Drawing on a Foucaultian genealogy to consider the constructions of psychopathology and sexualities in young people

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Abstract

This paper employs genealogical strategies to analyse examples from our own research in education relating to the construction of psychopathology and sexualities. We consider the application of four angles of scrutiny, discontinuity, contingency, emergences and subjugated knowledges (Foucault 1977, 1980, 1988). We explain the four angles of scrutiny and consider how these can be used to produce research practices commensurate with Foucaultian inspired genealogical strategies. For instance, we argue that subjugated knowledges form a critical component of the four angles of scrutiny. We propose that through their subjugation, these knowledges offer a different perspective to dominant knowledges on sexuality and psychopathology. It is our argument that it is precisely via this subjugation that these types of knowledges offer valuable perspectives to the construction of young people. Furthermore, highlighting contingency, discontinuity, emergences and subjugated knowledges makes for provocative moments, both substantively and methodologically, in the task of qualitative analysis.

Introduction

This paper discusses a strategy that draws on Foucaultian genealogy to analyse the construction of psychopathology and sexualities in young people. Significantly, this analysis takes as its point of departure an understanding of the constructed nature of truths. This constructed condition is depicted by Nietzsche, "Truth is undoubtedly the sort of error that cannot be refuted because it was hardened into an unalterable form in the long baking process of history" (Nietzsche, 1974, cited by Foucault, 1977, p. 144). Therefore, to shatter the 'unalterable form' of a particular truth, one needs a strategy that can disturb the impenetrability of its 'baking process'. This is precisely why we argue that genealogy is valuable for educational research on young people: it is an incisive strategy for getting at and disturbing the seemingly unalterable forms of truth produced about 'youth' in relation to psychopathology and sexualties. The paper is divided into three sections. We begin with a sketch of the theoretical strategy we intend to deploy. In sections two and three we go on to detail examples of the application of two components of this strategy. Section two discusses the application of contingency to analyse conduct disorder, a youth psychopathology. In section two discontinuity is used to analyse youth sexualities.

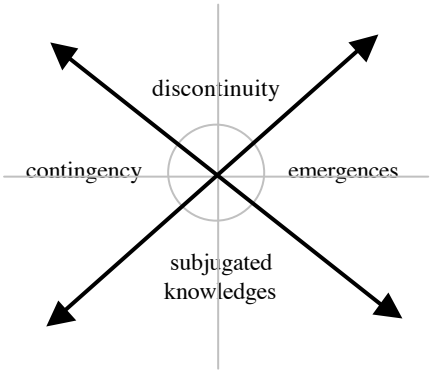
Drawing on Foucaultian genealogy

Psychopathology circulates in such a way that it has a truth function. Similarly, sexual identities may be sustained through recourse to scientific claims presumed to represent specific truths about particular groups of people. The task, therefore, is to devise a strategy to destabilise and jeopardise these truthful functionalities, a strategy that can unsettle their 'science'. Genealogy is especially valuable in this endeavour, a point Foucault (1980a) attests to, "...for it really is against the effects of the power of a discourse that is considered to be scientific that the genealogy must wage its struggle" (Foucault, 1980a, p. 84). In this struggle against the power of scientific discourse genealogy functions as "...insurrectionary knowledges, strategic interventions into the conditions of possibility of contemporary knowledge" (Jones & Ball, 1995, p. 48). By strategically intervening in the 'history of the present', genealogy can unsettle the truthfulness of conduct disorder and challenge the notion of choice in relation to 'sexual identity'.

In Harwood's (2000)[1] interpretation of Foucaultian genealogy, these four angles of scrutiny comprise the following genealogical tools: discontinuity, contingency, emergences and subjugated knowledges. These are depicted on the diagram below:

[1] This genealogical strategy was developed for Valerie Harwood's doctoral thesis titled "Truth Power and the Self: A Foucauldian analysis of the truth of Conduct Disorder and the construction of young people's mentally disordered subjectivity". Thesis completed under the supervision of Professor Jane Kenway, in the Centre for Studies in Literacy, Policy and Learning Cultures, School of Education, University of South Australia.

four angles of scrutiny



Discontinuity is the genealogical tool used in the first angle of scrutiny. As previously discussed, genealogical research concerns itself with a question from the present and then considers the question in terms of history of the present. To perform a genealogical 'history of the present' demands thinking very differently about 'history':

> ...if the genealogist refuses to extend his faith in metaphysics, if he listens to history, he finds that there is "something altogether different" behind things: not a timeless and essential secret, but the secret that they have no essence or that their essence was fabricated in a piecemeal fashion from alien forms. (Foucault, 1977, p. 142)

In performing this 'history of the present' the genealogist strives to create a jagged and discontinuous 'history of the present', a construction that is the opposite of a smooth and continuous history. This use of discontinuity is a valuable tactic to unsettle 'accepted' truths such as conduct disorder or notions such as the truth of sexual identity. For example, in relation to conduct disorder Bunton and Peterson (1997) assert that Foucault's "...method of genealogy or 'histories of the present' directs attention to discontinuities and ruptures in thought and involves recognition of multiple determinations and the role of chance" (1997, p. 3). The objective of applying this angle of scrutiny is to locate specific breaks and ruptures in the truth of conduct disorder and notion of choice related to sexual identity.

'Contingency' is the second angle of scrutiny we utilise in this genealogical strategy. The difference between contingency and discontinuity can be illustrated in terms of what the genealogist investigates. For discontinuity, the genealogist is looking for points of rupture and difference in the apparently 'continuous' truths. To consider contingency the genealogist asks questions such as 'on what conditions or occurrences was the creation of conduct disorder contingent?' This style of question implies that truths relating to sexual identity and conduct disorder are necessarily contingent on something and therefore were 'created' at certain points. Foucault (1988) explains this notion of contingency in Critical Theory/Intellectual History:

> ...the things which seem most evident to us are always formed in the confluence of encounters and chances, during the course of a precarious and fragile history. What reason perceives as *its* necessity, or rather, what different forms of rationality offer as their necessary being, can perfectly well be shown to have a history; and the network of contingencies from which it emerges can be traced. Which is not to say, however, that these forms of rationality were irrational. It means that they reside on a base of human practice and human history, and that since these things have been made, they can be unmade, as long as we know how it was that they were made. (Foucault, 1988, p. 37, author's emphasis)

Contingency thus functions as a practical tool because it brings to the surface the contingent nature of 'self evident' truths.

Ransom (1997) suggests that two aspects of contingency need to be considered by the genealogist. First, the genealogist needs to be aware that things "...which present themselves as natural end products of a comprehensible and progressive history are revealed as a cobbled patchwork of heterogenous elements" (Ransom, 1997, p. 88). Second, these things come together not in some regulated fashion, but "respond to haphazard conflicts" (Ransom, 1997 p.88 citing Foucault, 1977, p. 154). One means to take these points into consideration is to apply certain questions to the contingency of sexual identity and of conduct disorder. Foucault (1980b) suggests some possible tactical questions, including, "...why did that work? How did that hold up?" (Foucault, 1980b, p. 209). Taking these questions into account, one could ask a question also posited by Ransom, "what tactical alliances may have formed between different institutions or power groups or human-scientific discourses?" (Ransom, 1997, p. 91). Using these types of questions provokes a different interpretation of notions of sexual identity and of conduct disorder. One is prompted to ask, 'on what factors are these notions predicated' when they are deployed in educational settings?

Considering truth in terms of discontinuity and contingency enables the researcher to interpret truths as 'emergences'. In the previous quote, Foucault (1988) referred to 'emergence' and its relation to contingency when stating:

> What reason perceives as *its* necessity, or rather, what different forms of rationality offer as their necessary being, can perfectly well be shown to have a history; and the network of contingencies from which it emerges can be traced. (Foucault, 1988, p. 37, author's emphasis)

This consideration of truth as 'emergence' indicates that it emerged from somewhere, that it was created. We contend that describing truths as having 'beginnings' is a theoretical advantage because it points to the 'emergence' or 'emergences' of truths such as essential sexual identities or conduct disorder. By toying with the notion of beginnings, the genealogist can tactically exhume moments of emergence that disrupt this continuity. This type of manoeuvre engages genealogy in a Foucaultian ontology of the present.

Subjugated knowledge forms the fourth angle of scrutiny. This discussion of subjugated erudite and subjugated disqualified knowledges draws primarily from Foucault's (1980a) descriptions of subjugated knowledges in *Two Lectures*. In these lectures Foucault (1980a) outlines genealogy from the perspective of 'subjugated knowledges':

> Let us give the term *genealogy* to the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today. This then would be provisional definition of the genealogies which I have attempted to compile with you over the last few years. (Foucault, 1980a, p. 83, author's emphasis)

Foucault (1980a) refers to subjugated erudite knowledges and local memories as 'subjugated knowledges'. These subjugated knowledges are described by Foucault (1980a) as "...those blocs of historical knowledge which were present but disguised within the body of functionalist and systematising theory and which criticism - which obviously draws upon scholarship - has been able to reveal" (Foucault, 1980a, p. 82).

In order to demonstrate how the angles of scrutiny might be useful in the conduct of qualitative research we now offer two examples that indicate how these different angles of scrutiny may be engaged. The first example draws on contingency, to analyse a conduct disorder, a youth psychopathology.[2] The second example considers the notion of discontinuity and the production of subjugated erudite knowledges in relation to the problem of choice in sexual identity.

The contingency and youth psychopathology

In this section contingency, the first the angle of scrutiny, is discussed in relation to youth psychopathology, specifically to analyse the lack of a definition of 'mental disorder'. Conduct disorder is a mental disorder is defined by an influential compendium, the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders*. According to the American Psychiatric Association (1994), "Conduct Disorder is characterized by a pattern of behavior that violates the basic rights of others or major age-appropriate societal norms or rules" (APA, 1994, p. 38). In *DSM-IV* (APA, 1994, p. 38), conduct disorder is situated under the section "Disorders usually First Diagnosed in Infancy, Childhood and Adolescence". Other mental disorders listed in this section include 'Attention-Deficit/Hyperactivity Disorder (ADHD)", 'Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified', 'Oppositional Defiant Disorder' and 'Disruptive Behavior Disorder Not Otherwise Specified' (APA, 1994, p. 38). Because of this association with the *DSM-IV* (APA 1994), the use of the term conduct disorder in education makes a connection to an authoritative form of psychopathology. Those young people who are described as 'conduct disordered' and those young people placed in 'conduct

[2] For a detailed discussion of the application of using subjugated disqualified knowledges to analyse youth psychopathology see Harwood, V. (in press) 'Subjugation and Disqualification: Critiquing the discourses of psychopathological behaviour used in education', *Melbourne Studies in Education*.

disorder programs' are, through their relationships with schooling, connected to an extremely convincing scientific truth.

As stated above, conduct disorder is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, a manual this is considered to be one of the "most influential and widely used systems for classifying children with conduct disorders" (Frick, 1998, p. 216).[3] As its name would appear to indicate, this is a manual that defines mental disorders, and as such it seems logical to ask 'what is mental disorder?' It would seem appropriate that a definition of 'mental disorder could be located in the *DSM-IV*. In relation to this assumption a surprising answer can be found in a statement by Allen J. Frances, Chair of the *DSM-IV* Task Force:[4]

> DSM-IV is a manual of *mental disorders*, but it is by no means clear just what *is* a mental disorder and whether one can develop a set of definitional criteria to guide inclusionary and exclusionary decisions for the manual. Although many have tried (including the authors of the DSM-IIIR), no one has ever succeeded in developing a list of infallible criteria to define a mental disorder.[5] (Frances, 1994, p. vii, author's emphasis)

Given this admission, it is remarkable that the *DSM-IV* asserts a definition of conduct disorder and the definitions of many other 'mental disorders'. Further, in relation to the issue of definition, consider the following statement by two senior authors of an earlier edition, the *DSM-III*. Robert Spitzer, Chair of the *DSM-III* Task Force on Nomenclature and Statistics and Janet Williams, Text Editor of *DSM-III* and Coordinator of the *DSM-III* field trials (Grove, 1982) make this declaration:

> The DSM-III definition of mental disorder makes no assumption that each mental disorder is a discrete entity with sharp boundaries between it and other mental disorders or between it and no mental disorder. (Spitzer & Williams, 1982, p. 22)

If the Chief of the *DSM-IV* Task Force (the team responsible for overseeing the creation of *DSM-IV*) has difficulty enunciating a definition of mental disorder, and

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[3] The *DSM-IV* has been translated into several languages, including "Chinese, Danish, Dutch, Finnish, French, German, Greek, Hungarian, Italian, Japanese, Norwegian, Portuguese, Russian, Spanish, Swedish, Turkish and Ukrainian" (Caplan, 1995: xix). This influence has spread to Australia, where, for example, the "DSM system is deeply entrenched in Australian medical practice, and codes from the manual are required for lodging Medicare claims for psychiatric expenses" (Gosden, 1997: 59). Medicare is an Australian Government funded "health insurance scheme" that provides for free health care for public hospitals and subsidises treatment by medical doctors, including psychiatrists.

[4] This task force was responsible for overseeing the creation of *DSM-IV*.

[5] The following is the *DSM-III-R* definition referred to by Frances (1994), "In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder" (American Psychiatric Association, 1980: 6).

Spitzer and Williams (1982) can't specify any boundaries, then it seems extraordinary that conduct disorder can be so successfully defined. Moreover, it is perplexing that people are assigned diagnosis of mental disorder, such as conduct disorder, yet it is by "...no means clear just what *is* a mental disorder" (Frances, 1994, p vii). How is it there can be such confusion over what might be the most elemental of details? It could be imagined that the crux of diagnosing conduct disorder is knowledge of mental disorder, or at least differentiating between mental disorder and non-mental disorder.

Although this is apparently contradictory, here it is argued this very absentia is vital to the formulation of conduct disorder as a truth. Since the American Psychiatric Association's (1980, 1987, 1994) definitions of conduct disorder vary over three versions of the *DSM-III, DSM-III-R* and *DSM-IV*, designing and redesigning mental disorders such as conduct disorder can proceed with less restriction because this definition of mental disorder is inexact. From this perspective, such variation would be difficult if it was located within the constrictions of a well-defined notion of mental disorder. This 'indefinableness' of mental disorder is therefore contingent to creating, changing and deleting mental disorders. Thus as an angle of scrutiny, contingency enables a close analysis of how an influential and allegedly scientific diagnostic category is contingent on a less than 'scientific' and indefinable notion of mental disorder.

Contingency, as an angle of scrutiny, enables an analysis of the *contingent* foundations of conduct disorder, particularly that of an 'undefinable' notion of mental disorder. For conduct disorder to function as such a neat and exacting truth, its relationship to contingencies needs to be disguised. This raises the question as to whether conduct disorder is a phenomenon that has patiently awaited 'scientific' recognition. This we suggest is not the case. In this way contingency, as an angle of scrutiny, forms a valuable strategy for analysing this important youth issue.

Sexualities, choice and discontinuity

We now turn to a consideration of the problem of choice in relation to sexuality. People often discuss the notion of choice in relation to sexual identities, but in so doing, it is possible to see how the genealogist might perceive the language of 'choice' as a contested truth. Given that so much of contemporary US and Australian culture is deeply predicated on the notion that one's sexual identity is not a choice, a combination of relief and discomfort is an understandable response to the suggestion that sexual identities are not permanently fixed. However, the notion that young people's sexual identities are simply "up to them" is somewhat misleading. Schools and the broader society produce sexual identities and students are compelled to form themselves within forms that are already more or less in place (Butler and Connolly 2000; Epstein and Johnson 1998: 194). Whether or not people subscribe to the notion of choice, its deployment is an ongoing problem in secondary educational settings. These contestations surrounding sexual identity and the deployment of the language of choice in school settings can be analysed by drawing on discontinuity as an angle of scrutiny.

These problems may be partially situated in past practices whereby psychiatric diagnostic criteria was able to diagnosis people who identified as lesbian, gay and

bisexual as perverse and abnormal. It was only in 1973 that this was seemingly amended, and the American Psychiatric Association make the decision to remove homosexuality as a diagnostic category from future editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). It is our contention that this recent history of pathologising *sexual identity* is inextricably interrelated with the contemporary problem of *choice and sexual identity* in education. Building on the above discussion of discontinuity and the *DSM*, we will briefly consider the discontinuity of medical diagnosis relating to individual's sexual and gender identities in Australia.

There has been a discursive shift in Australian history from the classification of homosexuality as a criminal offence, to the treatment of homosexuality as a medical condition, a shift that has been traced by Robert Reynolds (1996). This discursive shift highlights the discontinuity surrounding scientific truths relating to sexual identification. According to Reynolds, in Australia in the 1960s and 1970s treatments to cure homosexuals of their pathology included aversion therapy whereby:

> Homosexuals…are shown projected still pictures of nude men. Just before this the patient is given an injection of apomorphine, a morphia derivative, which produces deep nausea, and is timed to produce a feeling of sickness just after the picture is screened. (Sydney Morning Herald, 14 October 1966, p.2 in REYNOLDS 1996: 29)

As Reynolds notes, medical experts' official prognosis "often deployed strategies of surveillance and regulation which were brutally invasive…neatly encapsulat[ing] the constraints of a medical discourse" (Reynolds 1996: 43). Officially, it is claimed that this practice of constructing homosexuality as an aberration has been halted within the discipline of psychiatry (at least in Australia and the US). Yet there is a discontinuity between this official affirmation and practices that continue to produce powerful truths sexual identities.

While people who identify as lesbian, gay and bisexual have now been removed from the official annals of pathology[6], people who identify as transgender, transsexual and intersex[7] are still commonly pathologised within medical discourse. In a study on how "technologies of gender"[8] work to produce sexual and gender identities, William Spurlin draws on Eve Sedgwick's analysis of the:

> … revisionary psychoanalytic developments…that depathologize *atypical sexual object-choice* (homosexuals) while in the same

[6] Notwithstanding these discursive shifts in official psychiatric discourse, groups within Australia such as the Association for Gay and Lesbian Orientation Research (AGLOR) are still intent on curing homosexuals of their pathology, see http://www.aglor.com/ accessed 04/09/01.

[7] For an in-depth discussion of the medical treatment of people who identify as intersex see Fausto-Sterling, A. 2000. *Sexing the body: Gender politics and the construction of sexuality*. New York: Basic Books, Kessler, S. 1998. *Lessons from the intersexed*. New Brunswick, New Jersey: Rutgers University Press.

[8] Spurlin borrows this term from Teresa de Lauretis, see de Lauretis, T. 1994. 'Habit changes'. *differences: A journal of feminist cultural studies* 6: 296-313..

> move, through the inclusion of gender identity disorder in the DSM[9], pathologising *atypical gender identification*. (Sedgwick, 1993: 158 in Spurlin 1998: 77)

The discontinuities in these shifting diagnoses relating to people's sexual and gender identities may be used to call into question the power of knowledges to pronounce disease and disorder. In short, to grasp the contemporary contestations relating to the problem choice in sexual and gender identity it is crucial to consider the discontinuities in past and present medical diagnoses.

The continuing power of the *DSM* to produce heteronormalising sexual and gender identities may be demonstrated by way of a brief outline of some contemporary debates regarding the construction of Gender Identity Disorder (GID). Young people who are thought to exhibit *atypical gender identifications* may now be diagnosed with GID in childhood. The criteria for the development of such a diagnosis in childhood include:

> …a repeated desire to be the other sex, a strong preference for cross-dressing, strong and persistent preferences for cross-sex roles in make-believe play, an intense desire to participate in the games and pastimes of the other sex, and a strong preference for playmates of the other sex. (APA, 1994: 537 in Spurlin 1998: 81)

Embedded in this diagnosis is the expert's investment in the maintenance of a distinct gender binary. For this diagnosis to exist it is necessary for practitioners to assume that there is some general agreement about what constitutes appropriate masculine and feminine attire, and masculine and feminine 'games and pastimes'. This delineation of masculine and feminine attire and behaviours must then be accompanied by the knowledge that the consistent desire to cross is somehow reflective of psychopathology.

Whilst GID is presented as an unproblematic diagnosis in the *DSM-IV*, there is clearly discontinuity in the way medical experts perceive this diagnosis. For instance, a bi-gendered therapist from Norway, Esben Benestad/Esther Pirelli, is critical of the construction of the GID diagnosis, arguing that the:

> …major proportion of children who have been diagnosed with GID grow into lesbian women and homosexual men with no transgender identity: a smaller proportion become heterosexual women and men with no transgender identity; a very small proportion[10] become transgendered. (Benestad 2001)

Benestad, draws on statistics regarding how children diagnosed with GID *choose* to construct their sexual and gender identities in adulthood in order to point to some of the problematics that may be associated with such a classification. These statistics

[9] American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*).

[10] Benestad quotes the figure of 4%, see Benestad, E.P., Esther 2001. *Options of gender belonging* Live video link, viewed 26/07/01.

imply strong links between GID diagnosis and the construction of lesbian and gay sexual identities.

In another example of discontinuity, William Spurlin, a queer theorist makes the case that GID diagnosis has homophobic and gender phobic underpinnings. In his study of 'Sissies and sisters' he argues that:

> …not only is the clinical domain not disembodied from heteronormativity…little attention is given to how what is proffered in the name of "clinical common sense" may have social and political consequences insofar as "treatment" of GID, usually at the behest of "concerned" parents, is often aimed at the prevention of gay outcome. (Spurlin 1998: 83)

For Spurlin and Benestad the diagnosis of GID appears inextricably tied to parental and medical anxieties about children's sexual identities. The links to previous diagnoses of *atypical sexual object choice* resonate in the formation of GID diagnoses, both are underpinned by the privileging of heterosexuality as the elemental form of sexual identity. This movement from the pathologisation of sexual identity disorders to the pathologisation of Gender Identity Disorders (GID) reflects the shifting assumptions that underlie the classification of *normal* sexual and gender identities; it appear those identities that do not conform to these norms may, at different historical moments, be classified as pathological.

The pathologisation of *atypical gender identifications* and *atypical sexual object choice* inevitably plays out in the discursive construction of choice in sexual identity in educational settings. The GID diagnosis demonstrates the processes by which scientific 'truths' may be utilised to exercise control over the lives of individuals through the development of medical diagnoses. These diagnoses, such as GID, are borne from the circulation of powerful knowledges that are inextricably connected to heteronormativity. Given this past and present history of the pathologisation of difference it is possible to understand how the prospect of choosing to identify as gay, lesbian, bisexual or transgender 'freaks out' young people, parents and teachers.

Conclusion

By using discontinuity as an angle of scrutiny it can be argued how the problem of choice may be 'buried' in educational contexts. Thus the above discussion of choice and sexual identity has demanded critical attention to the subject of sexuality and schooling. Similarly, using contingency as an angle of scrutiny we can interrogate the science that can name the psychopathological. In this way genealogy can be drawn on to provide a valuable means to consider the truth games relating to sexualities and to youth psychopathology. In *Nietzsche, Genealogy, History*, Foucault (1977) describes genealogy in terms of an interplay between domination and subjection, stating "Genealogy, however, seeks to re-establish the various systems of subjection: not the anticipatory power of meaning, but the hazardous play of dominations" (Foucault, 1977, p. 148). By finding a play of dominations in the truths of psychopathology and of sexual identity, a system of subjection can be located. From these subjections, those practices that essentialise young people can be made fragile. It is from this

perspective that we argue that the angles of scrutiny can be deployed to interrogate the seeming coherency of such truth games as they are applied in educational contexts.

References

American Psychiatric Association – Committee on Nomenclature and Statistics. (1952). *Diagnostic and Statistical Manual of Mental Disorders First Edition (DSM-I)*. Washington, DC: American Psychiatric Association.

American Psychiatric Association - Committee on Nomenclature and Statistics. (1968). *Diagnostic and Statistical Manual of Mental Disorders Second Edition (DSM-II)*. Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders (3rd edition, DSM III)*. Washington DC: Author.

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders (3rd edition-revised, DSM III-R)*. Washington DC: Author.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th edition, DSM IV)*. Washington DC: Author.

Benestad, E.P., Esther 2001. *Options of gender belonging* Live video link, viewed 26/07/01.

Bunton R., & Peterson, A. (1997). Foucault's Medicine. In R. Bunton, & A. Peterson (Eds.), *Foucault, Health and Medicine* (pp. 1-13). London: Routledge.

Butler, J. and Connolly, W. 2000. 'Politics, power and ethics: A discussion between Judith Butler and William Connolly'. *Theory and Event* http://muse.jhu.edu/journals/theory_&_event/v004/4.2butler.html accessed 18/01/03.

Caplan, P. (1995). *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Whose Normal*. New York: Addison-Wesley Publishing Company.

de Lauretis, T. 1994. 'Habit changes'. *differences: A journal of feminist cultural studies* 6: 296-313.

Epstein, D. and Johnson, R. 1998. *Schooling sexualities*. Buckingham [England]: Open University Press.

Fausto-Sterling, A. 2000. *Sexing the body: Gender politics and the construction of sexuality*. New York: Basic Books.

Foucault, M. (1977). Nietzsche, Genealogy, History. In D.F. Bouchard, (Ed.), *Language, Counter-Memory, Practice: Selected Essays and Interviews* (pp. 139-164). Ithaca, New York: Cornell University Press.

Foucault, M. (1980a). Two Lectures. In C. Gordon (Ed. & trans.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp.78-108). Sussex: Harvester Press LTD.

Foucault, M. (1980b). The Confession of the Flesh. In C. Gordon (Ed. & trans.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp. 194-228). New York: Pantheon.

Foucault, M. (1988). Critical Theory/Intellectual History. In L.D. Kritzman (Ed.), *Politics, Philosophy, Culture: Interviews and Other Writings 1977-1984* (pp. 17-46). USA: Routledge, Chapman & Hall.

Foucault, M. (1998). Return to History. In J.D. Fabion (Ed.), *Michel Foucault, Aesthetics, Method, And Epistemology The Essential Works of Michel Foucault, Volume 2*. New York: The New Press.

Frances, A. J. (1994). Foreword. In J.Z. Sadler, O.P. Wiggins, & M.A. Schwartz (Eds.), *Philosophical Perspectives on Psychiatric Classification* Baltimore: The Johns Hopkins University Press.

Frick, P.J. (1998). Conduct Disorders. In T. Ollendick, & M. Herson (Eds.), *Handbook of Child Psychopathology Third Edition*. New York: Plenum Press.

Gordon, R.G. (1938). The Neuro-Psychological Basis of Conduct Disorder. *Edinburgh Medical Journal, 45,* (Jan.), pp.43-59.

Gosden, R. (1997). The Medicalisation of Deviance. *Social Alternatives, 16*(2), 58-60.

Grove, W. (1982). Introduction. In W. Grove (Ed.), *Deviance and Mental Illness*. London: Sage Publications.

Harwood, V. 2000. Truth, Power and the Self. A Foucaultian analysis of the truth of conduct disorder and the construction of young people's mentally disordered subjectivity. Unpublished doctoral dissertation, University of South Australia.

Harwood, V. (in press) Subjugation and disqualification: critiquing the discourses of psychopathological behaviour used in education' *Melbourne Studies in Education*

Jones, D.J., & Ball, S.J. (1995). Michel Foucault and the Discourse of Education. In P.L. McLaren, & J.M. Giarelli (Eds.), *Critical Theory and Educational Research,* Albany: State University of New York Press.

Kessler, S. 1998. *Lessons from the intersexed*. New Brunswick, New Jersey: Rutgers University Press.

Nietzsche, F. (1974). *The Gay Science*. New York: Random House.

Ransom, J. (1997). *Foucault's Discipline: The Politics of Subjectivity*. Durham and London: Duke University Press.

Reynolds, R.H. 1996. 'Doctoral dissertation'. *Sexuality, citizenship and subjectivity: A textual history of the Australian gay movement 1970-1974* Department of History, The University of Melbourne.

Sedgwick, E.K. 1993. 'How to bring your kids up gay: The war on effeminate boys' in Warner, M. (ed.) *Fear of a queer planet: Queer politics and social theory*. Minneapolis: University of Minnesota Press.

Spitzer, R., & Williams, J.B.W. (1982). The Definition and Diagnosis of Mental Disorder. In W. Grove (Ed.), *Deviance and Mental Illness*. London: Sage Publications.

Spurlin, W.J. 1998. 'Sissies and sisters: Gender, sexuality and the possibilities of coalition' in Merck, M., Segal, N. and Wright, E. (eds.) *Coming out of feminism?* Oxford: Blackwell.

Taylor, N. 1994. 'Gay and lesbian youth: Challenging the policy of denial' in De Crescenzo, T. (ed.) *Helping gay and lesbian youth*. New York: Harrington Park Press.