital was supposed to create the conditions for the truth of the disease to manifest itself. It was therefore a place of observation and demonstration, but also of purification and testing. It was a sort of complex equipment for both revealing and really producing the disease: both a botanical site for the contemplation of species, and a still alchemical site for the elaboration of pathological substances.

This dual function continued to be taken on for a long time by the great hospital structures established in the nineteenth century. For a century (1760-1860), the theory and practice of hospitalization, and, in a general way, the conception of disease, were dominated by this ambiguity: as a reception structure for the disease, should the hospital be a space of knowledge or a place of testing?

Hence a series of problems pervaded the thought and practice of doctors. Here are a few:

1. Therapy consists in suppressing the illness, in reducing it to nonexistence; however, for therapy to be rational and grounded in truth, should it not allow the disease to develop? When should one intervene, and in what way? Should one intervene at all? Should one act so that the disease develops or so that it stops, so as to alleviate it or so as to lead it to its term?

2. There are diseases and modifications of diseases, pure and impure, simple and complex diseases. In the end, is there not just one disease, of which all the others are more or less distantly derived forms, or should we assume the existence of irreducible categories? (The debate between Broussais and his opponents concerning the notion of irritation. The problem of essential fevers.)

3. What is a normal disease? What is a disease that follows its course? Is it a disease that leads to death, or a disease that is cured spontaneously after completing its evolution? It was in these terms that Bichat wondered about the position of disease between life and death.

We know that Pasteurian biology brought a prodigious simplification to all these problems. By determining the agent of the sickness and identifying it as a specific organism, it enabled the hospital to become a
place of observation, diagnosis, and clinical and experimental identification, but also one of immediate intervention and counter-attack against the microbial invasion.

As for the testing function, we see that it may disappear. The place where the disease will be produced is the laboratory, in the test tube; however, the disease is not realized in a crisis there; its process is reduced to a magnified mechanism; it is reduced to a verifiable and controllable phenomenon. For the disease, the hospital milieu no longer has to be the site that favors a decisive event; it simply makes possible a reduction, a transfer, a magnification, an observation; the test (*épreuve*) is transformed into proof (*preuve*) within the technical structure of the laboratory and in the doctor's description.

If we wanted to produce an "ethno-epistemology" of the medical personality, we would have to say that the Pasteurian revolution deprived him of his doubtless age-old role in the ritual production and testing of the disease. The disappearance of this role was no doubt dramatized by the fact that Pasteur did not merely show that the doctor did not have to be the producer of the disease "in its truth," but that, due to his ignorance of the truth, he had on thousands of occasions made himself the propagator and reproducer of disease: the hospital doctor going from bed to bed was one of the major agents of contagion. Pasteur inflicted a formidable narcissistic wound on doctors, for which they took a long time to forgive him: the hands that the doctor had to run over the patient's body, palpate it, and examine it, those hands that had to discover the disease, bring it to light and display it, Pasteur designated as carriers of disease. Until then, the role of the hospital space and of the doctor's knowledge was to produce the "critical" truth of the disease; and now the doctor's body and the crowded hospital appeared as the producers of the disease's reality.

Disinfection of the doctor and the hospital gave them a new innocence from which they have drawn new powers and a new status in men's imagination. But that is another story.

These few remarks may help us to understand the position of the madman and the psychiatrist in the asylum space.
There is no doubt a historical correlation between the fact that madness was not systematically interned before the eighteenth century, and the fact that it was essentially considered a form of error or illusion. At the start of the Classical age, madness was still seen as belonging to the chimeras of the world; it could live amongst them and had to be separated from them only when it took extreme or dangerous forms. Under these conditions, we can understand why the artificial space of the hospital could not be the privileged place where madness could and had to manifest itself. The first of the recognized therapeutic sites was nature, since it was the visible form of truth; it had the power to dispel error and make chimeras vanish. The prescriptions given by doctors were therefore likely to be traveling, resting, walking, retirement, a break with the artificial and vain world of the town. Esquirol will recall this again when he was drawing up the plans of a psychiatric hospital and recommended that each courtyard open out wide onto the view of a garden. The other therapeutic site put to use was nature reversed, the theater: the comedy of the patient’s own madness was acted out and staged for him, given a fictitious reality for a moment; by means of stage props and costumes it was treated as if it was true, but in such a way that the error, caught in this trap, would finally become strikingly apparent in its victim’s own eyes. This technique also had not completely disappeared in the nineteenth century; Esquirol, for example, recommended staging proceedings against melancholics in order to stimulate their energy and taste for combat.

The practice of internment at the beginning of the nineteenth century coincides with the moment when madness is perceived less in terms of error than in relation to regular and normal conduct; when it no longer appears as disturbed judgment but as disorder in ways of acting, willing, experiencing passions, taking decisions and being free; in short, when it is no longer situated on the line of truth-error consciousness, but on that of passion will freedom; the moment of Hoffbauer and Esquirol. “There are insane people (aliénés) whose delirium is scarcely visible; there is not one whose passions, whose moral affections are not disordered, perverted, or destroyed (…) Weakening of the delirium is a sure sign of recovery only when the insane (les aliénés) return to their first affections.” What actually is the process of
recovery? Is it the movement by which error vanishes and truth becomes clear again? No, it is “the return of moral affections within their proper bounds, the desire to see one’s friends and children again, the tears of sensitivity, the need to open one’s heart, to be back in the bosom of one’s family, to resume one’s routine.”

What, then, might the asylum’s role be in this movement back toward regular behavior? First of all, of course, it will have the function that hospitals were given at the end of the eighteenth century: to make discovery of the truth of the mental illness possible, excluding everything in the patient’s milieu that may conceal it, muddle it, give it aberrant forms, as well as sustain it and stimulate it. But even more than a site of revelation, the hospital for which Esquirol provided the model is a site of confrontation; within it, madness, the disturbed will and perverted passion, must come up against a sound will and orthodox passions. Their head-on encounter, their inevitable and in fact desirable clash, will produce two effects: the unhealthy will, which could very well remain elusive if not expressed in any delirium, will bring its illness out into the open through its resistance to the doctor’s healthy will, and, on the other hand, if conducted well, the ensuing struggle should lead to victory for the healthy will and to the submission, the renunciation, of the disturbed will. There is, then, a process of opposition, struggle and domination. “A disruptive method must be applied, using the spasm to break the spasm (. . .) The whole character of some patients must be subjugated, their rage subdued and their pride broken, while others must be stimulated and encouraged.”

This is how the very strange function of the nineteenth century psychiatric hospital is established: a diagnostic and classificatory site, a botanical rectangle in which the species of disease are distributed in courtyards whose layout brings to mind a vast kitchen garden, but also an enclosed space for a confrontation, the site of a duel, an institutional field in which victory and submission are at stake. The great asylum doctor—whether Leuret, Charcot, or Kraepelin—is both he who can state the truth of the illness through the knowledge he has of it, and he who can produce the illness in its truth and subjugate it in reality through the power his will exerts on the patient. All the techniques or procedures put to work in the nineteenth century asylum— isolation,
public or private cross-examination, treatments—punishments like the shower, moral talks (encouragements or reproofs), strict discipline, obligatory work, rewards, preferential relationships between the doctor and some of his patients, relationships of vassalage, possession, domesticity and sometimes servitude, binding the patient to the doctor—the function of all of this was to make the medical figure the "master of madness": the person who makes it appear in its truth (when it is hidden, when it remains buried and silent) and the person who dominates it, pacifies it, and gradually makes it disappear after having artfully unleashed it.

Let us say, then, schematically, that the "truth-producing" function of the disease continues to diminish in the Pasteurian hospital; the doctor as producer of truth disappears in a structure of knowledge. In the hospital of Esquirol or Charcot, however, the "truth-production" function hypertrophies, redoubles around the figure of the doctor. And this takes place in a process in which what is at stake is the doctor’s surplus-power. Charcot, the miracle worker of hysteria, is doubtless the most highly symbolic figure of this type of operation.

Now this redoubling takes place at a time when medical power is guaranteed and justified by the prerogatives of knowledge: the doctor is competent, he knows the diseases and the patients, he possesses a scientific knowledge which is of the same type as that of the chemist or the biologist, and this is now what justifies his interventions and decisions. The power that the asylum gives to the psychiatrist will therefore have to be justified (and at the same time masked as primordial surplus-power) by producing phenomena that can be integrated within medical science. We can see why the technique of hypnosis and suggestion, the problem of simulation, and the diagnostic distinction between organic disease and psychological disease, were at the heart of psychiatric theory and practice for so many years (from 1860 to 1890 at least). The point of perfection, of a too miraculous perfection, was reached when, at the request of medical power-knowledge, Charcot’s patients began to reproduce a symptomatology whose norm was epilepsy, that is to say, a symptomatology that could be deciphered, known and recognized in terms of an organic disease.

This is a critical moment when the two functions of the asylum (testing and production of truth, on the one hand; observation and knowledge of
phenomena, on the other) are redistributed and exactly superimposed on one another. The doctor's power now enables him to produce the reality of a mental illness the distinctive feature of which is its reproduction of phenomena fully accessible to knowledge. The hysteric was the perfect patient, since she provided material to be known: she herself retranscribed the effects of medical power in forms that the doctor could describe in terms of a scientifically acceptable discourse. As for the power relationship that made this whole operation possible, how could its determining role have been detected when—supreme virtue of hysteria, unequalled docility, veritable epistemological sanctity—the patients took it upon themselves and assumed responsibility for it: the power relationship appeared in the symptomatology as morbid suggestibility. Everything was henceforth set out in the clarity of knowledge purified of all power, between the knowing subject and the object known.

A hypothesis: the crisis becomes apparent, and the still barely delineated age of antipsychiatry begins, with the suspicion, and soon after the certainty, that Charcot actually produced the hysterical fit he described. This gives us the rough equivalent of Pasteur's discovery that the doctor was transmitting the diseases he was supposed to be combating.

At any rate, it seems that the major tremors that have shaken psychiatry since the end of the nineteenth century have all basically called the doctor's power into question; his power and its effect on the patient, more than his knowledge and the truth he told regarding the illness. More precisely, let us say that, from Bernheim to Laing or Basaglia, what was at stake was how the doctor's power was involved in the truth of what he said and, conversely, how this truth could be fabricated and compromised by his power. Cooper has said: "At the heart of our problem is violence," and Basaglia: "The typical feature of these institutions (school, factory, hospital) is a clear-cut separation between those who hold power and those who do not." All the great reforms, not just of psychiatric practice but also of psychiatric thought, revolve around this power relation: they are so many attempts to shift it, conceal it, eliminate
it, or nullify it. Fundamentally, the whole of modern psychiatry is permeated by antipsychiatry, if by that we understand everything that calls into question the role of the psychiatrist previously given responsibility for producing the truth of illness within the hospital space.

We could, then, speak of antipsychiatries that have permeated the history of modern psychiatry. But perhaps it is more worthwhile to distinguish carefully between two processes that are quite distinct from the historical, epistemological and political point of view.

To start with there was the movement for “depsychiatrization.” It appears immediately after Charcot. It involves not so much invalidating the doctor’s power as shifting it in the name of a more exact knowledge, giving it a different point of application and new measures. Depsychiatrizing mental medicine so as to restore to its proper effectiveness a medical power that Charcot’s imprudence (or ignorance) had led to produce illnesses improperly, and so false illnesses.

1. A first form of depsychiatrization begins with Babinski, in whom it finds its critical hero. Instead of seeking to produce the truth of the illness theatrically, it is more worthwhile to seek to reduce it to its strict reality, which perhaps is often only its susceptibility to letting itself be theatricalized: pithiatism. Henceforth, not only will the doctor’s relation of domination over the patient not lose any of its rigor, but this rigor will focus on the reduction of the illness to its strict minimum: the necessary and sufficient signs for it to be diagnosed as a mental illness, and the indispensable techniques for ensuring the disappearance of these symptoms.

This involves, as it were, “Pasteurizing” the psychiatric hospital so as to obtain the same effect of simplification in the asylum that Pasteur had imposed on hospitals: directly linking diagnosis with therapy, knowledge of the nature of the illness with suppression of its symptoms. The moment of testing, the moment when the illness appears in its truth and arrives at its completion, no longer has to figure in the medical process. The hospital can become a silent place in which the form of medical power is maintained in its strictest aspect, but without having to encounter or confront madness itself. Let us call this “aseptic” and “asymptomatic” form of depsychiatrization “psychiatry of zero production.” Psychosurgery and pharmacological psychiatry are its two most notable forms.
2. Another form of dep psychiatrization is exactly the opposite of the preceding one. It involves making the production of madness in its truth as intense as possible, but in such a way that the relationships of power between doctor and patient are invested exactly in this production, that they remain appropriate for it, do not let themselves be outflanked by it, and keep it under control. The first condition for this maintenance of “depsychiatrized” medical power is its disconnection from all the specific effects of the asylum. Above all, to avoid the trap into which Charcot’s thaumaturgy fell, one must prevent hospital discipline from making a mockery of medical authority and, in this place of collusions and obscure collective knowledge, ensure that the doctor’s sovereign science is not caught up in mechanisms that it may have unwittingly produced. Hence, the rule of private consultation; the rule of a free contract between doctor and patient; the rule of the limitation of all the effects of the relationship to the level of discourse alone (“I ask just one thing of you, which is to speak, but to say really everything that crosses your mind”); the rule of discursive freedom (“you will no longer be able to boast of deceiving your doctor, since you will no longer be answering his questions; you will say what comes into your mind, without you even having to ask me what I think about it, and, if you want to deceive me by breaking this rule, I won’t really be fooled; you will be the one caught in the trap, since you will have disrupted the production of truth and added further sessions to those you owe me”); and the rule of the couch that grants reality only to the effects produced in that privileged place and during that particular hour in which the doctor’s power is exercised—a power that cannot be caught in any counter effect, since it has withdrawn entirely into silence and invisibility.

Psychoanalysis can be read historically as the other major form of dep psychiatrization prompted by the Charcot trauma: withdrawal outside the space of the asylum in order to get rid of the paradoxical effects of psychiatric surplus-power; but reconstitution of a truth producing medical power in a space arranged so that that production of truth is always exactly adapted to that power. The notion of transference as the process essential to the cure is a way of thinking this perfect adaptation conceptually in the form of knowledge; the payment of money, the
monetary counterpart of the transference, is a way of guaranteeing it in reality: a way of preventing the production of truth from becoming a counter-power that traps, nullifies and over-turns the doctor's power.

These two major forms of depsyctiatrization—both of which retain and preserve power, one because it invalidates the production of truth, the other because it tries to make the production of truth and medical power perfectly adapted to each other—are opposed by antipsychiatry. Instead of a withdrawal outside the space of the asylum, antipsychiatry involves its systematic destruction through work inside; and it involves transferring to the patient himself the power to produce his madness and the truth of his madness, instead of seeking to reduce it to zero. I think this enables us to understand what is at stake in antipsychiatry, which is not at all the truth value of psychiatry in terms of knowledge (of diagnostic accuracy or therapeutic effectiveness).

The struggle with, in, and against the institution is at the heart of antipsychiatry. When the great asylum structures were established at the beginning of the nineteenth century, they were justified by a marvelous harmony between the requirements of public order—which demanded protection from the disorder of the mad—and the needs of therapy—which demanded isolation of the patients. Esquirol gave five main reasons to justify isolating the mad:

1. to ensure their personal safety and the safety of their families;
2. to free them from outside influences;
3. to overcome their personal resistances;
4. to subject them to a medical regimen;
5. to impose new intellectual and moral habits on them.

Clearly, it is always a question of power: mastering the madman's power; neutralizing external powers that may be exerted on him; establishing a power of therapy and training (dressage)—an "orthopedics"—over him. Now it is in fact the institution as site, form of distribution, and mechanism of these power relationships that antipsychiatry attacks. Beneath the justifications for confinement that, in a purified site, would make it possible to observe what is the case and where, when, and how one should intervene, antipsychiatry brings out the relationships of domination peculiar to the institutional relationship: "The doctor's pure
power," says Basaglia, observing the effects of Esquirol's prescriptions in the twentieth century, "increases as vertiginously as the patient's power diminishes; the latter, simply by virtue of being confined, becomes a citizen without rights, handed over to the arbitrariness of the doctor and nurses, who can do with him what they like without any possibility of appeal." It seems to me that we could situate the different forms of antipsychiatry in terms of their strategies with regard to these games of institutional power: escaping them in the form of a contract freely entered into by the two parties (Szasz\(^8\)); creation of a privileged site where they must be suspended or rooted out if they are reconstituted (Kingsley Hall\(^9\)); identify them one by one and gradually destroy them within a classic type of institution (Cooper at Villa 21\(^10\)); link them up to other power relations outside the asylum that may have brought about an individual's segregation as a mental patient (Gorizia\(^11\)). Power relations were the \textit{a priori} of psychiatric practice: they conditioned how the asylum institution functioned, they determined the distribution of relationships between individuals within it, and they governed the forms of medical intervention. The typical reversal of antipsychiatry consists in placing them, rather, at the center of the problematic field and questioning them in a fundamental way.

Now, what these power relations involved first and foremost was the absolute right of nonmadness over madness. A right translated into terms of expertise being brought to bear on ignorance, of good sense (access to reality) correcting errors (illusions, hallucinations, fantasies), and of normality being imposed on disorder and deviation. This triple power constituted madness as a possible object of knowledge for a medical science, constituted it as illness, at the very moment that the "subject" affected by this illness was disqualified as mad—that is to say, stripped of all power and knowledge with regard to his illness: "We know enough about your suffering and its peculiarity (of which you have no idea) to recognize that it is an illness, we know this illness sufficiently for us to know that you cannot exercise any right over it and with regard to it. Our science enables us to call your madness illness, and that being the case, we doctors are qualified to intervene and diagnose a madness in you that prevents you from being a patient like other patients: hence you will be a mental patient." This interplay of a
power relationship that gives rise to a knowledge, which in turn founds
the rights of this power, is the characteristic feature of “classical”
psychiatry. It is this circle that antipsychiatry undertakes to unravel:
giving the individual the task and right of taking his madness to the
limit, of taking it right to the end, in an experience to which others may
contribute, but never in the name of a power conferred on them by their
reason or normality; detaching behavior, suffering, and desire from the
medical status given to them, freeing them from a diagnosis and symp-
tomatology that had the value not just of classification, but of decision
and decree; invalidating, finally, the great retranscription of madness as
mental illness that was begun in the seventeenth and completed in the
nineteenth century.

Demedicalization of madness is correlative with this fundamental
questioning of power in antipsychiatric practice. This enables us to take
the measure of the latter’s opposition to “depsychiatrization,” which
seemed to be the characteristic feature of both psychoanalysis and
psychopharmacology, both of which stemmed rather from an overmedical-
ization of madness. Straightaway the problem opens up of the possibility
of freeing madness from that singular form of power-knowledge
(pouvoir-savoir) that is knowledge (connaissance). Is it possible for the
production of the truth of madness to be carried out in forms other than
those of the knowledge relation? It will be said that this is a fictitious
problem, a question that arises only in utopia. Actually, it is posed con-
cretely every day with regard to the role of the doctor—of the statutory
subject of knowledge—in the depsychiatrization project.

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

2. Ibid.


10. The experiment at Villa 21, which began in January 1962 in a psychiatric hospital in North West London, inaugurated the series of antipsychiatric community experiments, one of the best known of which is Kingsley Hall. David Cooper, its director until 1966, provides an account in *Psychiatry and Antipsychiatry*.

11. An Italian public psychiatric hospital in northern Trieste. In 1963 Franco Basaglia and his team began to undertake its institutional transformation. *L'institution en négation* provides an account of this anti-institutional struggle that became an example. Basaglia gave up the direction of Gorizia in 1968 in order to pursue his experiment in Trieste.