Why gentle teaching is more needed than ever.
***Madness and civilization* (Foucault) revisited.**

We need history if we want to understand the present state of things. To be more specific: we need to know the history of madness if we want to understand the contemporary need for gentle teaching. Why does it have to be gentle, and why does it have to be teaching? Obviously, because the contemporary practices are not gentle and because teaching is not synonymous with disciplining.

Michel Foucault, one of the French intellectual giants has studied the history of caring for deviant individuals from the late medieval times up to Freud. He published his book 'Madness and civilization' in the early sixties of the previous century. This summer I have read this book again, and it became obvious to me that his conclusions are even more correct today than they were at the time of the publication.[1]

Foucault situates the origin of caring for deviant people in what he coins as 'the great confinement'. In 1656, by order of king Louis XIII, the Hôpital Général was founded. The name is misleading, it is not a medical establishment. As an early absolutist state, France needed an institution to lock up people who in one way or another represented a threat for the State. Religion had already taken care of the heretics, the courts condemned criminals, but there was a need for yet another disciplinary institution for those people who did not follow the expected moral and social rules without actually being criminals.

This criterion explains the heterogeneity of the group of people who were to be confined: beggars, freethinkers, wayward sons, people with debts, prostitutes, and the insane. The common denominator is that they did not meet the moral expectations; during their stay in the hospital, they needed to be disciplined, usually by obliging them to work. Initially, people with mental problems and special needs were locked up together with the rest of the socially deviant people, but soon enough they were treated differently. Not as patients who are ill, even on the contrary. At that time, madness was considered to be the expression of man in his most natural condition, i.e. as an animal that needs to be chained and locked up. The only way to master animality and hence, madness, was through discipline and brutalizing.

It took another century before people with mental problems became an object of study for medical doctors. During the heydays of the Enlightenment, madness is understood as an effect of the passions which have overruled reason. For Foucault, this association between madness and passion is crucial, because as a consequence, insanity will be considered as the expression of an illness. The medical tradition going back to Galenus understood passions as a somatic process. Consequently, from mid-eighteenth century onwards, madness becomes a medical object of study. The etiological reasoning runs as follows. If passions become too passionate, the result is an overstimulation of the nerves. If this is the case for a longer period, the consequence is a nervous illness. Another century later, nervous illness becomes brain pathology and the wet dream of psychiatry is to join neurology.

This does not change the fact that people with mental problems are still regarded as deviant. They may be ill, but their illness is their own fault. Insanity is a consequence of a wayward way of life. If somebody gives in to his passions, he has

[1] My conclusions will be published in a book (december 2019), in the series 'Nieuw Licht' by Prometheus, Amsterdam, see https://www.nieuwlicht.online

made the wrong choices. These choices are not only wrong because of their immorality; they are especially wrong because they go against nature. The result is an overstimulation of the nerves and the brain, and finally a nervous illness. On top of that, this illness becomes hereditary and will reappear in the children and in their children, thus installing a degenerative breed of madness.

This is probably the most important conclusion of Foucault's study. Historically speaking, the origin of a nervous illness is situated in a lack of morality and this explains why insane people do not behave normal. From the eighteenth century onwards, madness is judged from a moral point of view, whilst receiving at the same time the status of illness. The combination of a moral judgment and a medical diagnosis finds an expression in the treatments of that time.

Those treatments demonstrate the then fashionable medical theories about illness. The actual treatments seem to be purely somatic, but at the very same time, they have a moral aim and address both the body and the soul. Both body and soul of the patient must be made stronger, purer, cleansed and more regulated. Bodily techniques such as ablution and immersion, dieting, purging, walking, running aimed at restoring the patient to his original innocence. This is necessary, because his illness is a result of his immoral lifestyle, meaning that insanity is considered as something of which to disapprove. In the further evolution of the treatment methods, the medical aspect becomes less important, whilst the moral part comes into the foreground. Simply put, the treatments evolve towards discipline and punishment.

In retrospect, this is not so strange. The step from a moral judgment to accusation is a small one. Mental problems find their origin in moral aberrations, and hence, the treatment should correct the moral base of these patients. The asylum wants to cure its residents by what is known during the nineteenth century throughout Europe as 'moral treatment'. Patients can be cured on condition that they are conscious of their illness and, more importantly, on condition that they know they have themselves contributed to their being ill. If these conditions are fulfilled, the patient will be willing to cooperate in a treatment of both his body and his mind. If he is not prepared to admit guilt, the normal treatment will not work for lack of cooperation. At that moment, the method turns into authoritarian, and sometimes even brutal disciplining. There is nothing gentle to it, on the contrary.

The very same evolution can be seen in a new form of treatment that arises by the end of the nineteenth century, and that is psychotherapy. It seems as if this treatment is radically new and different. In some respects, this may be true, but in my opinion, there is an important structural resemblance with the medical approach of the Enlightenment. The initial psychotherapeutic praxis is of course Freudian psychoanalysis; the latest version is cognitive behavioral therapy. As different as they might be, they share the same inheritance. A psychotherapeutic treatment requires an awareness in the patient that there is something wrong in his thinking and in his behavior. Because of that awareness, he will cooperate with the therapist to change himself. If not, he is considered as 'resistant to change'.

In case of classic psychotherapy, the therapist invites the patient to engage in an internal debate with himself, via the therapy, to come to reason. Such a debate with oneself is needed to correct his unreasonable, insane ideas. At the start of the twentieth century, this conviction has entered the general discourse up to the point where even a five-year-old boy takes it for granted. I am referring to little Hans, who is the central figure in one of Freud's five classical case studies. Freud himself did not

treat the little boy, his information comes from the parents who came to see him about the phobic anxieties of their child, asking for his advice. It is remarkable to see how a five-year-old boy in Vienna of 1905 uses the word 'Unsinn', nonsense, when referring to his phobic anxieties. He is convinced that his anxieties are unreasonable, that he has to fight them in an inner debate with the help and support of a moral master to whom his parents have turned for advice.

Only five years of age, and he must enter a debate with himself to bring himself to reason. What I want to highlight in this inner discussion is our ontological division, which is here already obvious in a child. The possibility of an inner debate is always there, and especially when we are confronted with pain, anxiety or lust; i.e., with things that escape our inner control. A panic attack – which is a common phenomenon – confronts us with the anxiety to lose ourselves, to fall into the abyss of unreason. At such a moment, we are in dire need of somebody else, who reassures us, preferably in a gentle way.

In 1900, the idea of gentle teaching is non-existent. Early psychotherapy is more humane compared to the moral treatment techniques, but basically, it follows the same logic. There is a clear role distribution in the therapeutic relationship. The doctor represents the voice of reason, he is the incarnation of a healthy, albeit authoritarian morality. The patient stands for the immoral, unreasonable part that needs to be brought to reason.

The consequences of this logic become obvious in case the treatment fails, that is, when the patient refuses to identify with the role of someone who is willing to follow the expected rules. At that moment, the originally medical techniques of the moral treatment in the asylum shift towards a disciplinary approach, meant to punish and deter. Bathing is replaced by cold showers, healthy movements by being spinned around on a turning machine. The initial cures, i.e. consolidation, purification, immersion and regulation of movement – are changed into techniques to discipline and punish. The patient is made to fear both his 'therapists' and the consequences of his behavior. Illness leads to pathological behavior, meaning immoral behavior that should be corrected. In case the treatment techniques do not have the desired effect, the final answer is imprisonment within the confinement of the asylum itself.

The practitioners of the nineteenth century moral treatment knew that the curative effects of their approach rested with their moral authority. This dovetailed with their moral understanding of insanity and mad behavior. From our contemporary point of view, the mixture between medicine and morals, between a medical treatment and punishment is outdated, immoral and unscientific. You will have a hard time if you want to find a medical doctor or a psychotherapist claiming that his treatment aims at a moral reeducation of the patient via a mixture of therapeutic and disciplinary techniques. These ideas have disappeared because of a paradigmatic shift in the early twentieth century. Science became synonymous with natural science, and the body became the sole object of medicine. Morality is banned from the consultation room, and even from science as such. Madness and deviant behavior are the consequences of a defective brain that needs to be mended. The medical doctor is a scientist-practitioner, just as the psychologist-psychotherapist who will join the health care system half a century later. Both of them are using evidence based scientific techniques to help their patients get better.

From a Foucauldian point of view, the most important difference between the contemporary practices and those of the nineteenth century is the current denial of

the moral strain that runs through our scientific practices. In his study of the history of insanity, Foucault demonstrates the origin of the straddle that haunts the health care in general and psychiatry and psychology in particular. The moment that psychiatry claimed a scientific status, psychiatrists had to deny the moral implications of their practice. In the same period, their supposedly medical techniques shifted to what Foucault coins as an enduring and persisting re-education, maybe even a special education. Often enough, the treatment became a brutal disciplining. It is an irony of history that a scientific approach of psychiatry sticks to a moral practice that will be denied and endorsed at the same time.

A closer look at our contemporary treatment techniques reveals their inherent moral strand. The very same endorsement and denial that happened in psychiatry is repeated mid-twentieth century when psychology had the luminous idea to abolish itself by turning into a so-called behavioral science. At the very moment that psychology cherished the illusion of becoming truly scientific, it revealed itself to be an eminently moralizing practice. Early behaviorism uses expressions such as desired and undesired behavior and promises nothing less than an ideal society based on 'behavioral engineering'. The illusion of a scientific psychiatry – that madness is a brain disease, which can be medically diagnosed and cured – finds its mirror image in the illusion of a scientific behavioral science, where it is said that behavioral disorders are the result of wrong learning processes which can be remediated by negative and positive reinforcement. That is: by punishment and reward. A crucial question is carefully avoided: who decides which behavior is desirable and which not, what are the criteria upon which such decisions are made?

From those two turning points in the history of human sciences onward, respectively in the mid-nineteenth and the mid-twentieth century, the spread between a denied moral stance and a loudly claimed scientific status leads to a recurring open crisis. The last example of such a crisis is the so-called anti-psychiatry. During the sixties of the previous century, a number of young psychiatrists rediscovered and denounced the moral and patriarchal stance in the psychiatric practice. What they probably did not understood, is that a moral stance is by itself inevitable when working in the mental health care, although it does not have to be a patriarchal one. A contemporary illustration of this crisis can be found in discussions between specialists in psychotherapy or in special needs education. If you take part in such a discussion, it won't take long before you will hear a supposedly decisive argument: "This is not scientific!", or "That is not evidence-based!' Such supposedly final arguments emerge often enough at the point where somebody wants to deny an ethical or moral aspect in the research or in the praxis that is under debate. It is very telling that you will almost never hear a similar argument when listening to a discussion between e.g. physicists.

At this point of my talk, it is obvious that we must question our contemporary praxis, in psychiatry, in clinical psychology, as well as in special needs education. Of course, we should work as scientifically as possible and of course, we need to be aware of recent research findings. But time has come for a renewed awareness of the fact that our job is always embedded in moral choices and obligations. It is not difficult at all to lay bare the moral substructure and superstructure of our contemporary mental health practice. Substructure stands for diagnostics; superstructure stands for

treatment. The diagnosis determines the goal of the therapy and, in case of a medical diagnosis, the specific ways in which a disease will be treated.

It is still a matter of debate whether this is the case for a diagnosis in the field of psychiatry and psychology. The antipsychiatric movement demonstrated the unreliability of the traditional diagnostic system, based on research with often spectacular research results. E.g. it was very well possible for the same patient to receive different diagnoses with different doctors, and even experienced psychiatrists failed to recognize a normal person amongst their patients. It became also clear that most psychiatric hospitals aimed at disciplining the patients by using a combination of medical and psychotherapeutic methods.

These failures became associated with traditional European psychiatry; as a reaction, the American Association for Psychiatry started a largescale attempt to construct a scientifically and clinically reliable new diagnostic system. They discarded all the old theories and recognized only one basis: observation, observation, observation. Their hope was that, if we observe psychiatric patients long enough, it must be possible to construct an objective categorization of psychiatric disorders. The result today is the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

In Europe, there is long standing conviction that Americans are sometimes rather naïve. I am not sure if that is true, but I do know that the idea of objective observation is an illusion, especially when the object of observation is human behavior. The consequence of such a supposedly objective observation is that social normativity sets the tone. I will come back to that later.

The first thing to discuss is whether the DSM realized its main goal, that is to develop a reliable diagnostic system. The short answer is simply no. From a medical point of view, the only thing the DSM succeeded in doing, is to present categorized descriptions of qualities, behaviors and emotions which are considered as deviant, mainly because the patient produces too much or not enough of them. There is no convincing evidence for biological causations, hence their choice for the word ‘disorder’ instead of the hoped-for ‘illness’.

The same reasoning goes for the use of the word ‘symptom’. DSM-descriptions are not about symptoms, but about qualities or emotions which are normal when present in a normal proportion. Intelligence is a quality; shame is an emotion. But at which point do we decide that it is too much or not enough? Let us take a diagnostic label that is well known: the borderline personality disorder. One of its characteristics is described as follows: ‘inappropriate, intense anger or difficulty controlling anger’. When can we consider anger inappropriate, and how intense has anger to be in order to be considered as intense? The same question arises for the rest of the diagnostic criteria, where we find quantitative qualifications such as: frantic, intense, markedly and persistently, recurrent, chronic, severe. Time and again, the clinician must decide whether a certain quality or affect exceeds the normal limits, a decision which must be made without having an objective standard.

Precisely at this crucial point, it becomes obvious how the attempt to create a scientific and supposedly objective diagnostic system ends in a moral judgment. This means that the DSM produces exactly the kind of thing it wanted to avoid. A diagnostic decision whether a quality or an affect exceeds a normal limit, is implicitly based on social criteria, meaning on a moral evaluation. This will be even more the case when we are talking about behavior. Amongst the diagnostic criteria for ADHD,

we find amongst others: “Often does not seem to listen when spoken to directly” and “Often fidgets with or taps hands or feet or squirms in seat”**.** Estimating whether often is often enough remains a matter of subjective evaluation. Colleagues of mine who are working in schools, tell me that they deliberately direct particular children to particular teachers and avoid putting them with certain other teachers, because they know by experience that a certain child will be diagnosed with ADHD by certain teachers and not by other members of the staff.

The same line of critique was formulated by the British Psychological Association at the time of the actual publication of the fifth DSM edition. The following quote comes from their larger critical discussion:

> “The putative diagnoses presented in DSM-V are clearly based largely on social norms, with ‘symptoms’ that all rely on subjective judgements, with little confirmatory physical ‘signs’ or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations.” [i]

End of the quote. Normative social expectations imply a moral evaluation. Based on the work of Foucault, this does not come as a surprise. We should not forget that the original aim back in the 17th century was to install a disciplinary institution for people who did not follow the expected moral and social rules without actually being criminals. Even today, when you are working in the field of mental health care, moral evaluations are in many instances inevitable. In my reading, this is not a problem by itself, although it obliges us to make several difficult choices. In my perspective, it is the denial of these moral implications that is dangerous. We must make moral choices anyway, and in case of a denial, such choices will be presented as objective, scientific, evidence-based. Meaning that discussion and self-reflection are not necessary.

This illustrates a major conclusion of Foucault’s work. Namely that every effort in psychiatry and, by extension, in psychology and special education, to become truly scientific, implies both an endorsement and a denial of the moral implications of its practice. The DSM confronts us with the latest example of this conclusion.

These inevitable moral implications become all the clearer if we look at the clinical effects of this kind of diagnosis. A medical diagnosis implies an etiological understanding of an illness, resulting in a medical treatment that aims at removing the cause. The DSM refuses deliberately every etiological reasoning and sticks to observation, with as a result that pathology is defined in terms of too much or too little of a given quality, emotion or behavior. Consequently, the aim of the treatment is clear: either to enlarge what is not enough or to weaken what is too much, with as sole criterion social adjustment, without actually admitting that this is the goal.

By and large, this means that the contemporary treatment techniques are structurally not that much different from those of a long-forgotten past, as described by Foucault. The very possibility of a treatment resides with the capacity of the patient to be reasonable. That is: his capacity to recognize that he has a problem, that he needs to change his thinking and preferably his behavior. If this capacity is present, the treatment can proceed as expected, meaning that the patient is invited to and helped with an inner debate to correct his wrong ideas and to adjust his behavior.

The contemporary version of this eighteenth century procedure is cognitive behavioral therapy. Eva Meijer, a Dutch philosopher and artist who suffered from a

depression and anorexia, describes how the therapist invited and helped her to make a differentiation between ‘good’ and ‘bad’ thoughts. In the next step of her therapy she had to learn to fight the undesired bad cognitions, I quote, ‘by questioning their veracity and by demonstrating that they don’t work.’[ii] In the background sits the therapist as a moral master deciding which thoughts are unreasonable and undesirable, guiding the patient and his inner debate.

Just to make sure that you do not think that I am exclusively targeting CBT, I hasten to add that the same critic goes for early psychoanalysis as well. Freud wanted to make his patients conscious of the irrational underpinnings of their symptoms by presenting them his correct interpretations. Their anxieties and neurotic problems were nonsense, even the five-year-old Hans was convinced of that, and a correct interpretation coming from the analyst was considered a good way to get rid of them.

Historically speaking, the condition for a successful psychotherapy remains the same: the patient must cooperate based on the insight that he himself is wrong. If this conviction is lacking, therapy becomes impossible. Uncooperative patients are accused of being ‘therapy resistant’, an idea that you can find both in psychoanalysis and in CBT.

At that moment, the treatment reveals its true aim, i.e. to discipline those who do not follow the conventional social norms. And here, as well, there is a structural resemblance between the contemporary and the classic approach. Foucault describes how the moral treatment, in case it failed, shifted from a continuous educational regime to an authoritarian disciplinary approach, ending in a confinement within the walls of the asylum itself. We can recognize the very same evolution today. In case a patient does not cooperate, he will meet a harsher regime, because his unruly problematic behavior must be stopped in one way or another. The C drops from CBT and the treatment shifts to behavioral therapy is its most primal version. Our contemporary approach is more humane, mainly because of the use of psychotropic drugs. Administering psychotropic drugs to rule out unruly behavior is helpful for us; I am not so sure that it is always that helpful for the patient. It makes the disciplinary aspect less visible, but it is still there. Again, it is very well possible that we cannot do without it, but in that case, it is a matter of ethical honesty to admit this necessity.

The mainstream evolution goes exactly in the opposite direction. Contemporary language helps to camouflage the authoritarian approach. Today, it is politically incorrect to talk about the impossible behavior of some of our clients. Language has turned into a soft newspeak. Do you remember the disaster with Apollo 13, back in 1970? Jim Lovell contacted earth with the ever since proverbial words: “Houston, we have a problem”. In the next decade, the word ‘problem’ became problematic, and in the nineties, the communication would have been: “Houston, we have a *situation*”. Even that expression is no longer politically correct. Today, we would hear Jim Lovell saying “Houston, we have a *challenge*”. In the meantime, our American colleagues use the very same expression for our patients: from time to time, they present us with ‘challenging behavior’. The expression stands for many things, but the base line is that the physical integrity of the person himself and of some members of the staff is endangered. To coin this as ‘challenging’ is to deceive ourselves.

Special education is close to psychiatry and psychology. Both claim a scientific status, which means that the inherent ethical and moral impact of clinical work is denied. The advantage of working in the field of special education is that such a denial is hard to maintain. The important word in 'special education' is education, because it is impossible to think about an educational practice without considering which goals you want to reach and which methods you are going to use. This is even more the case because a treatment that is at the same time educational, albeit a special education, implies a role distribution with the professional staff members taking in one way or another a position of authority.

It is time to acknowledge an obvious truth: our work does not fall apart in a technical part based on a scientist-practitioner model on the one hand and a moral-ethical stance on the other hand. The two are always mixed and the most important one is the moral-ethical part, because it determines our way of looking, and hence our practice. We need to reflect on that mixture, time and again, because there are no final answers. We do not want to impose brutal adjustments based on social norms, but an always permissive attitude doesn't work either. We do not want to be authoritarian, but a group cannot function without some form of authority. Denying what is obvious, leads to hidden disciplinary actions. Recognizing this means a confrontation with ethical and practical questions.

How can we introduce authority without being authoritarian? Which norms and values are truly important, and how can we implement them? The obvious answer is: as gentle as possible.

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[i]. "The putative diagnoses presented in DSM-V are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgements, with little confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations. Many researchers have pointed out that psychiatric diagnoses are plagued by problems of reliability, validity, prognostic value, and co-morbidity. […].
Diagnostic systems such as these therefore fall short of the criteria for legitimate medical diagnoses. They certainly identify troubling or troubled people, but do not meet the criteria for categorisation demanded for a field of science or medicine (with a very few exceptions such as dementia). We are also concerned that systems such as this are based on identifying problems as located within individuals. This misses the relational context of problems and the undeniable social causation of many such problems"
British Psychological Society (2011). *Response to the American Psychiatric Association: DSM-5 Development.* June 2011, pp. 1 – 26. http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf

[ii] Meijer, E. (2019). *De grenzen van mijn taal. Essay.* Amsterdam: uitgeverij Cossee, pp. 75-76. Een paar bladzijden verder vertelt ze hoe psychotherapie, waarin verhalen en verlangen centraal staan, ook bijgedragen heeft tot haar herstel.