The Psychotropic Boundaries of Self-Formation

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Laura Kerr begins a provocative essay by drawing our attention to the prevalence of mood disorders, including depression and bipolar disorders. She then suggests that patient education can be utilized as a "tool against…stigma." She proposes that a Foucaultian perspective on care of the self provides guidance about practices that relate to technologies of the self.

I want to begin my response to Kerr with a set of friendly interrogatories that will, hopefully, give her a chance to expand the connections she makes in her text. Next I wish to propose a further examination of the contributions of Michel Foucault to this enterprise. Finally, I am going to look at two related contemporary problems for children that remain unresolved in Kerr's analysis.

Interrogatory 1. Can you say more about how you are employing the idea of moral action here? Foucault does not give us the usual signposts, and I would appreciate knowing more about how you see the connections between moral action and ethical self-formation.

Interrogatory 2. Can you elaborate on the consequences of holding a view that "each day we begin anew" within the practices of psychiatry?

Interrogatory 3. Do you have anything you would like to say about any connections to psychoanalysis or to psychoanalytic theory?

Foucault says, about his aims:

> My objective for more than twenty-five years has been to sketch out a history of the different ways in our culture that humans develop knowledge about themselves: economics biology, psychiatry, medicine, and penology. The main point is not to accept this knowledge at face value but to analyze these so-called sciences as very specific "truth games" related to specific techniques that human beings use to understand themselves.[1]

He then diagrams four technologies (and I think, by the way, that the use of "technologies" has room for further analysis outside of our current concerns — not necessarily by Kerr, but in connection to IT (information technology), biotechnologies, and our universities' obsessions with everything "tech." That is not for another day.).

1. Technologies of production, which permit us to produce, transform, or manipulate things;

2. Technologies of sign systems, which permit us to use signs, meanings, symbols, or signification;

3. Technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject; and

4. Technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and ways of being, so as to transform

themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality.[2]

Foucault concedes that much of his work has focused on Tech 3, and, as Kerr points out, he devotes considerable effort to the elaboration of Tech 4. But production, the sign, power and the self are not separable. Foucaultian analysis gives us lenses for rethinking the connection between knowledge, power, and subjectification. As he takes up the relationship between care of the self and knowing the self (as Kerr analyzes in her essay), I think we ought to be very careful to remember that he is not proposing a *proper* technology of the self. Rather, he suggests how different codes of subjectification make certain practices possible and makes others less likely. In this slice of Foucault's work he focuses on these ethically self-formative practices that emphasize aesthetic delight without metaphysical demands. Yet, for him, the subject remains a site of contestation — a "permanent provocation."

Psychiatry as a medical science has created what Kerr calls a "dialectic of the normal and abnormal." Kerr rightly reminds us that psychiatry is but one descriptive model of human behavior and attendant norms. Psychiatric diagnosis is one strategy for the elaboration of truth. While it is probable that diagnosis creates the conditions for *both* relief from and fear of stigma, psychiatry's medicalizing discourses presents problems for Kerr's self-forming subject. First, organic causation of mood disorders allows for individuals to be made into cases of pathology — subject to observation and categorization. Second, psychopharmacology is set up to compete with self-practices of care or of linguistically based notions of therapy. Managed care companies embrace drug therapies as substitutes, not supplements, for more discursively rich practices.

> I had to go in for my annual face-to-face with a psychiatric resident to get a prescription renewal. It was clear to me that this guy's experience was not in clinical psychotherapy. He asked me how I was doing. With two minutes to go in our fifteen-minute session, he told me that obviously my depression sprang from the fact that I was underemployed, given my education. That I knew that I was not making the money that I had a right to expect given what lawyers could make. He totally discounted the idea, which I did not have time to argue with him, that not for one day had I wished to go into corporate law as opposed to public service. He looked so satisfied at his diagnosis, I hardly had the heart to tell him what an idiot he was. (Personal correspondence, 1999)

The tension between a conception of care of the self and "caring" institutions becomes very clear in thinking about the psychiatric treatment of young children. The increasing surveillance of the emotional lives of school children — in order to diagnose, to predict, and to punish violence and violent tendencies — problematizes the goals and training of educators and poses questions of the developmental and pedagogical assumptions about children and self-possibility.

In *Youth Violence: A Report of the Surgeon General*, David Satcher offers a fairly optimistic view of the trends in youth violence.[3] He reports that youth violence peaked in 1993 bracketing out self-directed violence and intimate violence. And he holds the hope that science, both social science as a means of studying the trends and medical/behavior science as means of intervention, will be able to assuage the fears of parents and Americans at large about violent youth.

> The risk factors associated with early onset of violent activity (early being age 6-11) are classed as individual (for example, substance use, being male, hyperactivity, low IQ, antisocial attitudes and behavior, and exposure to violent television); family (for example, poverty, broken home, abusive parent, antisocial parent); school (poor attitude, performance); and peer group (antisocial peers, weak social ties). Community factors are not significant risk factors for young children according to this rubric.[4]

The suggestion is that we can intervene as educational or medical professional to mitigate risk. The factors as enumerated here are given without much elaboration — for example, whether it is maleness or rather the *norms of masculinity* that are in play for violence or how "low IQ" is related to factors outside of the "individual." The kind of "truth" that is accessible about the individual (as well as her/his capacity to intervene in the making of that truth) needs to be considered as we redefine educators' role to affect/emotion/psyche patrol.

Associated with the concern above, but different in its educational implications, is the increasing use of psychotropic drugs with young children. Now that childhood onset of brain disorders (anxiety, depressive and bipolar disorders) is acknowledged in child and adolescent psychiatry, the problem of diagnosis looms large for parents, pediatric specialists, and educators.[5] Developmental theories and notions of rapid change/growth in childhood are at odds, both discursively and practically with the diagnosis of serious psychiatric "conditions" that seem to fix the being of the child (as against the becomingness that we are accustomed to seeing). The political and social ramifications of psychotropic drug use in general — the debates over Prozac, Paxil, Haldol, and new drugs like Sarafem (a drug for Premenstrual Disphoric Disorder) — continue for adult users. Are we seeking to remake personality through medication? How long should people use these drugs? Is the changing of individual biochemistry the answer to every problematic fit between individuals and society?

It seems that those questions are magnified when we talk about children, whose ability to verbalize their suffering, much less engage in sustained activities of self-knowledge and self-care are severely circumscribed. This questioning should not be taken as a denunciation of the drugs themselves, but as a genuine question about how human beings are to constitute themselves or to understand themselves within regimes of self-determination that are not purely ecstatic or aesthetic but are at the same time limiting and self-limiting before the time in the life-cycle when we can have any comfort at all about a developed/developing person.[6]

Kerr's notions of care of the self, when read through different categories of selves, may be open to further rich discussion — even in light of my concerns. I hope that we can continue that discussion in this society and in other sites in the future.

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1. Luther H. Martin, et al., eds., *Technologies of the Self: A Seminar with Michel Foucault* (Amherst: University of Massachusetts Press, 1988), 17-18.

2. Ibid., 18.

3. David Satcher, "Youth Violence: A Report of the Surgeon General," (United States Printing Office, 2001), available online at: www.surgeongeneral.gov/library/youthviolence/report.html

4. Ibid., Table 4.1.

5. See National Institute of Mental Health website: gopher.nimh.nih.gov/publicat/childqa.cfm

6. James Bernauer, "Michel Foucault's Ecstatic Thinking," in *The Final Foucault*, ed. James Bernauer and David Rasmusson (Cambridge: MIT Press, 1988), 45-82.