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*A mixed figure: the monster, the masturbator, and the individual who cannot be integrated within the normative system of education. ~ The Charles Jouy case and a family plugged into the new system of control and power. ~ Childhood as the historical condition of the generalization of psychiatric knowledge and power. ~ Psychiatrization of infantilism and constitution of a science of normal and abnormal conduct. ~ The major theoretical constructions of psychiatry in the second half of the nineteenth century. ~ Psychiatry and racism: psychiatry and social defense.*

I WOULD LIKE TO close the problem I have dealt with this year, that is to say, the appearance of the abnormal individual and of the domain of abnormalities as the privileged object of psychiatry. I began by promising a genealogy of the abnormal individual on the basis of three characters: the great monster, the little masturbator, and the recalcitrant child. The third figure is missing from my genealogy and I hope you will forgive me for this. You will see its outline appear in today's exposition. I have not had time for its genealogy, so we leave it in outline.

By looking at a particular case, today I want to show the quite precisely compound and mixed figure of the monster, the little masturbator, and, at the same time, the recalcitrant individual, or anyway, the individual who cannot be integrated within the normative system of education. The case is from 1867 and you will see that it is ex-

tremely banal. However, if this case does not enable us to mark the exact date of birth of the figure of the abnormal as an individual who can be psychiatrized, at least it indicates roughly the period in which and the way in which the figure of the abnormal individual was psychiatrized.

Quite simply it is the case of an agricultural worker of the Nancy region who, in the months of September and October in 1867, was denounced to the mayor of his village by the parents of a little girl he had almost, partly, or more or less raped. He is charged. He undergoes a first psychiatric examination by a local doctor and is then sent to Maréville, which was and still is, I believe, the major asylum for the Nancy region. Here, over several weeks, he undergoes a thorough psychiatric examination by two psychiatrists, at least one of whom, Bonnet, was a prominent figure.<sup>1</sup> What does this individual's file reveal? He was about forty years old at the time of the events. He was an illegitimate child and his mother died when he was still very young. He lived as best he could, a bit on the margins of the village, poorly educated, a bit drunk, solitary and badly paid. In short, he is more or less the village idiot. And I assure you that it is not my fault that this character is called Jouy. The questioning of the little girl reveals that Charles Jouy first got her to masturbate him in the fields. In fact, Charles Jouy and the little girl, Sophie Adam, were not alone. There was another young girl who watched them, but when her young friend asked her to take over she refused. Afterward, they recounted what had happened to a peasant who was returning from the fields, boasting of having, as they said, made *maton*, the local dialect word for curdled milk, with Jouy.<sup>2</sup> The peasant seems not to have worried about it further, and it is only a bit later, the day of the village festival, that Jouy dragged young Sophie Adam (unless it was Sophie Adam who dragged Charles Jouy) into the ditch alongside the road to Nancy. There, something happened: almost rape, perhaps. Anyway, Jouy very decently gives four *sous* to the little girl who immediately runs to the fair to buy some roasted almonds. She says nothing to her parents, of course, for fear, she says later, of getting a

couple of slaps. It is only some days later that the mother, when washing the little girl's clothes, suspects what happened.

The fact that legal psychiatry took responsibility for a case like this—that it sought in the depths of the countryside for someone accused of an offense against public decency (and, I would say, a quite commonplace accused and a quite everyday offense), that it then took this individual and subjected him to a first psychiatric assessment and then to a second, much deeper, very thorough and meticulous examination, that it placed him in an asylum, that it easily got the investigating magistrate to declare that there were no grounds for prosecution, and finally that it obtained the definitive “confinement” of this character (if the text is to be believed)—represents not merely a change of scale in the domain of objects with which psychiatry is concerned, but actually a completely new way in which it functions. What is this new way for psychiatry to function that we see in this kind of case?

I would like to recall the first model case with which I started some months ago: the Henriette Cornier case.<sup>3</sup> As you know, Henriette Cornier was the servant who decapitated a little girl without a word or explanation, without the trappings of any kind of discursive support. An entire social landscape appears in the Henriette Cornier case. She, too, naturally, was a peasant girl, but the peasant girl who had moved to the town. She was a lost girl in many senses of the term since she had wandered from place to place; her husband or lover had abandoned her; she had had several children whom she had abandoned in turn; she had more or less been a prostitute. A lost girl, but a silent figure who, without explanation, committed a monstrous act that simply irrupted in the urban environment in which she found herself and passed before the eyes of the spectators like a fantastic, black, enigmatic meteor that no one can say anything about. Nobody would have said anything if the psychiatrists had not been interested in her for a number of theoretical and political reasons.

The Charles Jouy case has certain similarities, but he occupies a quite different landscape. In a sense, Charles Jouy is the fairly familiar

figure of the village idiot: He is the simpleton, the mute. He has no origins; he is an illegitimate child. He, too, is unsettled and goes from place to place. When he is asked, "What have you done since you were fourteen years old?" he answers, "I have been in one place and then another." He was also thrown out of school: "Were they pleased with you . . . at school?" Answer: "They didn't want to keep me." He was excluded from games: "Did you sometimes play with the other boys?" Answer: "They didn't want me." He was also excluded from sexual games. With regard to the masturbation, the psychiatrist quite sensibly asks him why he did not approach older girls. Charles Jouy answers that they mocked him. He was equally rejected in his home: "What did you do when you returned [from work; M.F.]" Answer: "I stayed in the stables." He is, then, a marginal figure, but he is far from being a stranger in his village. He is firmly inserted within the social configuration in which he moves and circulates, and he has a function within it. He fulfills a quite precise economic function since he is the last of the workers in the strict sense. That is to say, he does the worst jobs that no one wants to do and he is paid at the lowest rate: "How much do you earn?" He answers: "One hundred francs, food and a shirt." The going rate for an agricultural worker in this region at that time was four hundred francs. He is the internal immigrant who has a role and lives in the marginal society of the low paid.<sup>4</sup>

His floating, unsettled character has a very precise economic and social function. From what we can gather from the text, even the sexual games he engages in, and which are the object of this case, seem to be as firmly established as his economic role. When the two young girls masturbate the simpleton in a corner of the woods or along the side of a road, they boast about it to an adult without difficulty; they laugh and say they have been making curdled milk, to which the adult merely replies: "Oh, you little horrors!" The matter goes no further. All this clearly formed part of a social landscape and practices that were very familiar. The young girl more or less lets it happen; she seems to receive a few *sous* quite naturally and runs to the fair to buy some roasted almonds. She says nothing to her parents

simply to avoid being given a couple of wallops. Moreover, during his questioning, Jouy says that he had done it only twice with Sophie Adam but had often seen her doing it with other boys. Besides, the whole village knew it. Once he had come across Sophie Adam masturbating a boy of thirteen or fourteen along the side of the road while another young girl was doing the same thing with another young boy beside them. The psychiatrists themselves recognized that this was part of a social landscape that until then was quite familiar and tolerated, since in their report Bonnet and Bulard say: "He acted . . . in a way that one often sees children of different sexes behave with each other; we mean [they add as a precaution; M.F.] those badly brought up children whose bad tendencies are not [sufficiently; M.F.] restrained by supervision and good principles."<sup>6</sup> We have here a village infantile sexuality of the open air, the side of the road, and the undergrowth that legal medicine is cheerfully psychiatrizing. And it is doing so in a carefree way that, it must be said, raises a problem if we think of the difficulties encountered some years earlier in psychiatrizing something so enigmatic and monstrous as Henriette Cornier's crime or Pierre Rivière's crime.

The first thing to note is that we are dealing with a psychiatrization of practices and individuals that essentially seem to be well established in the social landscape of the village at that time. The first thing to keep in mind, I think, is that this psychiatrization does not come from above, or not only from above. It is not a codification imposed from outside with psychiatry fishing in troubled waters because of a problem, a scandal, or an enigma, the enigmatic figure of Jouy. Not at all: From the very start we begin to make out a real mechanism of appeal to psychiatry. We should not forget that it is the little girl's family who discovers the facts through the famous inspection of the dirty linen that I have spoken about in connection with masturbation and which I told you was one of the hygienic and moral instructions given to families from the end of the eighteenth century.<sup>7</sup> It is the family, then, that becomes aware of it and it is the family that asks the mayor to do something about it. The little girl expected to be walloped, but in fact the family had already given up

this kind of reaction and was already plugged into another system of control and power. The first expert, the doctor B chet, hesitated. Faced with this known and familiar figure he might very well have said: OK, yes, he did it, he is responsible. Now this doctor B chet says in his first report: Of course, legally, judicially, he is responsible. However, in a letter attached to the report and addressed to the investigating magistrate, he says that the "moral sense" of the accused "is insufficient to resist animal instincts." It is a case in fact of a "dim-witted person who can be forgiven because of his abstruseness."<sup>8</sup> The meaning of this fine phrase is mysterious but essentially it suggests that this doctor (who is no doubt a country doctor or the doctor of the canton) is clearly appealing to the possibility of a more serious and thorough psychiatrization. It seems, moreover, that the village itself had taken responsibility for the affair and had transferred it to a completely different level from that of the slaps expected by the young girl. The mayor was gripped by the case, and it is the mayor who called in the public prosecutor. Furthermore, after the report of the psychiatric experts, the entire population of Loupcourt, the name of the village, keenly desired that little Sophie Adam to be confined in a house of correction until she came of age.<sup>9</sup> What perhaps we see emerging here, and at a relatively deep level, is the concern of adults, of a family and a village, about this peripheral, floating sexuality that brings children and marginal adults together. Then, again at a relatively deep level, we see resort to an agency of control that branches out in different directions since what the family, village, mayor, and, up to a point, the first doctor demand is a house of correction for the little girl and either a court or the psychiatric asylum for the adult.

Faced with something that a few years earlier would doubtless have seemed perfectly commonplace and anodyne, the whole village makes an appeal, a somewhat confused, indifferent, and combined reference to higher authorities of technical, medical, and judicial control. How does psychiatry react to this appeal? How does a psychiatrization that is requested, rather than imposed, take place? To understand how a character like this was psychiatrized we need to look a bit more at the model I referred to a short while ago, that is to say, Henriette

Cornier. What did one look for when one sought to psychiatrize Henriette Cornier, or, more simply to demonstrate her madness, her mental illness? First of all, one looked for a physical correlation, that is to say, a physical element that could at least serve as the triggering cause of the crime, and one found, quite simply, her periods.<sup>10</sup> Above all, and more seriously and fundamentally, one tried to inscribe Henriette Cornier's decapitation of a child within an illness that was naturally very difficult to see but whose signs a practiced eye at least could detect. And this was how, not without difficulty and much subtlety, one came to refer all this back to a change of mood that affected Henriette Cornier at a certain time of her life and marked the insidious invasion of this illness that remained practically without any other symptom except the crime, but which was already signaled by this little crack in her mood. Then one tried to assign to this change a certain instinct that is monstrous, sick, and pathological in itself, which passes through conduct like a meteor, an instinct to murder that resembles nothing, corresponds to no interest, and is not inscribed within any system of pleasure. It is present as an automatism that passes through Henriette Cornier's behavior like an arrow and that nothing can justify except, precisely, a pathological basis. The sudden, partial, discontinuous, heterogeneous, senseless character of the act with regard to the whole of the personality is what enables Henriette Cornier's act to be psychiatrized.

Now the psychiatrization of Jouy's actions and behavior proceeds quite differently in Bonnet and Bulard's report. First of all, his behavior is not psychiatrized by situating it within a definite chronological process, but rather by inserting it in a sort of permanent physical constellation. What the psychiatrists look for in order to demonstrate that they are dealing with someone who can be psychiatrized, what they identify in order to claim Jouy's conduct for their competence, what they need, is not a process but permanent stigmata that brand the individual structurally. And it is in this way that they make the following observations: "The face and cranium do not present the standard symmetry that one should normally find. There is a lack of proportion between trunk and limbs. The cranium is faultily

developed; the forehead recedes, which, with posterior flattening, makes the head into a sugarloaf; the lateral sides are also flattened, which raises the parietal bones more than is usual."<sup>11</sup> I stress all these descriptions that indicate what should be normal, the arrangement one usually finds. The accused is subjected to a series of measurements of the occipital-frontal, occipital-chin, frontal-chin, and bi-parietal diameters, of the frontal-occipital circumference and of the anterior-posterior and bi-parietal semi-circumferences, and so on. In this way it is ascertained that the mouth is too wide and that the palate has an arch that is typical of imbecility. You can see that none of these elements given by the examination constitutes either a cause of or even a principle for triggering the illness, as when it was observed that Henriette Cornier was menstruating when she committed her act. In actual fact, all these elements, together with the act itself, form a sort of polymorphous constellation. The act and its stigmata refer—all of them, and in some way on the same plane, even if their nature is different—to a permanent, constitutive, congenital condition. The deformities of the body are, as it were, the physical and structural outcomes of this condition, and the aberrations of conduct, those precisely that earned Jouy his indictment, are its instinctual and dynamic outcomes.

Broadly speaking, we can say that for Henriette Cornier, and at the time of the mental medicine of monomania, starting from a crime that one wanted to turn into a symptom, one constructed beneath it a pathological process. In the case of Charles Jouy and in this new kind of psychiatry, the offense is instead integrated within a schema of permanent and stable stigmata. A psychiatry of the permanent condition that guarantees a definitively aberrant status replaces a psychiatry of pathological processes that create discontinuities. What is the general form of this condition? In the case of Henriette Cornier and what was called "instinctual madness," which was more or less constructed around cases like this, the pathological process that was supposed to support the criminal act had two characteristics. First of all, it was like the inflation, the turgescence, the looming up of the instinct and the proliferation of its dynamism. In short, it is an excess

that marks the pathological functioning of the instinct. The consequence of this excess was a blindness such that the mentally ill person could not even conceive of the consequences of his action; the force of instinct was so irresistible that he could not integrate its mechanisms within a general calculation of interest. So the pathological core is fundamentally the looming up, inflation, and exaggeration of an instinct that has become irresistible. As a result, there is blindness, absence of interest, and absence of calculation. This is what was called "instinctual delirium." In the case of Charles Jouy, however, the signs that are put together to constitute the condition that allows the act to be psychiatrized reveal a very different configuration in which it is not the excess and exaggeration of an instinct that suddenly wells up that is fundamental and takes precedence (as in the case of monomania and instinctual madness). What is primary, fundamental, and the very core of the condition in question is deficiency, lack, and arrested development. That is to say, Bulard's and Bonnet's description of Jouy does not look for an intrinsic exaggeration as the origin of his conduct but rather a sort of functional imbalance that means that in the absence of inhibition or control, or in the absence of the higher levels that secure the establishment, domination, and subjection of the lower levels, these lower levels will develop on their own account. Not that there is a sort of pathological bacillus in these lower levels that would suddenly throw them into turmoil and multiply their strength, dynamic, and effects. It is not at all a case of this, and these lower levels remain what they are; but they begin to dysfunction only when what should have integrated, inhibited, and controlled them is put out of play.<sup>12</sup>

There is no illness intrinsic to instinct. Rather, there is a sort of functional imbalance of the whole, a sort of bad setup in the structures that ensures that the instinct, or a certain number of them, is made to function "normally" in terms of their own regime, but "abnormally" in the sense that this regime is not controlled by levels whose function is precisely to take charge of the instincts, put them in their place, and delimit their action. A number of examples of this new type of analysis can be found in Bonnet and Bulard's report. I will

look at just a few of them. They are important, I believe, for a good understanding of the new interlocking or the new functional filter in terms of which one tries to understand pathological behavior. There is the way in which adult genital organs are described, for example. Bonnet and Bulard conduct a physical examination of the accused; they examine his genital organs. They note: "Despite the very small size [of the accused; M.F.] and his marked arrested physical development, his [genital; M.F.] organs are normally developed like those of an ordinary man. This phenomenon is found in imbeciles."<sup>13</sup> What is seen in imbeciles is not the abnormal development of the genital organs but a contrast between perfectly normal genitals and a lack of the enveloping structure that should restore the role of such organs to their proper place and proportions.<sup>14</sup>

The entire clinical description is carried out in the same way. Consequently, the reality of lack is the first spur, the point of departure of the behavior to be analyzed. Exaggeration is only the visible consequence of this primary and fundamental lack, the opposite of what we found with the alienists when they sought the pathological core in the irresistible violence of instinct. Thus in the analysis of Jouy there are a number of statements such as: He is not wicked, they say, and is even "gentle," but "the moral sense has failed." "He does not have sufficient mental self-possession to resist by himself certain tendencies that he may . . . regret later, without this however allowing us to conclude that he will not start again. . . . These bad instincts . . . are due to his original arrested development, and we know that sometimes their irresistibility is greater in imbeciles and degenerates. . . . Fundamentally affected by arrested mental development, lacking the benefit of any education . . . he does not possess what is needed to counterbalance the tendency to evil and to resist successfully the tyranny of the senses. . . . He does not possess the mastery of 'self' that would enable him to contain the incitements of his thoughts and carnal drives. . . . The mastery of such powerful animality . . . does not have the support of faculties that can soundly appraise the value of things."<sup>15</sup>

As you can see, what calls for psychiatrization and what charac-

terizes the condition is not an excess in quantitative terms or an absurdity in terms of satisfaction (as was the case, for example, with the psychiatrization of Henriette Cornier); rather, it is a lack in terms of inhibition, a spontaneity of lower and instinctual processes of satisfaction. Hence the importance of "imbecility," which is functionally and essentially linked to aberrations of behavior. We can say then that the condition that enables Jouy to be psychiatrized is precisely what caused his arrested development: It is not a process that plugs into or grafts itself onto him, or which passes through his organism or behavior; it is an arrested development, that is to say, quite simply his infantilism. The psychiatrists constantly refer to his childish behavior and intelligence: "We cannot liken his behavior better than to that of a child who is happy when he is praised."<sup>16</sup> Here is the infantile character of Jouy's morality: "Like children who have done wrong . . . he is frightened of being punished. . . . He will understand that it is wrong because he is told so; he will promise not to do it again, but he does not appraise the moral value of his actions. . . . We find him puerile, with no moral consistency."<sup>17</sup> His sexuality is also infantile. I have just quoted the text in which the psychiatrists say: "He acted like a child and, in this case, as one often see children of different sexes behave with each other," but "badly brought up children whose tendencies are not restrained by supervision," et cetera.<sup>18</sup> This, it seems to me, is the important point. At any rate, I do not know if it is important, it is just where I wanted to get to: a new position of the child is being defined vis-à-vis psychiatric practice. It is a matter of establishing continuity with childhood, or rather of immobilizing life around childhood. It is this immobilization of life, conduct, and performance around childhood that essentially makes psychiatrization possible.

In the analysis of the alienists (those of Esquirol's school who were concerned with Henriette Cornier), what really allowed one to say that the subject was ill? It was precisely that, as an adult, she did not resemble in any way the child she had been. What was said to demonstrate that Henriette Cornier was not responsible for her act? You recall that it was: When she was a child she was smiling, cheerful,

kind, and affectionate. Then, at a certain point, when she became an adolescent or adult, she became gloomy, melancholic, taciturn, not saying a word. Childhood, then, must be separated from the pathological process so that the latter can effectively function and play its part in the deresponsibilization of the subject. You can see why the signs of infantile wickedness were a stake and the object of an important struggle in the medicine of mental alienation. You recall, for example, the concern and perseverance manifested in the struggle over the signs of childhood wickedness in the Pierre Rivière case.<sup>19</sup> With these signs one could ultimately arrive at two conclusions. One could say: Look, when he was very young he was already torturing frogs, killing birds, and burning the soles of his brother's feet. That shows that the conduct that would one day lead him to kill his mother, his brother, and his sister was already being prepared in his earliest childhood. So, with this crime we are not dealing with something pathological, since from earliest childhood his whole life resembles his crime. You can see, then, that when the psychiatrists wanted to psychiatrize the affair and remove Rivière's guilt, they had to say: But these signs of wickedness are precisely paroxysmal signs of wickedness, and besides they are so paroxysmal that we only find them at a certain period of his childhood. Before he was seven years old there was no trace of them; it is only afterward that everything begins. This means that the pathological process that ten or thirteen years later will end up with the crime was already at work. Hence the legal-psychiatric battle around childhood wickedness, a battle whose echoes and traces will be found throughout the legal psychiatry of 1820, 1860-1880, and even beyond.

With this new mode of psychiatrization, with this new problematic that I am trying to define, signs of wickedness function in a completely different way. It is precisely inasmuch as an adult resembles what he was as a child and continuity can be established between childhood and the adult condition, that is to say, inasmuch as one can rediscover an earlier wickedness in today's act, that one can then identify that condition (*état*), along with its stigmata, that is the condition (*condition*) of psychiatrization. The alienists essentially said to Henriette

Cornier: You were not then what you later became, and for this reason we cannot convict you. The psychiatrists say to Charles Jouy: If we cannot convict you, it is because when you were a child you were already what you are now. You can see precisely why, from the beginning of the nineteenth century, the biographical history was required both by Esquirol's type of medicine of mental alienation and also by the new psychiatry I am now talking about. However, this history is made up of completely different lines, traces entirely different paths, and produces completely different effects of exoneration. In the medicine of mental alienation of the beginning of the century, one indicted when one said: He was already this; he was already what he is. Now, however, one exonerates when one says: What he is now he already was. In general terms, in the psychiatric assessment of Jouy we see childhood becoming an essential element in the new way in which psychiatry functions.

To sum up, Henriette Cornier murdered a child and she could be considered mentally ill only on the condition that she was radically separated from childhood in two ways. She was separated from the child she killed by showing that there were no bonds between her and this child whose family she hardly knew: There was no relationship of hatred and no bond of love between her and the child she scarcely knew. So the first condition for Henriette Cornier's psychiatrization is a minimum of relationships with the child she killed. The second condition is that she was herself separated from her own childhood. Her past, as a child and as a young girl, must resemble as little as possible the act she commits. Consequently there is a radical break between childhood and madness. Charles Jouy, however, can be psychiatrized only by establishing that he remains extremely close to and almost fused with his own childhood and the child with whom he had relationships. Charles Jouy and the young girl he more or less raped must be shown to have been so close to each other as to be of the same grain, of the same ilk, and—the word is not used but you will see it emerge—at the same level. It is their profound identity that will give psychiatry its hold. In the end, Charles Jouy could be psychiatrized because childhood and infantilism are features shared

by the criminal and his victim. Childhood as a historical stage of development and a general form of behavior becomes the principal instrument of psychiatrization. Moreover, I would say that it is through childhood that psychiatry succeeded in getting hold of the adult and the totality of the adult. Childhood has been the principle of the generalization of psychiatry; childhood has been, in psychiatry as elsewhere, the trap for adults.

I would like to say a few words now about how the child functions, about his or her place and role, in psychiatry. I think that with the introduction, not so much of the child, as of childhood as the central and constant point of reference for psychiatry, we can grasp quite clearly the new way in which psychiatry functions in comparison with the medicine of mental alienation, a new mode of functioning that will last for about a century, that is to say, until today. First of all, with regard to the discovery of childhood by psychiatry I would say that if I am right, then the discovery of the child or of childhood is not a belated phenomenon but takes place very early on. We have an example of it from 1867, but we could certainly find it earlier. Not only is it an early phenomenon but it also seems to me (and this is what I would like to show) that it is far from being the consequence of a broadening of psychiatry. Consequently, far from considering childhood as a new territory that is annexed to psychiatry at a certain point, it seems to me that it is by taking childhood as the target of its action, both of its knowledge and its power, that psychiatry succeeds in being generalized. That is to say, childhood seems to me to be one of the historical conditions of the generalization of psychiatric knowledge and power. How is the central position of childhood able to bring about this generalization of psychiatry? Summarizing things considerably, I think it is fairly easy to grasp the generalizing role of childhood in psychiatry. When childhood or infantilism becomes the filter for analyzing behavior, then to psychiatrize any conduct it is no longer necessary to insert it within an illness, to situate it within a coherent and recognized symptomatology (as had been the case in the period of the medicine of mental illness). It is no longer necessary to discover that little scrap of delirium that psychiatrists, even at the

time of Esquirol, sought with such frenzy behind what seemed to them to be a dubious action. The presence of any kind of trace of infantilism is enough for conduct to fall within the jurisdiction of psychiatry, for it to be possible to psychiatrize it. As a result, inasmuch as it is capable of fixing, blocking, and halting adult conduct and of being reproduced within it, all of the child's conduct is in principle subject to psychiatric inspection. Conversely, all adult conduct can be psychiatrized inasmuch as it can be linked to the child's conduct in one way or another, whether through resemblance, analogy, or a causal relationship. Consequently, all of the child's conduct is thoroughly scoured since it may contain an adult fixation within it. Conversely, adult conduct is scrutinized for any possible trace of infantilism. This is the first effect of generalization that the problematization of childhood introduces into the psychiatric field. The second effect arising from this problematization of childhood and infantilism will be the possibility of integrating three previously separated elements. These three elements are: pleasure and its economy; instinct and its mechanism; imbecility, or at least backwardness, with its inertia and insufficiencies.

Psychiatry during the Esquirol period (from the beginning of the nineteenth century until around 1840) was, as I have emphasized before, strongly marked by its failure to find a way of hitching together pleasure and instinct. It was not that pleasure could not figure in the Esquirol type of psychiatry, but that it figured only when invested in delirium.<sup>20</sup> That is to say, it was admitted that an individual's delirious imagination might well carry the direct and immediate expression of a desire (and this theme, moreover, goes back well beyond Esquirol to the seventeenth and eighteenth centuries).<sup>21</sup> Thus there are the classical descriptions of those who, when disappointed in love, imagine in their delirium that the person who has left them showers them with affection and love.<sup>22</sup> Classical psychiatry certainly accepted the presence of desire in delirium. However, instinct must be freed from pleasure if it is to function as a pathological mechanism because instinct ceases to be automatic if there is pleasure. An individual will necessarily recognize an instinct that is accompa-

nied by pleasure and will register it as liable to induce a pleasure. Therefore, because an instinct accompanied by pleasure naturally figures in a calculation, it cannot be regarded as pathological no matter how violent its movement. Pathologization through instinct excludes pleasure. As for imbecility, it was sometimes pathologized as the final consequence of the development of delirium or dementia and sometimes as a sort of fundamental instinctual inertia.

Now you can see that with someone like Charles Jouy, who has been subjected to this kind of psychiatrization, the three elements or three characters are brought together: the little masturbator, the great monster, and then the individual who rejects all discipline. Henceforth, instinct may well be a pathological element as well as bringing pleasure. The sexual instinct and Charles Jouy's pleasures are actually pathologized at the level of their appearance without the disconnection between pleasure and instinct that instinctual monomania required. It is enough to show that the process, the mechanism of instinct, and the pleasures that it gives, belongs to an infantile level and are marked by infantilism. Pleasure-instinct-backwardness, pleasure-instinct-retardation now constitutes a unified configuration in which these three characters are brought together.

When the major and privileged form of individuals who can be psychiatrized is defined by childhood, infantilism, and the blockage and immobilization around childhood, psychiatry is able to connect with neurology, on the one hand, and general biology on the other. This is the third way in which the problematization of childhood makes possible the generalization of psychiatry. Here again we could say that the Esquirol type of psychiatry could really become a medicine only through a number of what I would call imitative processes. It had to establish symptoms as in organic medicine; it had to name, classify, and organize different illnesses in relation to each other; it had to produce the same kind of etiologies as found in organic medicine, by looking in the body or in predispositions for elements that could explain the formation of the illness. The Esquirol type of mental medicine is medicine as imitation. However, when childhood becomes the focal point around which the psychiatry of individuals and be-

havior is organized, you can see how psychiatry can be made to function through correlation rather than imitation; the neurology of development and of arrested development, just as general biology with the analysis of evolution at the level of individuals or species, provides both the gap in which and the warranty with which psychiatry can function as scientific knowledge and as medical knowledge.

Finally, the fourth and, I think, most important way in which childhood is a factor of generalization for psychiatry is that childhood and infantilism of conduct offer psychiatry an object that is not so much, and perhaps even not at all, an illness or pathological process, but a certain unbalanced condition, that is to say, a condition whose elements do not function pathologically and that is not the basis of disease, but a condition that is nonetheless not normal. The system of reference of psychiatry, or at least the domain of objects that it tries to divide up and control, now comprises the emergence of an instinct that is not ill in itself, that is healthy in itself, but which it is abnormal to see appearing here and now, so early or so late and with so little control; the appearance of a type of conduct that is not pathological in itself but that should not normally appear within the constellation in which it figures. It is a hitch or a scramble in the structures that contrasts with normal development and constitutes the general object of psychiatry. Illnesses appear only secondarily, as a sort of epiphenomena, with regard to this condition that is fundamentally a condition of abnormality.

Psychiatry became the science of normal and abnormal behavior by becoming a science of behavioral and structural infantilism. Two consequences can be drawn from this. The first is that psychiatry was able to constitute itself as a general authority for the analysis of conduct through a kind of angled trajectory that increasingly focused on the little confused corner of life that is childhood. Consequently, it was not by capturing the whole of life and surveying the whole development of individuals from birth to death that psychiatry made itself a kind of general controlling body of conduct, the titular judge, if you like, of behavior in general, but rather by confining itself to childhood and digging ever more deeply into childhood. This enables

us to see why and how psychiatry was so relentless in putting its nose into the nursery or into childhood. It is not because it wanted to add an additional piece to its already immense domain. It was not because it wanted to colonize yet another little bit of life that it had not yet touched. Rather, psychiatry found in childhood the instrument of its possible universalization. However, the consequence that I want to underline is that by seeing psychiatry focusing on childhood in this way and making it the instrument of its universalization, we can, I think, if not remove, at least disclose, in any case quite simply draw attention to what could be called the secret of modern psychiatry, of the psychiatry inaugurated around 1860.

In fact, if we say that around 1850-1870 a new psychiatry is born that is different from the old medicine of the alienist (symbolized by Pinel and Esquirol),<sup>23</sup> we should nonetheless note that this new psychiatry dispenses with something that previously was essential for the justification of mental medicine. Quite simply, it dispenses with illness. Psychiatry ceases then to be a technique and knowledge of illness, or becomes such only secondarily and as a last resort. Around 1850-1870 psychiatry gave up at once delirium, mental alienation, reference to the truth, and then illness. What it considers now is behavior with its deviations and abnormalities; it takes its bearings from a normative development. Fundamentally, therefore, it no longer deals with illness and the person who is ill; psychiatry is a medicine that purely and simply dispenses with the pathological. And you can see that, starting in the middle of the nineteenth century, it finds itself in a paradoxical situation since mental medicine was essentially constituted as a science around the beginning of the nineteenth century by redefining madness as illness. It constituted madness as illness through a number of procedures, including those analogical procedures I referred to a moment ago. This was how psychiatry was able to constitute itself as a special science alongside and within medicine. By pathologizing madness through the analysis of symptoms, the classification of forms, and the search for etiologies, it could at last constitute a specific medicine of madness: This was the medicine of the alienists. Now from the period 1850-1870 psychiatry had to defend

its status as medicine since the effects of power that it was trying to generalize derived, in part at least, from this status. However, these effects of power and the status as medicine from which they derive are now applied to something that, even within the discourse of psychiatry itself, no longer has the status of illness but rather of abnormality.

To put things more simply, when psychiatry was constituted as the medicine of mental alienation, it psychiatrized a madness that was not, perhaps, an illness, but a madness that psychiatry was obliged to consider and assert as such in its own discourse if it was to be an authentic medicine. It could establish its power relation over the mad only by instituting an object relation that was one of medicine to illness: You will be ill for a knowledge that will then authorize me to function as medical power. Broadly speaking, this is what psychiatry said at the beginning of the nineteenth century. However, starting in the middle of the nineteenth century, there is a power relation that only holds fast (and still does so today) inasmuch as it is a medically qualified power, but a medically qualified power that brings under its control a domain of objects that are defined as not being pathological processes. Depathologization of the object was the condition for the generalization of psychiatric power that was nonetheless still medical power. This gives rise to a problem: How can a technological apparatus, a knowledge-power, function in such a way that, from the outset, the knowledge depathologizes a domain of objects that it nonetheless hands over to a power that can exist only as medical power? I think the central problem of psychiatry, perhaps you will say the obvious problem of psychiatry, is this medical power exercised over the nonpathological. In any case, this is where the problem is formed, and it is formed precisely around this investment of childhood as the central point on the basis of which generalization can take place.

I want now to reconfigure very schematically the history of what took place at that moment and starting from that moment. In the second half of the nineteenth century, to get these two differently orientated and even heterogeneous relations to work together, that is

to say, a medical power relation and a relation to depathologized objects, psychiatry had to construct a number of what could be called major theoretical edifices that are not so much the expression or reflection of this situation as its functional requirements. I think we should try to analyze the grand structures and theoretical discourses of psychiatry at the end of the nineteenth century in terms of technological advantages, starting from the point at which it became a question of maintaining or even increasing the power effects and knowledge effects of psychiatry through these theoretical or speculative discourses. I would like just to present schematically these grand theoretical constructions starting with three aspects of the constitution of a new nosography.

The first aspect involves organizing and describing a series of aberrant and deviant behaviors merely as syndromes of abnormalities, as abnormal syndromes valid in their own terms rather than as symptoms of an illness. In the second half or last third of the nineteenth century there is what could be called the consolidation of eccentricities into well-specified, autonomous, and recognizable syndromes. In this way the psychiatric landscape comes alive with a population that is completely new for psychiatry: the population of those who do not have symptoms of an illness but are the bearers of intrinsically abnormal syndromes, of eccentricities consolidated into syndromes. They form a long dynasty. I think that one of the first of these syndromes of abnormality is the well-known agoraphobia described by Krafft-Ebing, which is then followed by claustrophobia.<sup>24</sup> In 1867 Zabczyński writes a French medical thesis devoted to mentally ill arsonists.<sup>25</sup> There are the kleptomaniacs described by Gorry in 1879,<sup>26</sup> and the exhibitionists of Lasègue in 1877.<sup>27</sup> In 1870, in the *Archives de neurologie*, Westphal described the inverts. This is the first time that homosexuality appears as a syndrome within the psychiatric field.<sup>28</sup> Then the masochists appear around 1875-1880. In short, there is an entire history of these little people of abnormal individuals, of these syndromes of abnormality almost all of which emerge in psychiatry around 1865-1870 and populate it until the end of the twentieth [rectius: nineteenth] century. When, for example, a society for the protection of

animals conducts a campaign against vivisection, Magnan, one of the big names in psychiatry at the end of the nineteenth century, discovers a syndrome: the antivivisectionist syndrome.<sup>29</sup> I want to emphasize that, as you can see, there is nothing here that is the symptom of an illness: It is a syndrome, that is to say, a partial and stable configuration referring to a general condition of abnormality.<sup>30</sup>

The second characteristic of the new nosography being formed at this time is what could be called the return of delirium, that is to say, the reevaluation of the problem of delirium. Delirium was traditionally the core of mental illness. It is understandable, then, that psychiatrists should try to superimpose delirium on the abnormal when this becomes their domain of intervention, because with delirium they would have a medical object. The abnormal could be reconverted into illness if they could rediscover the traces or threads of delirium in all these abnormal behaviors whose grand "syndromatology" was being constituted by psychiatry. The medicalization of the abnormal thus implied or required, or in any case made desirable, the adaptation of the analysis of delirium to the analysis of the interplay between instinct and pleasure. Linking the effects of delirium to the mechanism of the instincts and the economy of pleasure would allow the formation of a true mental medicine, a true psychiatry of the abnormal. So, again in the last third of the nineteenth century, we see the development of the major typologies of delirium. However, these typologies of delirium are no longer organized around the delirious object or thematic, as in the time of Esquirol, but rather around its instinctual and affective root, around the interplay of instinct and pleasure underlying the delirium. It is in this way that the major classifications of delirium appear: persecution delirium, delirium of possession, the virulent crises of erotomania, and so on.

The third characteristic of this nosography, and this I think is the fundamental point, is the appearance of the curious notion of "condition" (*état*) introduced by Falret around 1860-1870 and which is then reformulated a thousand times, mainly in the term *mental background* (*fond psychique*).<sup>31</sup> What is a "condition"? As a privileged psychiatric object, a condition is not exactly an illness with a starting

point, causes, and processes; indeed, it is not an illness at all. The condition is a sort of permanent causal background on the basis of which illness may develop in a number of processes and episodes. In other words, the condition is the abnormal basis upon which illnesses become possible. You may wonder what difference there is between this notion of condition and the old, traditional notion of predisposition. The difference is that a predisposition was first of all a simple virtuality that did not mean that the individual was not normal: It was possible to be normal *and* predisposed to an illness. Second, predisposition meant that someone was predisposed to a particular type of illness and not another. The distinctive feature of the notion of a condition, as Falret and his successors use it, is that it is not found in normal individuals. A condition is not a more or less pronounced characteristic. The condition is a real, radical discriminant (*discriminant*). The individual who suffers from a condition, who has a condition, is not a normal individual. However, the peculiarity of this condition that is typical of so-called abnormal individuals is that it has an absolute, total etiological value. A condition can produce absolutely anything, at any time, and in any order. Both physical illnesses and psychological illnesses can be linked with a condition: dysmorphia, a functional disorder, a drive, an act of delinquency or drunkenness can all be linked to a condition. In short, anything that is pathological in the body or deviant in behavior may be a product of a condition. A condition does not consist in a more or less pronounced trait but essentially in a sort of general deficiency of the individual's levels of coordination. A condition is defined by a general disturbance in the play of excitations and inhibitions, by the discontinuous and unpredictable release of what should be inhibited, integrated, and controlled, and by the absence of a dynamic unity.

This notion of condition offers two big advantages. The first is that it allows any physical element or deviant behavior whatever, however disparate and distant they may be, to be connected with a sort of unified background that accounts for it—a background that differs from the state of health but nevertheless is not an illness. Consequently, this notion of condition has a formidable capacity for inte-

gration: It refers to nonhealth, but it can also bring into its field any conduct whatsoever as soon as it is physiologically, psychologically, sociologically, morally, and even legally deviant. The notion's capacity for integration in this pathology, in this medicalization of the abnormal, is clearly marvelous. At the same time, the second big advantage is that the notion of condition makes possible the rediscovery of a physiological model. This model was put forward successively by Luys, Baillarger, and Jackson, et cetera.<sup>32</sup> What is the condition? It is precisely the characteristic structure or structural whole of an individual who has either been arrested in his development or who has regressed from a later to an earlier state of development.

The nosography of syndromes, delirium, and conditions at the end of the nineteenth century corresponds to the major task that psychiatry could not avoid taking on and in which it could not succeed: that of promoting a medical power over a domain whose unavoidable expansion precluded it from being organized around illness. The paradox of a pathology of the abnormal gave rise to these grand theories or structures in order to function. However, if this notion of condition is isolated and developed as a sort of causal background that is an abnormality in itself, as it was by all the psychiatrists from Falret or Griesinger to Magnan or Kraepelin,<sup>33</sup> then this condition must be set within a sequence that can produce it and confirm it. What kind of body can produce a condition that definitively marks the whole of an individual's body? This gives rise to the need to discover the background-body, so to speak, that by its own causality confirms and explains the appearance of an individual who is the victim, subject, and bearer of this dysfunctional state (and here we open onto another immense theoretical edifice of the end of the nineteenth century). What is this background-body, this body behind the abnormal body? It is the parents' body, the ancestors' body, the body of the family, the body of heredity.

The study of heredity, or the attribution of the origin of the abnormal condition to heredity, constitutes the "metasomatization" required by the whole theoretical construction. This metasomatization and this study of heredity offer in turn a number of advantages to

psychiatric technology. First of all, it allows an indefinite causal permissiveness characterized by the fact that anything can be the cause of anything else. The theory of psychiatric heredity establishes that not only can a certain type of illness cause an illness of the same type in descendants, but also that with equal probability it can give rise to any other kind of illness of any type whatsoever. Furthermore, it is not necessarily an illness that causes another illness; it may be something like a vice or a defect. For example, drunkenness may be the cause of no matter what other form of behavioral deviation in descendants, whether this is alcoholism, of course, or an illness like tuberculosis, a mental illness, or even delinquent behavior. The causal permissiveness of heredity makes it possible to establish the most fantastic or, anyway, the most supple hereditary networks. Finding a deviant element at any point in the hereditary network will be sufficient to explain the emergence of a condition in an individual descendant. I will give just one example of this ultraliberal functioning of heredity and of etiology in the field of heredity. It is a study by Lombroso of an Italian murderer called Misdea.<sup>34</sup> He had a very large family so its genealogical tree was established in order to identify the point at which the "condition" was formed. His grandfather was very active but not very intelligent. One uncle was an imbecile, another was odd and irascible, a third was lame, and a fourth was a semi-imbecile, irascible priest. His father was odd and a drunkard. The murderer's eldest brother was obscene, epileptic, and a drunkard; his younger brother, the third in the line, was healthy; the fourth brother was impulsive and a drunkard; and the fifth brother was disobedient. Our murderer, then, was the second in the line.<sup>35</sup> As you can see, heredity functions—at the level of this metabody, this metasomatization—as the fantastic body of physical or functional or behavioral abnormalities that is the origin of the appearance of the "condition."

Another moral, rather than epistemological, advantage of this hereditary causality is that when the analysis of childhood and its abnormalities clearly shows that the sexual instinct is not naturally tied to the function of reproduction (you recall what I said last week),

heredity allows responsibility for aberrations appearing in descendants to be shifted back to previous mechanisms of reproduction in the ancestors. In other words, the theory of heredity allows psychiatry of the abnormal to be not just a technique of pleasure or the sexual instinct, and in truth not to be a technology of pleasure and the sexual instinct at all, but rather a technology of the healthy or unhealthy, useful or dangerous, profitable or harmful marriage. As a result, psychiatry focuses on the problem of reproduction precisely when it was integrating within its field of analysis all the aberrations that reveal a nonreproductive function of the sexual instinct. The consequence is a remoralization at the level of this fantastic etiology.

Finally, we can say that the nosography of abnormal states—reassigned to the great polycephalic, unstable, floating, and slippery body of heredity—is formulated in the theory of degeneration. "Degeneration" is formulated in 1857 by Morel,<sup>36</sup> that is to say, at the same time as Falret was getting rid of monomania and constructing the notion of condition.<sup>37</sup> It is the period in which Baillarger, Griesinger, and Luys put forward neurological models of abnormal behavior and Lucas scours the domain of pathological heredity.<sup>38</sup> Degeneration is the major theoretical element of medicalization of the abnormal. In a word, the degenerate is the abnormal mythologically—or, if you prefer, scientifically—medicalized.

On the basis of the constitution of the degenerate, set in place in the tree of heredity and bearing a condition that is not a condition of illness but one of abnormality, we can see that the theory of degeneration enables psychiatry, with its divergent power relation and object relation, to function. Even better, the degenerate gives a considerable boost to psychiatric power. In fact, you can see that when it became possible for psychiatry to link any deviance, difference, and backwardness whatsoever to a condition of degeneration, it thereby gained a possibility of indefinite intervention in human behavior. However, by giving itself the power to dispense with illness, by giving itself the power to dispense with the ill or the pathological and to connect a deviation of conduct directly with a definitive and hereditary condition, psychiatry gave itself the power of dispensing

with the need to find a cure. Certainly, at the beginning of the century mental medicine had made a great deal of incurability, but incurability was defined as such precisely in virtue of what was the necessary major role of mental medicine, namely, to cure. Moreover, incurability was only the current limit of the essential curability of madness. However, as soon as psychiatry becomes a technology of the abnormal, of abnormal conditions fixed by heredity through the individual's genealogy, it is easy to see that the project of curing has no meaning. In fact, this therapeutic meaning disappears along with the pathological content of the domain covered by psychiatry. Psychiatry no longer seeks to cure, or in its essence no longer seeks to cure. It can offer merely to protect society from being the victim of the definitive dangers represented by people in an abnormal condition (and this is what actually occurs at this time). With the medicalization of the abnormal and by dispensing with the ill and the therapeutic, psychiatry can claim for itself the simple function of protection and order. It claims a role of generalized social defense and, at the same time, through the notion of heredity, it claims the right to intervene in familial sexuality. It becomes the discipline of the scientific protection of society; it becomes the science of the biological protection of the species. I would like to halt here, at the point at which psychiatry takes on what for the time was its greatest power as the science and management of individual abnormalities. At the end of the nineteenth century it could claim to replace justice itself, and not only justice but also hygiene, and not only hygiene but eventually most social interventions and controls, so as to become the general body for the defense of society against the dangers that undermine it from within.

With this notion of degeneration and these analyses of heredity, you can see how psychiatry could plug into, or rather give rise to, a racism that was very different in this period from what could be called traditional, historical racism, from "ethnic racism."<sup>9</sup> The racism that psychiatry gave birth to in this period is racism against the abnormal, against individuals who, as carriers of a condition, a stigmata, or any defect whatsoever, may more or less randomly transmit to their heirs the unpredictable consequences of the evil, or rather of the non-

normal, that they carry within them. It is a racism, therefore, whose function is not so much the prejudice or defense of one group against another as the detection of all those within a group who may be the carriers of a danger to it. It is an internal racism that permits the screening of every individual within a given society. Certainly, there were very quickly a series of interactions between this racism and traditional Western, essentially anti-Semitic racism, without, however, the two forms ever being coherently or effectively organized prior to Nazism. We should not be surprised that German psychiatry functioned so spontaneously within Nazism. The new racism specific to the twentieth century, this neoracism as the internal means of defense of a society against its abnormal individuals, is the child of psychiatry, and Nazism did no more than graft this new racism onto the ethnic racism that was endemic in the nineteenth century.

I think, then, that these new forms of racism, which took hold in Europe at the end of the nineteenth century and the beginning of the twentieth century, should be linked historically to psychiatry. Nevertheless, it is clear that although it gave rise to this eugenics, psychiatry is far from being reducible to this form of racism, which covered or took over only a relatively limited part of it. However, even when psychiatry has got rid of this racism or when it did not activate these forms of racism, starting at the end of the nineteenth century, it nonetheless always essentially functioned as a mechanism and body of social defense. The three well-known questions currently put to psychiatrists who testify in court are: "Is the individual dangerous? Is the accused indictable? Is the accused curable?" I have tried to show how little meaning these three questions have with regard to the juridical edifice of the penal code that is still in force today. They are questions without meaning with regard to law, and they have no more meaning with regard to a psychiatry that really did focus on illness. However, they are questions that have a quite precise meaning when they are put to a psychiatry that essentially functions as social defense or, to adopt the terms of the nineteenth century, which functions as a hunt for "degenerates." The degenerate is someone who is a danger. The degenerate is someone who cannot

be reached by any kind of penalty. The degenerate is someone who, at all events, cannot be cured. These three questions with no medical, pathological, or juridical meaning have a very precise meaning in a medicine of the abnormal, which is not a medicine of the pathological and of illness. They consequently have a precise meaning in a medicine that essentially continues to be a medicine of the degenerate. This allows us to say that the questions the judicial apparatus still puts to psychiatrists today constantly revive and reactivate the problematic of the psychiatry of the degenerate at the end of the nineteenth century. Those well-known Ubu-esque descriptions that we still find today in medico-legal expert opinions, in which such an incredible picture is given of the individual's heredity, ancestry, childhood, and behavior, have a perfectly precise historical meaning. They are the remains (once, of course, the great theory and systemization of degeneration produced from Morel to Magnan has been abolished), the outcrops of the theory of degeneration that quite naturally find their home in answers to questions put by the court, but whose historical origin is the theory of degeneration.

I have tried to show that this seemingly tragic and crazy literature has its historical genealogy. It is bound up with the functioning, with the technology of psychiatry in the second half of the nineteenth century whose procedures and notions are still active today. I would like to take up again the problem of psychiatry as social defense at the end of the nineteenth century, starting with the problem of anarchy and social disorder. So, there is work to be done on political crime, social defense, and the psychiatry of order.<sup>10</sup>

1. Cf. H. Bonnet and J. Bulard, *Rapport médico-légal sur l'état mental de Charles-Joseph Jouy, inculpé d'attentats aux mœurs* (Nancy, 1868). Bonnet and Bulard were head doctors of the public insane asylum of Maréville where Jouy was confined after the declaration that there were no grounds for prosecution. Foucault refers to this case in *La Volonté de savoir*, pp. 43-44; English translation: *The History of Sexuality*, pp. 31-32.
2. Cf., H. Bonnet and J. Bulard, *Rapport médico-légal*, p. 3.
3. See the lecture of February 5, in this volume.
4. H. Bonnet and J. Bulard, *Rapport médico-légal*, pp. 8-9.
5. *Ibid.*, p. 3.
6. *Ibid.*, p. 10.
7. See the lecture of March 12, in this volume.
8. Béchét's report is found in H. Bonnet and J. Bulard, *Rapport médico-légal*, pp. 5-6.
9. *Ibid.*, p. 4: "The little girl's father complains a great deal about his daughter who is most undisciplined despite all the beatings she has been given. The population of Loupcourt . . . keenly desire that the little Adam girl be confined in a house of correction until she comes of age. . . . It would seem that the morals of the children and young people of Loupcourt are very lax." Cf. the lectures given by J. Bulard as president of the Société pour la protection de l'enfance (carton Rp. 8941-8990 of the Bibliothèque nationale de France).
10. See the lecture of February 5, in this volume. Cf. J. E. D. Esquirol, *Des maladies mentales*, vol. 1, pp. 35-36; vol. 2, p. 6, p. 52; A. Briere de Boismont, *De la menstruation considérée dans ses rapports physiologiques et pathologiques avec la folie*, (Paris, 1842) summarized in "Recherches bibliographiques et cliniques sur la folie puerpérale, précédées d'un aperçu sur les rapports de la menstruation et de l'aliénation mentale," *Annales médico-psychologiques* 3 (1851), pp. 574-610; E. Dauby, *De la menstruation dans ses rapports avec la folie* (Paris, 1866).
11. H. Bonnet and J. Bulard, *Rapport médico-légal*, p. 6.
12. *Ibid.*, p. 11: "Jouy is a natural child, and he has been congenitally warped. His arrested mental development has gone hand in hand with organic degeneration. He does possess faculties, however their strength is very limited. If from childhood he had been educated and been in contact with the general principles that govern life and society, if he had been subjected to a moralizing force, he could have made some progress; developing his reason, learning to organize his thoughts in a more relevant way, improving a debased moral sense that leaves him prey to drives appropriate to backward members of his kind, perhaps learning by himself the value of an action. Nonetheless, he still would have remained imperfect, but medical psychology would have been able to attribute him with a limited responsibility in regard to civil matters."
13. *Ibid.*, pp. 10-11.
14. *Ibid.*, p. 11: "This fact is seen in imbeciles and accounts in part for their tendencies because they possess organs that incite them, and as they do not have the faculty for judging the value of things or the moral sense to restrain themselves, they allow themselves be suddenly carried away."
15. *Ibid.*, pp. 9-12.
16. *Ibid.*, p. 7.
17. *Ibid.*, p. 9.
18. *Ibid.*, p. 10.
19. Cf., M. Foucault, editor, *Moi, Pierre Rivière*: English translation: *I, Pierre Rivière*.
20. Foucault is referring to those authors who, prior to the turning point represented by Griesinger and Falret (see the lecture of February 12, in this volume), applied Esquirol's ideas, *Note sur la monomanie homicide* (Paris, 1827).

21. The theme is already present in works such as those of T. Fienus, *De viribus imaginationis tractatus* (Louvain, 1608).
22. The first volume of R. Burton's *The Anatomy of Melancholy* (Oxford, 1621), and J. Ferriand's *De la maladie d'amour ou mélancolie érotique* (Paris, 1623), are devoted to "love melancholy."
23. See, for example, J. P. Falret, *Des maladies mentales et des asiles d'aliénés. Leçons cliniques et considérations générales* (Paris, 1864), p. iii: "The sensualist doctrine of Locke and Condillac then dominated with almost absolute mastery. . . . This doctrine of the philosophers. . . was imported into mental pathology by Pinel." Even more radical is the perception of distance ("The doctrines of our masters, Pinel and Esquirol, dominated mental medicine absolutely. . . . It is rare to see scientific doctrines so firmly consolidated that they are able withstand the successive efforts of three generations") and the awareness of a break starting in the 1850s, in J. Falret, *Études cliniques sur les maladies mentales et nerveuses* (Paris, 1890), pp. v-vii.
24. According to H. Legrand du Saulle, *Étude clinique sur la peur des espaces (agoraphobie des Allemands), névrose émotive* (Paris, 1878), p. 5, the term was not invented by Krafft-Ebing but by C. Westphal, "Die Agoraphobie. Eine neuropathische Erscheinung," *Archiv für Psychiatrie und Nervenkrankheiten*, 3/1 (1872), pp. 138-161, on the basis of a request from Griesinger in 1868.
25. E. Zabé's thesis, *Des Aliénés incendiaries devant les tribunaux* (Paris, 1867), was preceded by C. C. H. Marc, *De la folie*, vol. 2, pp. 304-400 (initially published under the title, "Considérations médico-légales sur la monomanie et particulièrement sur la monomanie incendiaire," *Annales d'hygiène publique et de médecine légale*, 10 (1833), pp. 388-474); H. Legrand du Saulle, *De la monomanie incendiaire* (Paris, 1856); (cf. Marc, *De la folie devant les tribunaux*, pp. 461-484).
26. T. Gorry, *Des aliénés voleurs. Non-existence de la kleptomanie et des monomanies en général comme entités morbides* (Paris, 1879). See also C. C. H. Marc, *De la folie*, vol. 2, pp. 247-303.
27. Ch. Lasègue, "Les exhibitionnistes," *Union médicale* 50 (May 1, 1877), pp. 709-714 (then in *Études médicales*, vol. 1 [Paris, 1884], pp. 692-700). Cf. the article cited, "Des exhibitionnistes" by V. Magnan.
28. J. C. Westphal, "Die conträre Sexualempfindung," (French translation: "L'attraction des sexes semblables," *Gazette des hôpitaux* 75 [29 June 1878]); Cf. H. Gock, "Beitrag zur Kenntniss der conträren Sexualempfindung," *Archiv für Psychiatrie und Nervenkrankheiten*, 5 (1876), pp. 564-574; J. C. Westphal, "Zur conträre Sexualempfindung," *Archiv für Psychiatrie und Nervenkrankheiten*, 6 (1876), pp. 620-621.
29. V. Magnan, *De la folie des autovivisectionnistes* (Paris, no date, 1884).
30. M. Foucault, *La Volonté de savoir*, pp. 58-60; English translation: *The History of Sexuality*, pp. 43-44.
31. Cf. J.-P. Falret, *Des maladies mentales et des asiles*, p. xi: "Instead of going back to the initial lesion of the faculties in mental illnesses, the specialist doctor must devote himself to the study of complex mental conditions (*états psychiques*) as they exist in nature."
32. J. G. F. Baillarger's studies are cited in the lecture of February 12, in this volume. The work of J. Luys to which Foucault refers are collected in *Études de physiologie et de pathologie cérébrales. Des actions réflexes du cerveau, dans les conditions normales et morbides de leurs manifestations* (Paris, 1874). Between 1879 and 1885, J. H. Jackson edited the review of neurology *Brain*. See in particular his essay, "On the Anatomical and Physiological Localisation of Movements in the Brain" (1875) in *Selected Writings* (London: s.l., 1931). Foucault's interest in Jackson's *Croonian Lectures* and in Jacksonism goes back to *Maladie Mentale et Psychologie* (Paris: P.U.F., 1954). English translation: *Mental Illness and Psychology* (New York: Harper Colophon, 1976), translated by Alan Sheridan.
33. To the authors already cited must be added E. Kraepelin, *Lehrbuch der Psychiatrie*, (Leipzig, 1883) and *Die psychiatrischen Aufgaben des Staates* (Jena: s.l., 1900); French translations: *Introduction à la psychiatrie clinique* (Paris: s.l., 1907), especially pp. 5-16, 17-28 and 88-89. Cf., *Clinical Psychiatry*, abstracted and adapted from the sixth German edition of *Lehrbuch der Psychiatrie* by A. R. Defendorf (New York: s.l., 1902).

34. On the Misdea case, see C. Lombroso and A.C. Bianchi, *Misdea e la nuova scuola penale* (Turin, 1884), pp. 86-95.
35. Cf. the genealogical tree of Misdea, *ibid.*, p. 89.
36. B. A. Morel, *Traité des dégénérescences*.
37. J. P. Falret, "De la non-existence de la monomanie" and "De la folie circulaire," in *Des maladies mentales et des asiles d'aliénés*, pp. 425-448 and pp. 456-475 (the two articles first appeared in 1854).
38. P. Lucas, *Traité philosophique et physiologique de l'hérédité naturelle*.
39. Cf. M. Foucault, *Il faut défendre la société*, p. 230; English translation: *Society must be defended*.
40. Foucault's seminar at the Collège de France in 1976 was devoted to "the study of the category of "the dangerous individual" in criminal psychiatry. The notions connected with the theme of "social defense" were compared with the notions connected with the new theories of civil responsibility, as they appeared at the end of the nineteenth century in *Dits et Écrits*, vol. 3, p. 130. (*The Essential Works*, vol. 1, p. 64.). This seminar brought to an end the series of investigations devoted to psychiatric expertise that began in 1971,