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Bio-Somatic-Power

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Abstract

Biopower is a prominent force in mental health, with psychiatry having a strong influential grasp across the areas of definition of mental disorders, diagnosis, care, treatment, and legislation. One area that impacts upon the everyday lives of community mental health service users is treatment, largely dominated by medication. This paper will explore biopower in relation to the practices and management of mental health service users' medication regimens. Michel Foucault's insistence in his later work that power is the product of bodily forces will be drawn upon in highlighting the importance of undertaking analysis of medication regimens. Taking examples from a project focused on service user experience, the concept of 'somatic enactment' is suggested as a means through which to open up biopower to the localised concerns of service users with regard to the issue of managing one's body on a day to day basis, as affected by medication. In doing so, the author seeks to move towards a notion of biopower that does not only work on a 'top down' manner, and in which processes of embodied subjectification can be illuminated, without recourse to a straightforward power-resistance framework.

Biopower and Mental Health

Psychiatric medication remains the dominant form of treatment for mental health problems. Since its introduction into psychiatry, medication has been the front-runner of treatments for a wide range of psychiatric diagnoses. Its role in psychiatry has been the subject of long-standing critical enquiry, from those espousing its use as unnecessary, incorrect and even immoral, to ardent fans of the progression through technological advancements of medication. In this article I will explore this relationship, but rather than attempting to ascertain whether it is 'correct' to use medication, I will offer preliminary analysis of the practice of medication, in terms of what forms of action are facilitated, or reduced, through its administration. The aim of the paper is to offer a micro-analytic informed conception of biopower, which focuses on practices of medication regimens that produce mental health service users' bodies. Emphasis is on the 'doing' of bodies, rather than any form of essentialist framing of embodiment.

It is difficult to talk about psychiatric practice without addressing the issue of power. Given the features of current mental health legislation that allow for things such as involuntary treatment, it could be argued that psychiatry is the arena for the greatest flexing of biopower muscle. Psychiatric power can be argued to operate in many ways, from exposing people to what can be stigmatising diagnoses, to taking them into institutional settings against their will. People's bodies reside at the heart of this, both in terms of being conceptualised as potentially 'abnormal' along with being infiltrated by what can be an array of neurochemicals in the form of medication. Consequently the materiality of the body acts as the grounding for psychological life, and the experience of living with mental distress categorised and treated by psychiatric services, the body is the foundation, operating as the link between psychological well being and biochemical alteration through medication. In the area of critical psychiatry this has been argued to be a reality that is intrinsically misguided and detrimental on the lives of service users. For instance, the work of Peter Breggin (1994) suggesting that psychiatry is 'toxic', poisoned by the powerful and irrepressible reach of the pharmaceutical companies, whose activity has led to the widespread administration of medication for treatment for mental distress. This Breggin argues is wrong because the evidence for the biochemical factors being underlying causes of mental distress is limited, and moreover the effects of taking medication can be severe (e.g. the diverse range of so called 'side effects'). When you add the capitalist drives of the pharmaceutical industry to make profit out of mental distress, psychiatry becomes 'poisoned' for Breggin. In such accounts power is exercised in a top down fashion from psychiatry onto service users. It is argued the need to be seen to be adhering to treatment means that service users' ability to 'resist' such power is limited, if not non-existent (Deegan, 2005). The idea of service users as 'docile bodies' fits well to such accounts. The question in this paper is how to relate such a notion of power to the everyday life experiences of medication for service users. Can it provide a thorough theoretical explication of the everyday realities of lived medicated bodies? One could begin with investigating the various somatic forms produced by biomedicine. For instance, a body in which the phenomena of hearing voices is reduced, or eradicated. And/or, a body in which singular or multiple physical effects are experienced as due to the administration of medication (i.e. so called 'side effects'). And/or, a body in which no noticeable alteration in somatic state is recognised post administration of medication. Immediately we see that multiple possible somatic outcomes are possible once someone is exposed to biopower. Indeed, biopower is referred to here through its impact on somatic experience, which is to utilise only a narrowed sense of the term, as biopower can have a broader range of effects than enacting various somatic states. In this paper I would like to offer one potential avenue (out of many possible) of theoretical and empirical engagement utilising biopower, with specific focus on embodied subjectivity of medicated bodies.

Foucault and power

Foucault's concern with biopower has been well documented, particularly in relation to psychiatric practice (e.g. Blackman, 1996; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995; Porter, 1990). In psychology it has featured as a means through which to argue that psychological knowledge acts as forms of constitutive power in relation to what it is to be a subject in contemporary society. This tradition was catalysed by the publication of *Changing the Subject* (Henriques et al, 1984), in which the operation, organisation and distribution of psychological knowledge as a mode of production of

subjectivity was explored. The notion of psychology having power was central. Psychology is seen as a core member of the ‘expert disciplines’ focused on delivering knowledge about the human condition and is related to other human science disciplines, or ‘psy-disciplines’ as the sociologist Nikolas Rose puts it, as a prominent ‘actor’ in the production of new forms of living as subjects. In such accounts it is largely the idea that psy-disciplines are institutional forms of knowledge that play a central role in constituting what it is to be a ‘subject’ in the world. The role of psychiatric practice has been seen as such a practice, particularly due to its power to define forms of mental distress as ‘illnesses’ through to the forms of treatment that come with such a model (i.e. medication). The notion of power acting as a force ‘from above’ defining particular modes of subjectivity can be perceived in such accounts. The realm of individual action comes to be seen in direct relation to the initial force of power, and subsequently is termed ‘resistance’. It was in *The Will to Knowledge*, the first of his three volumes on the history of sexuality, that Foucault introduced the notion of resistance as the fifth proposition in the chapter on method: “[W]here there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power” (1998: 95). Within such a model resistance becomes the means through which to attempt to counter power, it exists at the interface of individual activity and social force. Power is vested with the domineering role of oppression, and resistance the lesser (and sometimes futile) role of fighting against power.

Resistance implies resistance *of* something, with that thing being power. A notion of resistance remains in an analytic framework of power, as the latter is a necessary precondition of the former (Brown & Stenner, 2009). Thus power and resistance become opposite ends of a conceptual framing, with the former a necessary condition for the latter to occur. This reality led Foucault to question whether everything could be explained according to power relations. Is there anything, in the production of subjectivities, that cannot be accounted for by an analytic of power? Deleuze asks “[W]hat happened during the fairly long silence following *The History of Sexuality*? Perhaps Foucault felt slightly uneasy about the book: had he not trapped himself within the concept of power relations?” (1988: 94, emphasis in original). This questions whether the power-resistance couplet becomes a form of prefigured theory, with the latter always factored in when the former is present. An analysis following these lines then becomes constrained by the necessary features of power and resistance, with individual actions always-already seen as instances of resistance. In terms of medicated bodies power relations can be said to contribute significantly to their understanding. But, are there features of the somatic activity of medicated bodies that cannot be accounted for by such an account of biopower?

This is the task Foucault sets himself in the third volume of *History of Sexuality*, to introduce a third wave of analysis, this time concerned with subjectivity and individuality. It was an exploration beyond that encompassed by the pre-existing power-resistance couplet. Deleuze’s (1988) analysis of this stage in Foucault’s writings is useful, as he points out that a feature of relations of forces of power is that “*a relation which force has with itself, a power to affect itself, an affect of self on self* (101, emphasis in original). For Deleuze a power over oneself is a necessary requirement for power over others, which he discusses in relation to Foucault’s analysis of the Greeks. A point opens up here for self-devised activity, namely that its existence is granted through a wider notion of power of others, which had featured so heavily in Foucault’s previous work. Deleuze notes a key facet of this ‘third force’ is its independence from forces of power. Not a complete

unrelatedness, but an independence nonetheless: ‘Foucault’s fundamental idea is that of a dimension of subjectivity derived from power and knowledge without being dependent on them’ (Deleuze, 1988: 101). Foucault seeks to introduce a mode of power that cannot be reduced to notions of power featuring in his previous work (such as *Discipline and Punish*). The new dimension is located in the production of individuals by individuals, which Foucault (2000) terms ‘technologies of the self’. It is the Greeks that Foucault argues propagated modes of ‘making oneself’ in relation to sexuality. He sought to point to the ways that forms of sexuality did not pre-exist subjects at the time, but came to life through patterns of self-making. It becomes an ethical process, how to ‘know’ and ‘care’ for oneself in the context of the production of everyday life. This is not to suggest only one homogenising mode of making oneself, but that there are multiple forms of subjectivity emerging through the variety and difference in forms of individual life. So Foucault’s efforts are not to posit a universal mode of subjectivity, but to emphasise that forms of subjectivity are produced as individualised actions, and as such a theory of what subjectivity is would pre-empt the reality of the need to *create* subjectivities. This is what led him to question earlier propositions of power-resistance that pre-figured what an analysis of subjectivity would be.

In the field of mental health the idea of power as a heterogeneous relational product shifts focus towards the localised practices through which it emerges. This in turn directs analysis towards the kinds of strategic relations present in mental health care. For the purposes of this paper this orients us towards the everyday life experiences of community mental health service users. Moreover it is everyday life as ground in bodily experience and activity through which power relations are produced. This is somewhat different to the Kafkaesque notion of inscribing power on bodies, the idea of ‘docile bodies’ in Foucault’s *Discipline and Punish* (1977), as service users’ bodies are not just affected by psychiatric activity, but the actualisation of their experiences is formed through the inter-relation of biochemistry (e.g. medication effects) and how this feeds into psychological awareness. To gain some analytic grasp on this process consequently involves addressing accounts of medication practices. In so doing, the formation of biopower can begin to be seen as an accumulative force formed through relations between the practical consequences of being a mental health service user (e.g. receiving medication), the implications for bodily experience of this, and the psychological awareness of the aforementioned two. This will help us to understand the role of biopower in such contexts, and indeed is a more fruitful way of approaching it than if we just adopted a straightforward notion of power as a reified oppressive force, which places the spotlight on a concept of ‘power’ rather than the everyday practices through which forms of power emerge.

Relational bodies

The approach developed so far leads us to consider power not as a *thing*, but as a product, formed through patterns of activity that produce everyday life. Power then is not homogeneous, but instead is a product, a result of the effects of the actions of bodies. Force exists through bodies, rather than upon them, and given the diversity of life such practices will always be heterogeneous, and power also. Moreover, it is the connections between bodies where power is said to emerge. So, forms of resistance do not reside *in* bodies but *between* them. Following this line of thought involves recalibrating analysis from ‘things-in-themselves’ towards ‘relations-between-things’. In fact this can be taken further still, to the point where we think of ‘things-as-relations’. This is quite a step, and

yet aids in understanding how multiple factors come together to form experience, be it emotion, bodily activity, or global stock markets. Thinking about relations rather than substances is a subtle yet important shift in analysis. Power can then be thought of as firstly, a product of localised bodily activity, and secondly, as a relational force. According to this relational model it can no longer straightforwardly be said that power works as an *oppressive* homogeneous force, with life ordered and organised according to its forces. In place of this, power becomes a mode of life produced by strategies of relation, which exist as bodily forces. Focus switches to these strategies of relation, and the settings in which they are produced.

Rather than see biopower as a central exemplar of the translation of the overarching force of psychiatry on the localised bodies of psychiatric service users, Deleuze and Guattari (1987; 1994) would posit them as features of a dominant relation between multiplicities. By multiplicities they mean the many interconnected aspects of any given phenomenon. For example biopower of psychiatry in relation to medication can be seen to be organised around a set of interconnecting constituents (e.g. pharmaceutical companies that produce and market drugs, research teams that are relied on to provide evidence as to the effectiveness of drugs, psychiatrists who prescribe drugs), which themselves form one 'side' of the relation that acts in people's bodies through another set of interconnecting constituents (e.g. biochemical activity, service user activity of taking medication, local community mental health professionals administering medication in the case of depot injections). Such an account draws attention to the complexity of the constitutive features that inter-relate as the production of everyday somatic life for service users. Moreover, it reinforces the idea that bodies are not stable entities that come to be through relatively unchanging modes of being, but rather are required to be made through continually reworking practices. This emphasises notions of process and relationality in terms of conceptualising bodies as produced through their activity, and as such always dependent on the process of time, and as not existing as 'things-in-themselves', but rather as relational products understandable only through their relations to other things.

The emphasis on process and relationality is attractive in Deleuze-Guattarian theory, and benefits a re-worked notion of biopower. It allows a concept of embodiment that recognises that somatic states exist in a state of instability, with the continuous presence that current states could be reworked into new states. This is based on the idea of somatic states being formed through multiple relations interconnecting. Understanding exactly the relations present *within* bodies is difficult (although efforts have been made (e.g. Wilson, 2006), although evidence from neuroscience gives an idea of how medication is absorbed and put to work in the body (e.g. Bustillo et al., 2002; Jarskog, Gilmore, Selinger, & Lieberman, 2000; van Vliet, Slaap, Westenberg, & Den Boer, 1996; Yovel et al., 2000)). Knowledge of how medication 'acts back' upon somatic activity can be gained through observing its effects. But are all effects visible? For instance, if an antipsychotic has an adverse effect of back pain, this requires the noticing and reporting of such experience. It cannot be straightforwardly observed, or analysed by any medical means. It is a micro analysis that is required to illuminate the relation between biopower and medicated bodies. One that recognises the large-scale arenas from which medication originates, down to the very localised patterns of activity within which biochemicals are ingested and then affect somatic activity. Additionally a sense of the ever-present proneness for potential change is valuable to make visible the variability in patterns of somatic activity enacted by medication. And, how quickly and frequently patterns can change. To think of biopower

as a relatively stable oppressive force manifesting itself in people's lives in various ways belies the actual complexity of medicated bodies, not only between different patients, but also within individual patient's own experiences.

Examples of Somatic Enactment

The following data comes from a wider social psychological project exploring long term community mental health service use. The extract below comes from the part of the project analysing service users' experiences of treatment, which transpired to be medication, almost without exception. The analytic concern was how medication taking impacted upon everyday life as a community service user, and how any challenges experienced through medication taking were managed. The analysis in this paper is not meant to give an overview of all service users in the wider project. Unsurprisingly much variability and diversity was found in service users' experiences, so analysis is designed to provide an example of the kind of challenges that service users can face. In the following extract an account is given by a female service user (Beatrice¹ aged 41 and diagnosed with schizophrenia) about the onset of an illness episode though a description of the effects of medication on her body:

- I: mm but ho..how then did it your sort of second episode come around, was the medication not working or something?
 B: no it wasn't work (I) it was working but it was just hurting my legs
 I: did you stop taking it?
 B: so (I: mm) so badly (I: mm) I was restless I couldn't sit still it was awful the pains were in my legs so I thought, I told my key worker and she says "I don't know what it could be" and um the I think she told my doctor but nothing was happening I so I thought I'm not taking this anymore taking this medication anymore and that's where it all started where I became ill again

Beatrice recalls the events leading up to the episode, which revolved around issues with her medication. Beatrice states that the medication was causing her considerable pain in her legs. This pain was not seen as a sign that the medication was not having the desired effect on her mental health. Indeed she states it was working. The issue was the pain in her legs, a separate concern regarding her everyday activity, and not primarily in relation to mental health. Indeed further detail of the process of 'deciding' whether it was working or not is absent. The focus is very much on the somatic features enacted by the medication. How might we want to go about understanding this? It could in the first instance appear purely as an instance of the power of psychiatric practice impacting upon Beatrice's life in a negative way through the pain effects she feels after taking her medication. The subsequent act of cessation could then fit into the 'resistance' side of the 'power-resistance' framework. The alternative is to approach this as a process of power production, rather than an incidence of power implementation, and the effects thereof. For Beatrice, power is not felt in a straightforward sense, but features as the relational emergence of a particular pattern of activity at a given time. In the extract we see one instance of this during which Beatrice starts to feel severe pain in her legs post administration of psychiatric medication. This emerges though a series of stages, the first

¹ Pseudonyms were used for all participants.

of which is Beatrice noticing the pain, and then reporting it to her key worker. The 'noticing and reporting' stage is central to the *practice* of Beatrice's medicated body. Members of Beatrice's mental health team are not able to know how the medication is making Beatrice *feel*, without asking her. Indeed the precise nature of the biochemical changes in her body caused by taking medication are not known to Beatrice, who comes to register medication effects through the body providing signs that register in her consciousness (i.e. the pain in her legs). The body acts as a mediator.

It is through Beatrice communicating this pain that her Key Worker is made aware of the problem, something she was driven to do by the pains in her leg. These were causing considerable distress and invasiveness in her life, even stopping her from 'sitting still', such a common taken for granted action. This stage is 'self devised activity', in which Beatrice reports that she ceased taking her medication. Having not received an adequate response, in her view, to the reporting of the leg pain, Beatrice decided to stop her regimen. This is the point where the initial enactment of her body by the medication flows into the period of Beatrice enacting a new pattern of bodily activity, in an attempt to reduce the leg pain brought on by her medication. Beatrice notes the associated problems that can arrive in this stage, which in her case was a return to mental ill health, as the 'working' medication was no longer present. The point is that Beatrice was not to know what the exact outcome would be. The process of biochemical change through administration of medication and the subsequent psychological logging of this as *pain*, becomes the means through which power is enacted. Moreover, this occurs through a bio-looping effect of medication (an external source) being ingested and the 'acting back' on the body through the sensation of pain, which is registered psychologically, prior to being communicated back to an external source (the Key Worker). Thus, power is not just working *on* Beatrice's body, but *through* it. Moreover it involves the inter-relation of a number of actants, namely the medication (originating in the laboratories of a pharmaceutical company), biochemical change, psychological awareness, self-devised activity, and discursive communication. Such a pattern may well be specific to Beatrice, with other service users not experiencing the same process of somatic enactment through taking medication. It is something instigated by psychiatric practice but not wholly explainable through it, as at certain stages (e.g. Beatrice ceasing taking her medication) operates outside of the 'control' of her psychiatric team, albeit briefly, as she is aware of the implications of such actions on her ongoing care (i.e. that she will become 'mentally ill' again). The process of everyday life is grounded in the enactment of her body, and this oscillates between different organisations of control, all playing an accretive role in the ongoing embodied production of her life. Another example of this second stage can be seen in this extract:

C: I am going through a phase which I do every so often, I don't take it, I heave even at the thought of taking it because I am on that much, I mean suffered with my nerves since a child, they find it difficult when they have got to change my medication because you name it, I have had it and also as regards what other medications that I am on for other things that are wrong with me and I don't know, I suppose we all wish somebody could wave that magic wand, you know? I hate taking tablets but when I, if I do stop taking them I am bad, I know I need them, you know, I know, well I know I am on them for the rest of my life, I know I need them but every so often I do think 'oh, I cant be doing with these things' and I cant, I do, I stop taking them until I feel myself slipping back again which it does, then I have to start again.....(lines 387-397)

This extract demonstrates how Claire (a 52 year old service user who was diagnosed with Schizophrenia about fifteen years ago) deals with the challenges of managing a very complex medication regimen, which involves a large number of different medications, for mental health and non mental health conditions. Claire reports how it is difficult to maintain a stable regimen, as would be required by the prescription. She recognises the value and benefit of taking medication, and states that she knows she needs them. This is backed up when discussing what happens when she stops taking the medication, in that she feels herself “slipping back again”. What is interesting about this extract is the fluid nature of the everyday reality of Claire’s medication regimen. At times Claire ceases adhering to her prescribed regimen (“every so often I stop taking them”), due to the stress caused by continuing such a major administration task. Cessation though produces its own challenges, namely a recurrence of ill health. Although not specified, the “slipping back” marks a return to previous ill health, a lowering of well being from the time of medication taking. At these times Claire reinstates the medication regimen. Claire’s account points to a rather complex ongoing process of monitoring and experimenting. At moments when she stops taking the medication Claire monitors her well being, in anticipation of its lowering, to a point at which medication taking will be required to resume. This process is one managed by Claire, rather than a member of her Mental Health Team. She goes on to state that:

C: Well I have got into it now, but I have got a Dosset box and then I have got things as well that don’t need a Dosset box and whatever but with the carers coming in, they have to make sure I take my morning medication and then my midday and afternoon and they do at night as well, when they come at night to sort me out at night but they have got out of doing that, it is just now “have you got your medication?” and I will say “yes” so they have put down the tick, whether I am, and half the time I am not, apart from my morphine, which I cant get through the day without my morphine but other than that, at the moment it is a bit hit and miss as to when I take it....(lines 408-416)

Although Claire’s regimen is monitored by carers, this no longer goes beyond asking whether she has taken the medication, which they respond affirmatively. The actual reality of the regimen is managed by Claire on a daily basis. In the second extract something is added to this process with the aim of assisting Claire with the aim of ensuring medication is administered correctly. The dosset box divides her medication into separate days, and then times of the day, meaning that if followed correctly her regimen will be enacted appropriately. The dosset box becomes a member of the network of relational nexus of Claire’s body and her medication. The question is not just ‘Is Claire taking her medication?’, but ‘How is her medication regimen enacted and what are the important factors in its manifestation?’ Monitoring her own well-being and body state, ceasing medication when continuation of such a bruising schedule becomes too much, and reinstating when well-being becomes too low. Pointing to a continuous process of monitoring and enacting, seen in the following extract:

I: But you notice when you are not taking it, do you?
 C: Oh yes.
 I: You start feeling lower.
 C: Yes, I do, I am at the moment yet I cant bring myself, I could sling them, I could just chuck them the other side of the room, now I am slipping down again, but my morphine and my diazepam, I cant, I cant manage without those at all but as regards the other things, but

I do find it difficult managing time-wise because I take another pain killer which I cant have until two hours after I have had the morphine and I do find all of that a struggle, yes.

I: Is there any particular way you have found that is most effective in just trying to remember how to take them or is it just...?

C: Well to be honest, no, if I get as I am in severe pain, I just take it, I mean whether the two hours are there or not, I just take it, yes. I have not really got a time for any of it, I suppose I just take the first lot at seven in the morning after they have, they finish about quarter to seven and just work from there, if I think about it midday and then tea but then as I say the others in between, if I am getting in pain, I take them, then the last lot, well it used to be ten o'clock because the carers used to come at ten but it is earlier now but it is as and as I say apart from my morphine, I have just, I mean I am on over 170 tablets a week, yes, I just get sick of it and yet I know stopping them I go downhill but I just look at them and I feel, I don't know what to say how I feel, you know, I don't know how, it doesn't bother me then, I go through a phase it does, I cant even look at them let alone thoughts of swallowing them and I am not one of these can put them all in your hand, I have to take one individually and swallow so yes, but unless I happen to say to anyone "I am not taking them", then nobody, you know, knows.....(lines 387-412)

This extract demonstrates the dilemmas that can operate at the level of everyday domestic life for service users. Claire's considerable medication regimen, of over 170 tablets a week, proves an ongoing struggle given the challenges attaining adherence can bring. For Claire it is an ongoing process of almost daily rigour. This is not just the result of psychiatric system upon Claire as passive recipient of the medication, but she is enrolled into the system and required to play an active role in its production. She has a series of different medications attempting to serve varied needs. These can be conflicting if not managed carefully, highlighted by the reporting that one pain killer cannot be taken until at least two hours after a previous one (morphine). The hefty regime is not easily altered, such as from once daily administration to twice daily. Managing a regimen involving over 20 tablets daily is a more ongoing process. Claire reports that this operates through a complex process of monitoring, alterations to regimen, and deceit. Monitoring involves assessing pain level and ongoing mental health. Judgements about the tolerance and ability to manage varies, and is managed through altering drug taking in line with decisions made on almost a daily basis. For instance, if the pain is too much then pain killers are required. Added to this are the outward facing implications of such self-devised activities. Keeping them out of the sight of the community mental health team ensures that maintenance can remain in one's own hands. Claire states unless they inform as to cessation of medication taking then "nobody knows".

The crucial point to be made here is that the self devised activity seen in the extracts in relation to their medicated body state, or 'somatic stasis' is seen as an active productive process. It could be argued that Claire and Beatrice are attempting to resist the power of psychiatry as realised through administration of medication. But that does not really uncover what is happening in their lives at that time. They are not trying to remove psychiatric influence from their life. Indeed, they are keen to maintain their medication regimen. The problem is how to make it 'work'. Taking it as prescribed proves a fallible strategy as it results in such negative somatic experiences, rendering some semblance of 'normal' daily activity not possible. Instead a subtle, yet intricate, re-working process is engaged in with the aim of enacting (or 'doing') a somatic state that is functional in relation to attaining some level of adequate somatic stasis. One could think of this as a form of 'somatic enactment', a complex practice involving a series of steps: 'noticing and

reporting'; 'self-devised activity'; and 'enacting new patterns of activity'. Here power is not oppressive, but productive, formed through the organisation of a series of factors that enact bodily life in a continuous fashion. This is not about repetition of previously formed states that require no ongoing monitoring or managing, but is a continually active process of forms of somatic enactment. This relates to the ideas Foucault had about power towards the end of his life:

“a power that is not part of the superstructure but that is integrated in the play, distribution, dynamic, strategy, and effectiveness of forces; a power, therefore, that is invested directly in the distribution and play of forces. It seems to me that the eighteenth century established a power that is not conservative but inventive, a power that possesses within itself the principles of transformation and innovation” Foucault, 1999: 52

Bio-somatic-power

A series of practices have come under the analytic lens in this paper. Whilst this does not result in a homogeneous set of activity, a shared element exists that is offered as a possible means through which to forge a notion of biopower cognizant with the level of people's everyday lives. This level has been shown to be formed through complex processes of somatic enactment. That is, modes of bodily experience that are rooted in the relation between biological alterations and psychological awareness, mediated by somatic 'signs' (e.g. leg pain). With regard to the oft referred to psychiatric power at work in the control of service users lives, Foucault's idea of power as relational and inventive (i.e. a productive rather than repressive force) is useful for illuminating the *production* of bio-somatic-power, and in doing so, to point towards the necessary specificity required in analysis. Power as a ubiquitous repressive and negative force fails to address this specificity, the uniqueness of individualised processes of power that come to be through the production of people's everyday lives. Moreover, for service users day to day living can orient more around issues and concerns of one's body rather than the more commonly referred to mental health problems. The argument developed in this paper is that to understand how something like psychiatric power works we need to analyse the modes of individualised production that it enacts, which involves alluding to notions of process, production and specificity. Such an approach avoids the problem that can arise with accounts that simply refer to power and resistance, in which power features as some form of 'top down' force, and individual action framed only as resistance to this oppressive force. The complexity and specificity of the everyday is lost. In its place is an approach that posits power as a *product of* rather than *producer of* bodily life, re-directing analysis towards the productive force of life. Power consequently becomes an inventive force, formed through the production of forces working towards developing new modes of life. In the extracts seen in this paper forms of somatic enactment emerge as attempts to forge new modes of bodily life. For instance, in ceasing to take her medication Beatrice was trying to remove the pain in her legs. This was not a process in which she had total control, but a retained ability to alter her everyday life was enacted. For other service users the production of everyday life would be different, and would require specific modes of analysis to illuminate.

This attendance to the specificity of everyday life can often be seen as occupied by the mundane, but this layer of mundanity can conceal a rich arena of complex variability in terms of managing one's body. This aspect of our existence is often taken for granted,

unless we are suffering ill health, at which point somatic states suddenly become far more prescient. For some service users, this taken for grantedness of somatic state and activity is not a reality. Facing long-term regimens of medication that can have a range of somatic effects can be challenging, due to the number and unpredictable nature of adverse effects of different medications (let alone combinations of medications). Within a wider conceptual framework of biopower, we see gaps when focus turns to the everyday level, and yet it is on localised scales that power relations are produced. Deleuze and Guattari use the example of the French Revolution to emphasise this; they state “what one needs to know is which peasants, in which areas of the South of France, stopped greeting landowners” (1987: 238) to understand the existence and production of the Revolution. It is argued here that what one needs to know is how service users are managing the somatic concerns of maintaining medication regimens to explore the operation and organisation of bio-somatic-power.

In this paper an engagement with somatic activity has been undertaken, which has highlighted some of the complexity involved in medication taking. Informed by Foucault’s ideas about power as a form of relational production, a version of *bio-somatic-power* has been developed, based on a broader framing of embodiment as practiced and performed, the concept of ‘somatic enactment’ is suggested as a way to connect a theory of biopower with the everyday practices that are devised and enacted by service users faced with maintaining long-term medication regimens. Service users do not simply resist biopower, they engage in a variety of processes of quite rigorous maintenance and evaluation. These can involve experimenting with different regimens in attempting to enact adequate somatic stasis. But, producing and retaining some form of stability can be severely problematic. For some, the best that can be achieved is an ongoing process of monitoring, deviating regimen, and subsequent evaluation. This process, framed here as ‘somatic enactment’ can operate in dialogue with mental health teams, or information can be withheld. The pressure to be visibly adherent is an additional stressor for service users. It is hoped this paper can illuminate some of the challenges that can be faced by service users whose lives are produced as a complex web of power relations.

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