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Title: Foucault and the birth of psychopolitics : Towards a genealogy of crisis governance

Year: 2021

Version: Published version

Please cite the original version:

Article

Foucault and the birth of psychopolitics: Towards a genealogy of crisis governance

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Abstract
The article contributes to the genealogy of current tendencies in crisis governance by reconstructing Michel Foucault's analysis of the application of the notion of crisis in 19th-century psychiatry. This analysis complements and corrects Reinhart Koselleck's history that viewed crisis as originally a medical, judicial or theological concept that was transferred to the political domain in the 18th century. In contrast, Foucault highlights how the psychiatric application of the concept of crisis was itself political, conditioned by the disciplinary power of the psychiatrist. Unlike the ancient medical concept of crisis that emphasized the doctor's judgement in observing the event of truth in the course of the disease, psychiatric crisis is explicitly forced by the doctor in order to elicit the desired symptoms in the patient and convert their power of disciplinary confinement into medical diagnosis. The article argues that this notion of crisis resonates with the tendencies observed in contemporary crisis governance in Western societies. While these tendencies are often addressed in terms of 'psychopolitics' that presumably succeeds Foucault's 'biopolitics', we suggest that Foucault's own work on psychiatric power offers a valuable genealogical perspective on the contemporary governance of crises.

Keywords
Biopolitics, crisis, Foucault, governance, Koselleck, psychiatry

Introduction

We have become accustomed to viewing contemporary politics as moving from crisis to crisis, be it financial or environmental, pertaining to migration or democracy. These crises are often presented as objective events that governments must respond to in a reactive manner. However, in recent years a number of approaches in social sciences have begun to pay more attention to the way crises are used by governments in a more proactive way, as opportunities to be seized in order to transform various aspects of social reality (Hay, 1999; Roitman, 2014; Milstein, 2015). In this understanding, crisis is not something to be merely avoided or prevented by governments but

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rather an instrument of governance deployed to achieve policy goals. Studies of neoliberal *governmentality* have addressed the way crisis is deployed in governmental rationalities as a technology for the promotion of particular forms of subjectivity, framed in terms of flexibility and resilience (De Larrinaga and Doucet, 2010; Nadesan, 2010). Similarly, *critical security studies* have addressed the way security is no longer treated in governmental rationalities as an absolute good to be provided at any cost. Instead, a modicum of insecurity is tolerated and even appreciated as the condition of enhancing responsibility, flexibility and resilience of individuals and communities (Chandler, 2012; Dillon, 2015). Finally, studies in the field of *risk governance* confirm this tendency by addressing the spread of insurance-based technologies of governance whose aim is to transform individuals and collectives into entrepreneurial subjects, successfully managing and bounding back from whatever crisis they may find themselves in (Aradau and Van Munster, 2007).

In this article we shall elucidate this aspect of crisis by addressing a particular episode from the genealogy of the concept, namely the deployment of crisis in 19th-century psychiatry. The medical concept of crisis dates back to Ancient Greece, while its transition to the political context is usually traced back to the 18th century. The standard motif of the conceptual history of crisis is thus that of the *extension* of ostensibly nonpolitical medical, judicial and theological concepts of crisis to the realm of history and politics, in which these originally demarcated meanings were intertwined in various ways at the cost of the gradual loss of 'clarity and precision' (Koselleck, 2006: 397). This standard history suggests, firstly, that the original three senses of crisis in law, medicine and religion were distinct prior to their eventual entanglement in the new domains. Secondly, it posits that the movement of the concept of crisis from these distinct domains to the more general realm of history and politics was unidirectional and irreversible: the idea of crisis simply moved from the realm of medicine to the realm of politics, without there being any movement in the other direction.

In this article we venture to challenge this interpretation by focusing precisely on the reverse process, whereby politics enters the medical concept of crisis. Of course, a certain political dimension may be said to have been present there all along in the form of the *authoritative judgement* of the doctor who alone can decide on when or whether the crisis takes place. Yet, we shall argue that this political element becomes paramount in the modern modification of this concept in 19th-century psychiatry, as the disciplinary power of confinement is used to compensate for the epistemological deficiency of psychiatric knowledge. Drawing on Michel Foucault's 1973–1974 lecture course *Psychiatric Power*, we shall reconstruct the logic of this modification and address its significance for contemporary politics of crisis governance.

In our argument, this significance is twofold. Firstly, we shall demonstrate that Foucault's analysis of the psychiatric crisis explicates and accentuates the doctor's power to *force* a crisis to make the desirable symptoms appear under the conditions of disciplinary confinement. Thus, crisis marks the transitional moment, where the unfounded *power* of the doctor is converted into *knowledge*, albeit the knowledge that remains epistemologically deficient in comparison to organic medicine. While we are accustomed to thinking of crisis as a metaphorical application of a medical concept to politics, we shall argue that the only reason why this concept could function in psychiatric medicine was because of its already political character. Highlighting this originally political aspect of the notion of crisis serves to further elucidate its instrumental role in government and challenge the objectivist interpretation of crises.

Secondly, the analysis of the psychiatric crisis offers a genealogical corrective to the contemporary discussion of 'psychopolitics', often advanced as an alternative to Foucault's allegedly outdated concept of biopolitics. In contrast, we demonstrate how a certain 'psycho-power' is already present in Foucault's analysis in 1973–1974, i.e. before his explicit engagement with biopolitics. Moreover, it is the transformation in this mode of power that actually led to the constitution of the

domain of sexuality in medical science that was one of the epistemic correlates of the rise of bio-power in Foucault's argument. Rather than succeed biopolitics, psycho-power appears to precede it and feed into it. Even more importantly, Foucault's approach to psychiatric power offers a more nuanced perspective on this mode of power and the possibilities of resisting it than the contemporary analyses of psychopolitics, which leave little room for resistance and critique.

Our argument unfolds in four steps. In the following section we shall discuss the traditional or 'ancient' concept of the crisis, drawing on both Reinhart Koselleck's conceptual history and Foucault's genealogical account. We then proceed to the analysis of the modification of this concept in 19th-century psychiatry – a development not addressed by Koselleck but central to Foucault's reconstruction of psychiatric power. In the third section we discuss three key differences between the two concepts, paying particular attention to the resonances between the logic of psychiatric crisis-forcing and the tendencies in contemporary governance. In the final section we address the connections between Foucault's analysis of psychiatric crisis and contemporary discussions of 'psychopolitics' that claim to advance beyond Foucault's approach, and discuss the implications of Foucault's analysis for rethinking politics outside the conceptual horizon of crisis.

Medical crisis as an event of truth

In his history of the concept of crisis, Koselleck argues that in Ancient Greece the word 'crisis' had 'relatively clearly demarcated meanings in the fields of law, medicine and theology' (Koselleck, 2006: 358). Crisis denoted a stark choice between alternatives: life or death, right or wrong, salvation and damnation, etc. The medical meaning, which Koselleck views as dominant until the 17th century, originated in the *Corpus Hippocraticum* and was 'entrenched' by Galen for over 1,500 years (2006: 358). It referred to the decisive moment in the development of the disease that permitted one to determine whether the patient would live or die. Crisis thus pertains both to the intrinsic *condition* of the patient and the *judgement* of the doctor on this condition. The contemporary ambivalence of the concept of crisis may therefore be traced to its very origins.

While the ancient use of the concept was split between distinct disciplinary fields, in early modernity it was metaphorically extended to the domains of politics, economy and history, where its legal, theological and medical meanings begin to overlap and intersect. The metaphor of 'body politic' made it possible to apply the medical meaning of crisis to the collective entity, be it community or empire. We could thus speak of a crisis in the case of a shift in the balance of power between European powers (Koselleck, 2006: 368), internal upheaval in a city (2006: 369) or civil war on a continental scale (2006: 375). As Koselleck notes, with Rousseau and Diderot

> the concept incorporates (in different degrees) all the various functions the term had come to perform: as historical assessment and judgement, as medical diagnosis, and as theological entreaty. It is precisely the exciting possibility of combining so many functions that defines the term as concept: it takes hold of old experiences and transforms them metaphorically in ways that create altogether new expectations. Hence, from the 1770s on, 'crisis' becomes a structural signature of modernity. (2006: 374)

In this wider historico-political context, the concept retained its dual sense of intrinsic condition and subjective judgement. For example, in the philosophy of history of the Young Hegelians, crisis was both a state of affairs in the society and the correct judgement about this state of affairs that could eventually set it right (2006: 385). Similarly, the economic crisis in Marx's thought was both a recurrently observable symptom of the contradictions of capitalism and the quasi-eschatological presentiment of its demise. Finally, Nietzsche's philosophy both issued a premonition of a crisis 'such as never before existed on earth' (Nietzsche, 2004: 90–91) and linked this crisis to the

operation of Nietzsche's own thought that consists in the revaluation of all values. Crisis is at once something that is already there or soon to come, and something to be discerned, decided on or even brought about. Even though, as Koselleck notes, since the 19th century 'there has been an enormous quantitative expansion in the variety of meanings attached to the concept of crisis, but few corresponding gains in either clarity or precision' (Koselleck, 2006: 397), this dual sense of crisis has arguably been maintained in spite of the dazzling proliferation of the uses of the concept.

Koselleck completes his study by arguing that 'the concept of crisis, which once had the power to pose unavoidable, harsh and non-negotiable alternatives, has been transformed to fit the uncertainties of whatever might be favored at a given moment' (2006: 399). While the overuse of the concept and the imprecision of its application are evident, Koselleck's conclusion risks both understating the degree to which the reference to crisis remains an effective speech act legitimizing governmental practices and overstating the degree to which the earlier use of the concept was clear, rigorous or restricted to a particular field. The overall narrative that emerges from Koselleck's history is that of gradual dilution of formerly rigorous crisis concepts through their extension into the historico-political realm where they lose clarity while gaining in popularity. Yet, this suggests that before this extension the concepts in question were devoid of political content.

With regard to the medical notion of crisis, this view may be challenged from the Foucauldian perspective, which is well attuned to explicating the power relations involved in ostensibly nonpolitical fields. Foucault addressed the notion of crisis extensively in his 1973–1974 lecture course at the Collège de France, called *Psychiatric Power*, which dealt with the emergence of psychiatry in the context of disciplinary power. The lectures prefigure both *Discipline and Punish* (Foucault, 1977) in their focus on disciplinary techniques of power and *History of Sexuality I* (Foucault, 1990) in their methodological shift away from the 'macrophysics' of sovereignty. In line with his principle of the mutual constitution of power and knowledge, Foucault also addresses the way psychiatry sought to establish itself in the regime of truth prevalent in the medical science of the time. This discussion leads Foucault to the medicine of crises, which, along with judicial torture and alchemical research, he analyses as examples of the 'evental' approach to truth.

In contrast to the modern, scientific or 'demonstrative' view of truth as always already present and only waiting to be discovered with the help of the scientific method, the evental approach insists that the advent of truth occurs only at particular times and places under certain conditions and is not accessible to everyone but only to specific authoritative figures. Crisis in ancient medicine was precisely such an event, which was foundational for medical knowledge for 22 centuries before becoming eclipsed by the demonstrative technology of truth in the 18th century after the emergence of pathological anatomy.

What is crisis in premodern medicine? It is a moment in the development of disease, at which it manifests itself most clearly, the moment

> [at] which the evolution of the disease risks being resolved, [. . .] risks the decision of life or death, or also transition to the chronic state. [. . .] The crisis is the moment of combat, the moment of the battle, or even the point at which the battle is decided. The battle between Nature and Evil, the body's struggle against the morbific substance. (Foucault, 2006: 242)

This moment takes place at a specific time: every disease has its own rhythm that is typical for it and in terms of which it can be described. Crisis is, in this sense, an 'intrinsic feature of the disease' (2006: 243).

On the other hand, crisis is also 'the opportunity to be seized' (2006: 243), an instrument whose correct application will permit the doctor to correctly identify the disease and possibly cure the patient. This is the case precisely because the crisis is an event of the truth of the disease:

> When the crisis occurs, the disease breaks out in its truth. [I] won't say 'reveals' a hidden truth but appears in its own truth. Before the crisis the disease is one thing or another; it is nothing in truth. The crisis is the reality of the disease becoming truth. And it is precisely then that the doctor must intervene, engage in battle against the disease, so that nature triumphs over the disease. (2006: 243)

Thus, most of the doctor's work is actually preparatory: he 'must first foresee the crisis, identify when it will occur, wait for the exact day when it will take place, and then, at that point, engage in battle against the disease, so that nature triumphs over the disease' (2006: 243). Foucault even qualifies the final part of this statement, arguing that it is actually nature *itself* that does most of the battle: 'the doctor does not cure, and it cannot even be said that he directly confronts the disease, since it is nature that confronts the disease; he foresees the crisis, he gauges the contending forces and he succeeds if he manages nature's success' (2006: 244).

What the doctor does in the management of the crisis is to reinforce the energy of nature that resists the disease. Since it is a matter of reinforcement, it is important not to overdo things, since the patient might not survive a particularly violent confrontation with the disease. On the other hand, if the reinforcement is insufficient, the disease will survive the combat and no crisis will take place. 'In this technology of the crisis the doctor is much the manager and arbitrator of the crisis rather than the agent of a therapeutic intervention' (2006: 244). Moreover, the judgement of the doctor may itself be subjected to a second-order judgement that may entail promotion or disqualification in the professional community: 'Just as the disease comes up for judgment on the day of the crisis, so the doctor, in this role as a kind of arbitrator, is judged in turn by how he presides over the combat, and he may come out as victor or vanquished in relation to the disease' (2006: 245). Thus, in medical crisis the nature of the living being confronts the disease, while the doctor intervening in the crisis confronts other doctors with their own opinions about the correct time and manner of intervention.

This emphasis on judgement leads Foucault to the conclusion that both recalls and qualifies Koselleck's history of the concept, in which the judicial notion of crisis was posited as originary (Koselleck, 2006: 359–360):

> In its general form the technique of the crisis in Greek medicine is no different from the technique of the judge or arbitrator in a judicial dispute. In this technique of the test you have a sort of model, a juridico-political matrix, which is applied both to the contentious battle in a case of penal law and to medical practice. (Foucault, 2006: 244)

While, as we have seen, Koselleck argues that the ancient concepts of crisis were distinct across medical, juridical and theological fields, Foucault chooses to approach crisis as a 'juridico-political' matrix of decisive judgement which could be applied in much the same way in medicine and law. Thus, a certain (pre- or para-)political aspect is present even in the ancient concept of the crisis prior to any spillover into other domains: after all, it is the authority of the doctor that permits the identification of a crisis and the possibility of incorrect identification places this authority in question, paving the way for its contestation.

Just as the evental notion of truth gradually gives way to the demonstrative notion of truth in science, law and other procedures, so in medicine the ancient concept of crisis disappears in the 18th century. Foucault offers three main reasons for this disappearance: the establishment of hospitals that enable continuous observation of patients, the invention of pathological anatomy that integrates the dead body into the process of studying the disease through autopsy, and the emergence of statistical medicine that makes it possible to inspect large sets of populations (Foucault, 2006: 247–248). As a result, the old technique of crisis gradually becomes redundant.

It was precisely at the moment of its redundancy in medical science that the concept of crisis began to spill over to the domain of politics and history. As medicine started to abandon the evental idea of truth in favour of demonstrative techniques of pathological anatomy, the ancient idea of the discernment of instantly vanishing truth by authoritative figures legitimized by particular modes of knowledge gained traction in the emergent genres of philosophy of history and political economy (Koselleck, 2006: 370–396). Abandoned at its source, the ancient concept of crisis thrived in the historico-political discourse of Western modernity. The transformations in the rationalities of government that Foucault would in later lectures and books discuss under the aegis of biopolitics coincided with the increasing reliance on the medical concept of crisis in the interpretation of history and politics. As sites of periodic crises, history and politics have become the veritable disease of modernity.

Psychiatric crisis as a reality test

The spillover of the medical concept of crisis into the historico-political field marks the end of the story of the medical concept in Koselleck's account, as it now appears conflated with both juridical and eschatological meanings and no longer pertains specifically to medicine. And yet, in his study of 19th-century psychiatry, Foucault notes a persistence of the concept of crisis. Since the displacement of the evental approach to truth by inquiry and demonstration did not occur in psychiatry, the notion of crisis became ever more important in psychiatric practice, even as its meaning was substantially transformed.

At first glance, crisis would appear to be definitively ruled out in the psychiatric field due to its very nature. As a disciplinary space, the emergent psychiatric hospital could not be the place for the 'raging and raving outburst of the crisis of madness' (Foucault, 2006: 248). Secondly, the spread of pathological anatomy led to the theoretical rejection of the idea of the crisis in medical sciences, even though this spread did not succeed in ascribing a physical cause to mental illness. Nonetheless, if there was truth in madness, it was not to be sought in the discourse of the mad, but would rather be established by autopsy after their death. Thirdly, the connections established between madness and crime led to the foundation of psychiatric power less on truth than on danger: if every madman is possibly a criminal, the task of the psychiatrist is ultimately not to cure the patient but to protect society as such (see more generally Foucault, 2003). In this logic, a madman's crisis could well manifest itself in a crime, leading to another person's death, which is a good reason to exclude the notion of crisis not only theoretically but also in practice.

And yet, despite these grounds for exclusion, Foucault argues that the idea of crisis persisted in psychiatry for two reasons. Firstly, the concept of crisis was needed since psychiatry could not establish itself epistemologically in any other way. The disciplinary space of the psychiatric hospital, the reference to pathological anatomy and the danger of crime did not suffice to endow psychiatric discourse with truth value. While general medicine of the time 'functions at the point of the specification of the illness' (Foucault, 2006: 251), which makes differential diagnosis its main mode of operation, the psychiatry of the period is focused on the rather more basic question of the *reality* of disease rather than its *type*. The key question is whether the patient is mad or not, not what kind of disease their symptoms point to.

In Foucault's argument, the purpose of the psychiatric hospital is not to study illnesses in comparison with each other but to 'give madness reality, to open up a space for realization for madness' (2006: 252). Ironically, this realization of madness 'itself' is combined with the disappearance of all its symptoms (violence, disruption, offensiveness) precisely as a result of the disciplinary structure of the hospital. Dementia is the paradigmatic form of mental illness as constituted by psychiatric power: all possible symptoms of illness have been flattened out, yet the fact of illness remains

assured. In contrast, hysteria responds to this approach by a hyperbolic display of symptoms defining other illnesses, without these symptoms having any organic substratum. 'The only way not to be demented in a nineteenth century hospital was to be a hysteric' (2006: 254).

The second reason for the persistence of crisis is that, in contrast to general medicine, the body is largely absent from psychiatry. While psychiatry tried to follow the general trend in 19th-century medicine in looking for organic correlations of diseases, it did not succeed in introducing the procedures of demonstration and verification that became the norm with pathological anatomy. Since there was no organic correlate to madness as such, its reality had to be established in some other way. This is why 'the psychiatric hospital literally invented a new medical crisis. This was no longer that old crisis of truth played out between the forces of the disease and the forces of nature that was typical of the medical crisis put to work in the eighteenth century, [but] a crisis of reality, which is played out between the mad person and the power that confines him, the doctor's power' (2006: 252). When faced with the request for the confinement of a person to the psychiatric hospital, the doctor must decide on whether the motivations of this request can be translated into the language of symptoms and illnesses. By means of this translation, the doctor can convert disciplinary power in the hospital into medical knowledge. In this manner, the person to be confined will become ill, while the person who confines will become a doctor.

> In organic medicine, the doctor vaguely formulates the following demand: show me your symptoms and I will tell you what your illness is. The psychiatric test, the psychiatrist's demand is much weightier, much more surcharged and is: with what you are, with your life, with the grounds for people's complaints, with what you do and what you say, provide me with some symptoms, not so that I know what your illness is, but so that I can stand before you as a doctor. (Foucault, 2006: 268)

The test in the psychiatric hospital both translates the life of the individual into the terms of mental illness and officially identifies the psychiatrist as a doctor. This test can never be definitely completed since the latter establishment remains forever precarious. 'One cannot leave the asylum not because the exit is far away but because the entrance is too near. One never stops entering the asylum and every encounter, every confrontation between the doctor and the patient begins again and indefinitely repeats this founding initial act by which madness will exist as reality and the psychiatrist will exist as doctor' (2006: 269).

Thus, while the disciplinary space of the hospital endows the doctor with surplus power, the patient is never left entirely powerless. In full accordance with Foucault's more general approach to power, the patient, exemplified in the lectures by the hysteric, is also endowed with surplus power to the extent that only he or she can provide the symptoms that make the doctor's activities something more than mere exercise of power, i.e. a medical act. If the patient refuses to provide these symptoms for some reason, the act of the doctor loses all reference to medicine and becomes that of pure force. As we shall see below, the patients designated as hysterics used this power, eventually undermining the attempt to give psychiatry a firmer medical foundation via neurology.

It is this game of two powers that constitutes the new, specifically psychiatric crisis in which the subject must bring its madness to presence to be verified by the doctor who thereby validates his or her own expertise. This takes place in the procedure of psychiatric *questioning*, which, along with the administration of drugs and hypnosis, is the main method that the psychiatric test applies to actualize the reality of madness (2006: 269–270). Foucault describes four processes by which psychiatric questioning realizes madness. Firstly, it produces the *medical history* of the patient, compensating for the lack of any organic correlate to the illness by the production of the 'huge fantastical body of the family affected by a mass of illnesses' (2006: 271). Secondly, it searches for signs of *predisposition* in the individual medical history in order to identify possible phases in the

approach of madness that testify to the individual's 'abnormality' (2006: 272; see also Foucault, 2004). Thirdly, questioning produces a chiasmus between *responsibility and subjectivity*, offering the patient relief from legal or moral responsibility in exchange for the subjective acceptance of the facts of their behaviour that would permit the doctor to establish them as symptoms: 'Give me some symptoms, I will remove the fault' (2006: 273). Finally, and most importantly for our purposes, the procedure of questioning is always directed towards its end, when the questioned subject would *actualize* their madness within the interview (2006: 274). Ideally, this is to be attained through the subject's confession of their delirium, hallucinations, etc. Alternatively, this can be attained by the eruption of the hysterical crisis in the course of the examination itself.

> The subject must be forced into a sort of tight corner, a point of extreme contraction at which he is constrained to say 'I am mad' and really play out his madness. He is constrained to say: really, I am someone for whom the psychiatric hospital was built. I am someone for whom a doctor was needed. Since I am sick, it is clear that you, whose major function is to confine me, are a doctor. (2006: 274)

The theme of confession as a technique of power is familiar from Foucault's *History of Sexuality I* and the lectures of the early 1980s (Foucault, 1990, 2014). What interests us is less the analogies with religious practices, which are quite evident, than the rather less evident way in which psychiatric questioning also ventures to imitate the principles of modern medicine to which it aspires but never really achieves.

> Psychiatric questioning constitutes a body through the system of ascriptions of heredity; it gives body to an illness which did not have one; around this illness, it constitutes a field of abnormalities; it fabricates symptoms from the demand for confinement; it isolates, delimits and defines a pathological source that it shows and actualizes in the confession or in the realization of this major and nuclear symptom. (Foucault, 2006: 275)

In these four aspects of the questioning procedure, the psychiatrist emulates the demonstrative mode of knowledge that their own discourse cannot reach. What compensates for this epistemological deficiency is the disciplinary power of the doctor that sets up the relationship with the patient as a situation of confinement and permits to ceaselessly question the patient in order to elicit the symptoms that will validate the authority that made confinement possible to begin with. Forcing a crisis through questioning translates the reality of power exercised by the doctor into the knowledge of the reality of the patient's madness.

In the remainder of the lecture course, Foucault discusses the way the search for better epistemic grounding eventually led to the emergence of neurology, which managed to ascribe organic correlations to some mental disorders, which in turn made it possible to move them into the domain of 'true' medicine, while psychiatry remained tied to language, hypnosis and drugs (2006: 288, more generally lecture 12). Neurology replaces psychiatric questioning with the examination that analyses the body's responses to various stimuli, 'which can be clinically deciphered at the level of the body and which one can consequently submit to a differential examination without fear of being duped by the subject who responds' (2006: 304). It is no longer the subject who is asked to confess to their illness by producing its symptoms in a crisis forced by the doctor. It is now the body itself that speaks, if only to the doctor who alone can decipher what it says.

> The test of reality is no longer necessary. Clinical neurology will enable differential diagnosis to get a hold, like organic medicine, but on the basis of a completely different apparatus. Broadly speaking, the neurologist says: obey my orders, but keep quiet, and your body will answer for you by giving responses that, because I am a doctor, I alone will be able to decipher and analyze in terms of truth. (2006: 304)

In this conversion the neurologist is able to appear as a 'proper' doctor who needs no longer to resort to the power of confinement and questioning to produce symptoms, while the patient ultimately ceases to be mad and becomes respectably ill: 'she will acquire citizenship within a hospital worthy of the name. The hysteric acquires the right to be ill and not mad thanks to the constancy and regularity of her symptoms' (2006: 310). And yet, this apparently mutually beneficial arrangement was, in Foucault's argument, undermined by the hysterics themselves, who responded to the request for regular display of bodily symptoms with a veritable eruption of discourse that recounted their lives in luridly sexual terms. '[You] want to find the cause of my symptoms, the cause that will enable you to pathologize them and enable you to function as a doctor; you want this trauma, well, you will get all my life, and you won't be able to avoid hearing me recount my life and, at the same time, seeing me mime my life anew and endlessly reactualize it in my attacks' (2006: 322).

In Foucault's reading, this 'sexual pantomime' is not the 'as yet undeciphered residue of the hysterical syndrome' but rather a *countermanoeuvre* of the hysterics, who, understanding their surplus power as the providers of symptoms and the guarantors of the doctor's expertise, used it to attain the surplus pleasure of putting their desire into discourse and making the doctor listen (2006: 322). Faced with this eruption of discourse, the doctors could either disqualify hysteria as an illness altogether or try to give a medical meaning to this discourse, which led to the constitution of sexuality as an object of power and knowledge, the process Foucault will take up again in the first volume of the *History of Sexuality*:

> [By] breaking down the door of the asylum, by ceasing to be mad so as to become patients, by finally getting through to a true doctor and by providing him with genuine functional symptoms, the hysterics, to their greater pleasure, but doubtless to our greater misfortune, gave rise to a medicine of sexuality. (Foucault, 2006: 323)

Thus, psychiatric crisis ends up as a passing phase in the development of psychiatry. What makes this episode nonetheless significant for studies of politics and government is that it certainly did not have to wait for any extension into the political domain to acquire political content. This is no longer the crisis of ancient medicine, in which the doctor patiently and studiously awaited the manifestation of the truth of disease – the crisis that could legitimately be termed intrinsic to the illness, even if it still took external expertise to ascertain it. In the exercise of psychiatric questioning the crisis is instead explicitly forced by the doctor, who thereby simultaneously *demonstrates* the reality of madness and *validates* the position of doctor as authority. Crisis does not precede the power of confinement and the knowledge of psychiatry but is rather an instrument by which the former is *translated* into the latter and unfounded acts of power end up grounded in knowledge and thereby rendered legitimate. If today's governments so easily resort to the medical language of crisis, this is probably because 19th-century psychiatrists could only establish themselves as doctors by first engaging in acts of government. Foucault's analysis of psychiatric crisis challenges the familiar image of the spillover of the ostensibly nonpolitical concept of crisis into the political realm. Prior to any such spillover, politics is always already there in the apparatus of psychiatric confinement and the technique of crisis-forcing through questioning.

Crises compared: Temporality, epistemology, object

Let us now address three key differences of the psychiatric crisis from the ancient notion of crisis that make this notion a helpful paradigm for grasping contemporary governmental rationalities. To speak of a paradigm in this context is certainly not to suggest that the rationalities of crisis governance today are derived directly and immediately from the 19th-century concept of psychiatric crisis.

As Koselleck's history of the concept of crisis shows (Koselleck, 2006: 397), the period in which this concept was developed was already marked by the 'quantitative expansion' of meanings and the correlate loss of 'clarity and precision', which makes any attempt at its derivation from a single source problematic. Rather than attempt to derive today's crisis governance, whose rationalities are manifold and often contradictory (Roitman, 2014: 41–70), from the 19th-century medical concept, we shall merely indicate the areas in which the key features of this concept resonate most strongly with the widely discussed tendencies in crisis governance today.

The first difference pertains to the *temporality* of crisis. While in the classical model the crisis was temporary and transient, a fleeting opportunity that must be seized to grasp the nature of the disease, in the psychiatric model the crisis is an 'endless test' of admittance, in which the power of the doctor confronts the power of the patient. Since the psychiatric crisis is no longer posited as intrinsic to the disease and in need of discernment by the doctor, but can be forced any time by the questioning procedure (or drugs and hypnosis), it can be repeated incessantly at the doctor's will, whenever the reality of disease needs to be demonstrated. Crisis is thereby liberated from any discipline of anticipation and the imperative of judgement and becomes permanently available as a method of the production of knowledge through the exercise of power.

This temporal difference is highly pertinent to the functioning of crisis in contemporary politics in Western liberal democracies, which has arguably all but lost the connection of the theme of rarity and brevity of crises that characterized ancient medicine, but rather deploys crises periodically if not permanently (see Agamben, 2012: 40–41; Agamben, 2019: 74). As a result, contemporary politics appears as an endless series of protracted crises (financial, environmental, social, etc.) that governments resort to in order to legitimize their existence: since any condition may be designated a crisis, there is always something for government to do, which makes its existence necessary, even if its specific anti-crisis measures may be found dubious or unsuccessful. In the latter case we merely have yet another crisis on our hands, to be resolved by another, hopefully more competent government. Thus, crises are easy to declare but difficult to resolve, since any such resolution would remain exposed to yet another declaration of a crisis. While this tendency is all but inconceivable in terms of the ancient concept of crisis that emphasized a watchful anticipation of a crisis that would be necessarily transient and fleeting, it clearly resonates with the permanent availability of the technique of crisis-forcing in the psychiatric concept.

The second difference pertains to the *epistemology* of crisis. While the classical model fits rather neatly into Foucault's canonical argument about the mutually constitutive relationship of power and knowledge, the psychiatric crisis introduces an important asymmetry into this relationship: there is always an *excess of power over knowledge*. While the power exercised by the psychiatrist through confinement and various treatment procedures is easily observable, the knowledge in question is somewhat dubious, perpetually falling behind the better-founded knowledge in organic medicine. Moreover, this knowledge only counts as such by virtue of the power of confinement and questioning that compensates for the lack of organic correlates of mental illness. In the forcing of the psychiatric crisis, we observe the operation of the *conversion* of power into knowledge: by forcing the patient into the corner and making him manifest his madness, the very power that forces the crisis erases its nature as force and becomes an ultimately benign exercise of knowledge and professional judgement.

Once again, this paradigm appears closer to contemporary governance than the idea of symmetrical mutual constitution of power and knowledge that is perhaps better suited to describing the genealogy of the modern welfare state, constituted by the cooperation of newly emergent economic and social sciences and new technologies of population management (Gordon, 1991; Donzelot, 1997; Dean, 1999: 53–55). In the context of neoliberal government, founded on the universalization of economic rationality (Dean, 1999: 55–59, 149–175; Rose, 1996: 54–58), it is difficult to observe

such a symmetry. Just as the production of the hysterical crisis in psychiatric questioning is enabled by the asymmetries of power that characterize the hospital as the disciplinary space of confinement, the recasting of various social spheres and subsystems in economic or even entrepreneurial terms has no epistemic justification and appears to be a direct translation of political hegemony. As we have seen, psychiatric questioning aims to elicit from the patient the kind of symptoms that would make him recognize himself as mentally ill. By the same token, neoliberal governance, especially in the post-2008 phase of austerity politics, appears to force various population groups into admitting that their problems are, indeed, economic and it is only by recasting themselves as economic subjects that they can hope to resolve them (see Roitman, 2014: 65–70). While contemporary crisis governance is usually associated with neoliberalism (Klein, 2008; Brown, 2015), its parallels with 19th-century psychiatry suggest a longer and perhaps a more complex genealogy.

The final difference pertains to the *object* of both power and knowledge at work in the constitution of the crisis, which is *physical* in the case of the ancient model and *psychical* in the case of the psychiatric version. As we have seen, there is nothing in the body that serves as the organic correlation of 'mad' behaviours, hence the body is no longer the object of power and the source of knowledge. Any attempt to make it such, as in 19th-century neurology, only serve to move the illness in question from the realm of psychiatry to the domain of 'proper' illnesses. Instead, it is the individual's psyche that is the site of the reality test undertaken by forcing a crisis, in which the subject is called upon to confess or act out their madness and thereby verify their interlocutor's status as a doctor. We may therefore term this technique of crisis-forcing *psychopolitical*.

The term 'psychopolitics' has been used generically to denote the psychological aspects of political power, including propaganda and brainwashing, but also the political use of psychiatry (Sedgwick, 2015; Oghourlian, 2012). It has also been applied in the more specific context of Foucauldian governmentality studies to highlight the dimension of subjectivation and the role of psychological knowledge in the governance of subjectivity (Rose, 1989, 1998; Rau, 2010, 2013; Thomas, 2016).

> In a long historical process, with the help of different agencies, institutions, techniques, and also due to social movements struggling for different ways of being and living, we have learnt to be human beings that 'understand and relate to ourselves as "psychological" beings, and to interrogate and narrate ourselves in terms of a psychological "inner life"'. (Rau, 2013: 608)

While this 'psy-' turn in governmentality has been critically addressed from various perspectives to emphasize its depoliticizing function that translated public and political problems into private and psychological ones (Cruikshank, 1999; Rimke, 2000; White and Hunt, 2000), the concept of psychiatric crisis rather elucidates the political dimension that was always already constitutive of our subjectivation as 'psychological beings'. In Foucault's account, the subject and crisis appear intertwined and mutually reinforcing: it is the subject's intransigence that leads to the forcing of the crisis by the psychiatrist, which in turn forces the subject to render its life into discourse, thereby acquiring an 'inner life'. Foucault's analysis of psychiatric power does not merely expose the lowly origins of psychological sciences in the disciplinary practices of 19th-century psychiatrists but also demonstrates how our very understanding and narrating of ourselves in terms of psychological interiority is a historically contingent side effect of the myriad crises forced by psychiatrists to convert their disciplinary power into knowledge.

Yet, more recently, the notion of psychopolitics has also been used to criticize and advance beyond Foucault. In their own different ways, Bernard Stiegler and Byung-Chul Han have deployed this notion as an alternative to Foucault's notion of biopolitics that they view as outdated. In the final section we shall critically engage with this claim and demonstrate the advantages of Foucault's account of psychiatric crisis as an episode in the genealogy of psychopolitics.

Psychopolitics: How to resist 'smart power'

In recent discussions in critical theory, the notions of psycho-power and psychopolitics have been advanced as an alternative to Foucault's idea of biopolitics. Given Foucault's interest in psychiatry and psychology from his earliest writings onwards, this claim is quite striking and deserves careful consideration, particularly in the light of our preceding analysis of the forcing of crisis as the key technique of psychiatric power.

Bernard Stiegler has used the term 'psychopower' to describe the ensemble of communication and entertainment technologies that capture and mobilize our attention to transform us into subjects of consumption, incapable of critical thought and thus failing ever to attain the 'maturity' that Kant famously associated with the Enlightenment (Stiegler, 2010: 26). This rationality of government goes beyond Foucault's biopolitics since its object is the psyche and not the body. It is rather the later work of Foucault on the ancient techniques of the self that, in Stiegler's argument, came closest to psychopolitical analysis, even though he also notes that Foucault did not understand or explicate its full significance, both due to his early death and because of 'motives internal to his work' (Stiegler, 2010: 31). For Stiegler, Foucault's theory is too holistic and overly generalizing from a highly specific 19th-century rationality of government, aimed at the organization of populations for the purposes of production. In the second part of the 20th century, the primacy of production gave way to the primacy of consumption, for which old biopolitical techniques were no longer appropriate. This new rationality of power sought not to enhance the productivity of bodies but to capture the attention of minds, even at the cost of the perpetual dissipation of attention and the transformation of the population into 'eternal adolescents': 'The question is not longer that of a biopower over producers, but a psychopower over consumers' (Stiegler, 2008).

Byung-Chul Han follows Stiegler in arguing that Foucault's theory of biopolitics is outdated and misleading, but criticizes him for focusing on television as the paradigm of the psychopolitical diversion and capture of attention, ignoring the plurality of more advanced digital technologies characteristic of the neoliberal era. Yet, Han's overall line of reasoning remains similar to Stiegler's:

> Biopolitics, which makes use of population statistics, has no access to the psychic realm. It can deliver no material for drawing up a psychogram of the population. Demography is not the same thing as psychography. It cannot tap into or disclose the psyche. On this score, statistics and Big Data lie worlds apart. Big Data provides the means for establishing not just an individual but a collective psychogram – perhaps even the psychogram of the unconscious itself. As such it may yet shine a light into the depths of the psyche and exploit the unconscious entirely. (Han, 2017: 21)

Engaging with these bold claims in detail is beyond the scope of this article. We shall merely focus on Stiegler's and Han's criticism of Foucault's apparent inability to recognize psychopolitical forms of power that define our time (see De Landazuri, 2019; Van Camp, 2012). As we have seen, Stiegler approaches biopolitics in a rather reductive manner as the mode of organizing populations for industrial production in the 19th century. Han's notion is somewhat more expansive, yet also strictly focused on bodily and physical aspects to the exclusion of the psychical:

> [Biopolitics] fundamentally concerns the biological and the physical. But neoliberalism is not primarily concerned with 'the biological, the somatic, the corporal'. It has discovered the psyche as the productive force. Now, immaterial and non-physical forms of production are what determine the course of capitalism. The body no longer represents a central force of production, as it formerly did in biopolitical, disciplinary society. Now, productivity is not to be enhanced by overcoming physical resistance so much as by optimizing psychic or mental processes. (Han, 2007: 25)

Similarly to Stiegler, Han argues that Foucault only came close to grasping this form of power in his late work on the techniques of the self in antiquity. What he was unable to grasp, though, was the way neoliberalism expropriates these techniques for its own purposes, making any liberation attained through them ultimately illusory.

> [The] self-as-a-work-of-art amounts to a beautiful but deceptive illusion that the neoliberal regime maintains in order to exhaust its resources entirely. It does not lay hold of individuals directly. Instead, it ensures that individuals act on themselves so that power relations are interiorized and then interpreted as freedom. Such engineering of freedom and exploitation, which occurs in order to effect self-exploitation, is what escaped Foucault. (Han, 2007: 28)

In the light of our analysis of psychiatric power this criticism appears problematic for two reasons. Firstly, both Stiegler and Han posit psychopolitics as a *successor* to Foucault's biopolitics that is apparently limited to 19th-century industrial society. This view of biopolitics is overly restrictive, if not outright caricaturistic. In fact, our analysis above permits us to make the diametrically opposed claim that psychopolitics does not succeed biopolitics but rather *precedes* it and eventually feeds into it. As we have shown above, the technique of crisis-forcing, which was deployed to compensate for the absence of organic etiology of mental illness, was gradually abandoned, first in the attempts by neurology to find this etiology by studying the body's responses to stimuli and then in the reconceptualization of the symptoms of the hysteric in sexual terms. By responding to the crisis forced by the psychiatrist in a sexually explicit manner, the hysterics made possible the emergence of the very *scientia sexualis* that, in Foucault's well-known account, is the epistemic correlate of the rise of biopolitics (Foucault, 1990: 117–119).

Of course, the complex genealogy of biopolitics also involved other epistemic elements, from the historico-political discourse on race (Foucault, 2003: 65–86) to the economic theories of the physiocrats (Foucault, 2008: 27–73). Yet, mutations and transformations in 19th-century psychiatric knowledge were nonetheless central to the emergence of biopolitical governance, hence the identification of 'psycho-power' as a contemporary successor to biopower being somewhat dubious. While neoliberalism has produced many innovations in governance, it did not discover the psyche, nor was it the first mode of power to mobilize it. The proclamations of a 'new' regime of power thus appear decidedly premature, as is the rehashing of Baudrillard's (2007) injunction to forget Foucault.

The claim about the succession of biopolitics by psychopolitics becomes even more dubious if we consider that the logic that Han describes is a perfect summation of the argument of Foucault's first volume of *History of Sexuality* (1990) as well as his other works on confession as a technology of power. What Han appears to add as a *correction* to Foucault is already present in Foucault's analysis, even if it is not stated in quite such a bombastic fashion. Han's idea of 'smart power' that avoids repression and operates via injunction to freedom merely extends Foucault's critique of the repressive hypothesis (1990: 15–35), even though he might be overstating both the 'friendly' character of power and the effectiveness of this friendliness (Han, 2017: 13–15). In contrast, Foucault's analysis of psychiatric power demonstrates how this power operates both by offering rewards and relief and by disciplinary arrangements that permit it to suppress or elicit the desired symptoms at will.

This brings us to the second problem with the contemporary accounts of psychopolitics. By overemphasizing the cunning of 'psycho-power' and its disavowal of open coercion and violence, Stiegler and Han foreclose numerous possibilities of resisting it. If power is not repressive but seductive, friendly and smart, if it operates through games, entertainment and communication, then it can only be resisted by an extreme self-exclusion from the entirety of its apparatuses, which Han calls 'idiotism', the affirmation of exteriority and otherness against all integration, communication and networking, and ultimately against all knowledge and all subjectivity (Han, 2017: 81–87).

'Only the idiot has access to the wholly Other. Idiotism discloses a field of immanence of events and singularities for thought; this field eludes subjectivation and psychologization altogether' (2017: 81). Given Han's efforts in the preceding pages to argue that there is no longer any outside or alterity in the psychopolitical regime of power, one cannot help but wonder, only half-jokingly, if 'smart power' is a bit too smart to be eluded by idiots: if power invests the individual psyche, any transgressive step outside merely extends the reach of its operations, as power literally goes along with the idiotic subject. Yet, if Han's idiotism does not seem to work, one might have better luck as a Foucauldian hysteric.

As we have shown above, Foucault viewed the separation of psychiatric knowledge from the physical body not as a sign of the strengthening of psychiatric power but rather as a sign of its weakness, which led to the highly problematic status of psychiatric knowledge that could only be compensated for by the intensification of the disciplinary power of confinement and questioning. Rather than endlessly dupe its hapless victims, in the Foucauldian approach psychopolitics is a fragile constellation perpetually at risk of dissolution: the excess of power risks transforming it into pure force, while any relaxation thereof risks revealing the epistemic void at its heart. The instability of this constellation not merely ensures the existence of the 'other', who is at once the object of power and the source of knowledge, but also grants this other significant counter-power. The surplus power of the hysteric, who derives from its function as the guarantor of the doctor's expertise the freedom of explicit discourse, demonstrates that it is never a matter of total domination or even full co-optation of all resistance into the apparatus of power. It is possible both to exercise counter-power and to escape the grip of particular powers.

Of course, any optimism must be qualified, since the escape in question does not lead one into the bliss of anarchic freedom but into an entanglement with new forms of power relations, e.g. the emerging science of sexuality and its correlate in biopolitical governance in the case of Foucault's hysterics. Yet, the emphasis of Foucault's approach on contingency and reversibility in power relations is an important corrective to the tendency in the discussion of psycho- or bio-politics to overemphasize the cunning of power that is always a few steps ahead of any attempts to resist it. In contrast, Foucault demonstrates that psychopolitical power is at its weakest when it tries and fails to convert itself into knowledge, and crisis as the moment of this conversion is precisely the line of fragility that could be targeted by those who choose to resist it.

Thus, the ultimate advantage of the Foucauldian approach is that it permits us to think of politics outside the horizon of crisis. In her magisterial *Anti-Crisis*, Janet Roitman argues that crisis has become a quasi-transcendental condition of intelligibility of history and politics (Roitman, 2014: 5–13), which provides us with access to the latter domains by constructing them *a priori* in terms of the narratives of 'what went wrong?'

> [The] dizzying array of crisis narratives all proceed from the question 'what went wrong?' These narratives are structured in terms of a quest for the 'roots', 'origins', and 'causes' of the crisis; none hesitate over the matter of positing the term 'crisis' itself. (Roitman, 2014: 42).

In contrast, the effect of Foucault's analysis is precisely a certain hesitation over the term itself. Crisis no longer appears as a quasi-transcendental condition of our access to politics or history but as itself an irreducibly historical and political instrument of the conversion of the doctor's disciplinary power into professional knowledge. Crisis is that pivotal moment when power appears to found itself on knowledge and thereby effaces itself as power, making its operations seem self-evident and necessary. It is precisely at this moment that critical discourse may intervene most fruitfully, demonstrating the contingency of what power presents as necessary:

No power goes without saying, no power, of whatever kind, is obvious or inevitable, no power warrants being taken for granted. Power has no intrinsic legitimacy. All power only ever rests on the contingency and a fragility of a history. (Foucault, 2014: 77)

To think outside the horizon of crisis is to restore to politics and government their contingency and fragility that can never be effaced through claims of necessity and urgency. Perhaps, then, it would be possible to exit the vicious circle, whereby politicians act like doctors who themselves could only become such by acting like politicians.

Funding

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