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ARTICLE

Stultitia and Type 2 Diabetes: The Madness of Not Wanting to Care for the Self

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ABSTRACT: This paper explores the condition of stultitia, which is described by Michel Foucault in *The Hermeneutics of the Subject* as a condition one is in, before having started to care for the self. The purpose is to shed light on one of the paradoxes of patient education by introducing and elaborating an aspect of Foucault's literary activities, which has not, to my knowledge, been investigated empirically before. To illustrate this condition, the paper targets the relation between type 2 diabetes, contemporary norms of healthy living, diabetes education, and the situation that sometimes occurs when individuals are not capable of, or motivated to, taking care of themselves. It specifically targets a situation, which is both incomprehensible to health professionals and patients alike; when patients desire a healthy life, but at the same time do not pursue it according to the recommendations. Thus, it is a condition of madness, which is investigated; madness in the sense that patients have internalised a rationality, against which their own behaviour rebels.

Keywords: Care of the self, diabetes education, Foucault, health, lifestyle, madness, stultitia.

Contemporary Health Norms, Lifestyle Disease, and Madness

It is commonly held that people, predominantly in the Western World live longer and suffer from diseases that are caused by unhealthy lives. Thus, lifestyle diseases have become a health political and economic burden to society, wherefore patients and citizens are increasingly encouraged to manage their health by, for instance following current dietary health norms. No doubt the ideas of risk and susceptibility¹ play an important role in transferring responsibility from a State level to an individual level.² Type 2 diabetes is often mentioned as a serious disease that has reached 'epidemic proportions.'³ Moreover, there is an affinity be-

¹ Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2007), 84.

² Christopher Ziguras, *Self-Care – Embodiment, Personal Autonomy, and the Shaping of Health Consciousness* (London: Routledge, 2004).

³ Marideli C. Scanlan & Lawrence Blonde, "Adherence to Practice Guidelines for People with Diabetes Mellitus," in Mark N. Feinglos & M. Angelyn Bethel (eds.), *Type 2 Diabetes Mellitus – An Evidence-Based Approach to Practical Management* (Totowa, NJ: Humana Press, 2008), 235-249.

tween the recommendations given to diabetics⁴ and the more general, common advice in public health policies.⁵ Eat food rich on fibre, polyunsaturated fat, quit smoking, lead an active life and use alcohol in moderation.

The contemporary, ubiquitous, moral imperative that everybody should live healthily is not only expressed by health authorities, but through the media, through company policies⁶ and by people in general. The existence of such a moral imperative is not a controversial claim, but the degree to which the health recommendations are presented, and the ways in which they are perceived, may be a matter of dispute. It is not the purpose of this paper to describe these differences, conflicts, or disputes. Others have done that with great insight.⁷ It is rather a central claim that there is a common norm of healthy living, regardless of the fact that norms are always multifaceted and contested.

This study focuses on the lack of self-care among diabetics, on the condition one is in before having started to apply the technical and practical changes that are necessary for practicing a healthy life. People who do not exercise the responsibility demanded, who do not take proper care of themselves, appear, vis-à-vis the public moral imperative mentioned above, unmotivated, ignorant, in denial, unaware, incapable, unable or careless. Their actions seem mad to others, and sometimes to themselves as well. Why would someone not want to take care of the self? The paper takes as its point of departure this seeming madness, and analyses the concept *stultitia* found in Foucault's lectures *Hermeneutics of the Subject*⁸ from 1981-82, using experiences from an empirical study of diabetes education to illustrate the potential of this concept for empirical research. Although mentioned briefly in various Foucault-inspired literature,⁹ this aspect of Foucault's work has not been applied in empirical work before, nor has it been the primary target of analysis when others have analysed Foucault's late works on the Stoics, practices of the self, ascetics, self-transformation, or subjectivity. An obvious reason is that the concept is only a parenthetical remark in the lectures mentioned above that Foucault uses to link these late lectures with his early work on the *History of Madness*.¹⁰ However, the purpose of the paper is to explore and discuss its potential, and to illustrate the implications for further theoretical and empirical research. The paper therefore diverts from

⁴ Leslie A. Consitt, Kristen E. Boyle & Joseph A. Houmard, "Exercise as an Effective Treatment for Type 2 Diabetes," in Mark N. Feinglos & M. Angelyn Bethel (eds.), *Type 2 Diabetes Mellitus – An Evidence-Based Approach to Practical Management* (Totowa, NJ: Humana Press, 2008), 135-150.

⁵ Lars T. Larsen, 'The Truth Will Set You Free' – A Genealogy of Public Health Policy in Denmark and the United States, 1975-2005, Ph.D. dissertation, Department of Political Science, Aarhus University 2005.

⁶ Nanna Mik-Meyer, "Managing fat bodies: Identity regulation between public and private domains," *Critical Social Studies*, vol. 2, (2008), 20-35.

⁷ See for example Georges Canguilhem, *The Normal and the Pathological* (New York: Zone Books, 1998 [1943/1966]); Uffe J. Jensen, *Sygdomsbegreber i praksis: Det kliniske arbejdes filosofi og videnskabsteori* (Copenhagen: Munksgaard 1983); and Annemarie Mol, "Lived Reality and the Multiplicity of Norms: A Critical Tribute to George Canguilhem," *Economy and Society*, vol. 27, no. 2-3 (1998), 274-284.

⁸ Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège de France*, edited by Frédéric Gros, translated by Graham Burchell (New York: Palgrave Macmillan, 2005).

⁹ For example in Michael V. Ure, "Senecan Moods: Foucault and Nietzsche on the Art of the Self," *Foucault Studies* vol. 4, (2007), 19-52. See page 47 and 51 for a connection between self-transformation and *stultitia*.

¹⁰ Michel Foucault, *The History of Madness* (London: Routledge, 2006 [1961/1972]).

conventional social science because the primary target of the analysis is not the empirical findings, but rather the concept *stultitia* in Foucault's lectures. The empirical data is used to illustrate the utility of this concept, and how it could be used in for example social science focusing on health and illness.

An Introduction to Type 2 Diabetes Education and the Empirical Field¹¹

One of the major problems in diabetes care, as reported by diabetics as well as health professionals, is the fact that diabetes patients often feel normal—they do not necessarily experience any bodily discomfort or displeasure the first ten to fifteen years.¹² Therefore it is difficult for them to think of themselves as ill, although they know they have a disease. In the case of diabetes, the meaning of René Leriche's claim that 'health is life in the silence of the organs'¹³ is broadened. This is the reason why diabetes health education is a struggle to 'make aware,' to fight bad habits, and the self-denial and neglect of the diabetics.

Most type 2 diabetics struggle with obesity, high cholesterol levels, hypertension, late complications that follow from these conditions, and subsequently an increased need for medication.¹⁴ Certain characteristics are statistically traceable in diabetes—for example, the influence of variables such as age, gender, number of years with diabetes, and weight. People with diabetes differ in terms of jobs, careers, lifestyle, norms, and values, and therefore manage their illness in different ways. Type 2 diabetes was formerly known as 'old man's diabetes' [Danish 'gammelmandssukkersyge'], because, typically, old or elderly people developed what was understood as a mild form of diabetes. When type 2 diabetes was discovered it was regarded primarily as a geriatric disease—with old age come changes in the metabolism that can cause the average glucose level to rise.¹⁵ Within the last thirty years, however, type 2 diabetes has increasingly, and quite strongly, been associated with lifestyle choices and bad habits, and people are younger when they develop this condition. This is presumably to do with the changes on the labour market from physical work to service jobs.

The institutional side of the diabetes field that I have investigated empirically, should be explained carefully. The hospital, located on the outskirts of Copenhagen, Denmark, cooperates with the local municipality about developing appropriate offers of health promotion and education. The municipality and the hospital have jointly applied for project funding concerning type 2 diabetes, which involves one month of diabetes school, a two months exer-

¹¹ The article is based on one specific aspect of my Ph.D. dissertation *Patho-Epistemology: An investigation of contemporary lifestyle norms through type 2 diabetes self-care practices and techniques of life* (Copenhagen: The Danish School of Education – Aarhus University, 2012). Some passages have been taken from the dissertation and re-composed or changed to fit the style of the journal.

¹² Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (London: Routledge, 2008), 26.

¹³ Quoted in Canguilhem, *The Normal and the Pathological*, 91, in Nikolas Rose, *The psychological complex. Psychology, politics and society in England, 1869-1939* (London: Routledge & Kegan Paul, 1985), 228, and in Rose, *The Politics of Life Itself*, 85.

¹⁴ Frank L. Greenway & William T. Cefalu, "Obesity and Its Treatment in Type 2 Diabetes," in Mark N. Feinglos & M. Angelyn Bethel (eds.), *Type 2 Diabetes Mellitus – An Evidence-Based Approach to Practical Management* (Totowa, NJ: Humana Press, 2008), 333-350.

¹⁵ Steward B. Harris, Robert J. Petrella & Wendy Leadbetter, "Lifestyle Interventions for Type 2 Diabetes: Relevance for Clinical Practice," *Canadian Family Physician*, vol. 49 (2003), 1618-1625, 1619.

cise programme afterwards, followed up by the constitution of patient networks, which were supposed to run independently, or with a minimum of involvement from health professionals. Alongside the diabetes school and the exercise programme, the patients attended either their GP or the Hospital for periodic consultations. In recent years there has been much funding for health projects addressing chronic illness and lifestyle diseases. Type 2 diabetes has in particular been targeted as an important focus area. Therefore, the health project focused on here is one among many that targets lifestyle issues, and thus addresses a highly charged contemporary health issue, attracting funding and political attention. A relatively large number of diabetics live in the general area where the empirical work has taken place, and preventing lifestyle diseases thus constitutes an on-going health political objective. Political as well as medical systems both strive to enhance the participation and involvement of citizens and patients in the area. The rationale is that if patients are able to take proper care of themselves, the public hospitals and the municipalities (and ultimately the State, that is) will be able to save money on expensive treatment. This is due to the fact that health care services in the Scandinavian welfare states are paid for by taxation.

The age range of the participants in my research was between 35 and 74, of which there were many younger people among the participants, i.e. who were around forty years of age. Quite a few were retired, placing the average age of participants at the high end of the scale. Moreover, there were roughly as many men as women in the diabetes school, the diabetes exercise team, as well as in the motivational groups. There were newly diagnosed participants in the groups as well as more experienced diabetics (from a few months of experience up to seven years). A dietician and a nurse presented the diabetes school curriculum; they led a three-hour session, offered once a week for four weeks. There were at most sixteen and no less than twelve participants. The diabetes exercise programme was led by a physiotherapist. It met twice a week for one hour throughout the eight weeks. There were always between eight and fourteen participants in the exercise programme.

The diabetics in the diabetes school and in the diabetes exercise group seemed to be there for reasons other than diabetes. Some would be there because they had retired, perhaps lost a partner, and felt they had considerable time at their disposal and therefore saw these activities as a chance to meet other people; others came because they wanted the free exercise to help them lose weight. Another reason for attendance: one's wife would like one to participate, allowing her to sit in as a relative, and take notes on everything concerned with healthy food recipes. Some had physical conditions (i.e. a broken hip or a sprained ankle) that might benefit from the activity programme. Some were lonely. Most of them were there because they wanted to lose weight. Diabetes seemed to be the 'ticket' to access this offer from the hospital and the municipality.

Method

I participated and observed during the diabetes school and in the exercise programme, sometimes passively and at times actively involved in talking to the participants and taking part in the exercises. I took notes during the classes and on the way home, and that same evening or the following day, I composed a more detailed account of what had transpired during the diabetes school and the exercise programme. I participated actively in sweating through the ex-

ercises, while talking to the participants during the breaks. After these sessions, I wrote down keywords and the same evening or the day after, collected those notes and constructed a more cohesive account of the events. During the doctors' and nurses' consultations in the diabetes out-patient ward I participated passively and made an ethnographic report using the keywords I wrote down after each session.

Three individual interviews were conducted with three different male participants in the diabetes school, at different times throughout the four weeks. Afterwards, during the exercise programme, where most of the same individuals from the diabetes school would participate, a focus group interview with four participants was conducted. One of the participants had already participated in an individual interview. Two of the individual interviews were conducted in the private homes of the diabetics, and one individual interview and the focus group interview with the diabetes school participants were both conducted at the rehabilitation centre, where the diabetes school and the exercise programme were held. Moreover, two focus group interviews were conducted with the participants in two motivational groups (six and seven participants, respectively), organised by the local Diabetes Association. For the purpose of this article the interviews that were conducted in Danish have been translated into English. Schematically:

The different settings, number of professionals, participants and interviewees in the study, and duration of observations.

Setting	Hospital consultations		Diabetes School	Exercise Programme	Motivational Groups	
Professionals	2 doctors	2 nurses	Nurse and dietician	Physiotherapist	1 Diabetes Instructor	2 Diabetes instructors
Number of patients or participants	9 patients	3 patients	12 – 16 participants	8 – 14 participants	6 particip.	7 particip.
Interviews			3 individual interviews + 1 focus group int. (4 informants)		1 focus gr. Int. (6 inf.)	1 focus gr. Int. (7 inf.)
Duration of observations	10 min. x 9	1 hour x 3	4 x 3 hours	1 x 5 hours	2 hours	2 hours

The purpose of the fieldwork was to describe the self-care practices used by diabetics to prevent future complications. I focussed on the techniques used by diabetics in their attempts to change their lifestyle, to work on themselves in an effort to become 'healthy.'¹⁶ I followed

¹⁶ The Stoic care for the self, *epimelaia heauton*, and the transformation of the self through a work of the self is described among others by Ure in 'Senecan Moods,' 25-29. See also Darryl De Marzio, "The Care of the Self:

James P. Spradley's reflections on participant observation¹⁷ and was inspired by Harold Garfinkel's ethno-methodological approach¹⁸ in an attempt to describe and analyse these practices. There was an interesting issue that stood out in the interviews and observations. This was precisely the failure to care for the self that appeared in some of the diabetics' accounts, indicating irresolution, or a divided self. This is where the concept *stultitia* appears relevant.

A Diabetes Education Paradox—Experiences From an Out-patient Ward

The above mentioned specific feature of the interviews and observations is particularly interesting to focus on. Of course, the fieldwork comprises much more than this perspective, but in the following I will focus on this specific issue in order to show how the concept *stultitia* could be applied in analysis. During the fieldwork the following situation took place. After the last day of the diabetes school courses, when the participants had all left, I stayed and talked to the nurse who had been teaching in the diabetes school. The last participant who left the room was a very obese individual, who had consulted the nurse for an individual, informal talk after the end of the course. Since I represented a university, the teacher was therefore keen to discuss a pressing issue, which concerned her, more specifically the fact that the diabetics all seem to enjoy the course, but do not seem to change their lifestyle.

As [the last diabetic] has left the building, the nurse asks me about the diabetes education. She would like to hear my opinion. She is clearly frustrated, because she feels that she does not reach the participants, and is not able to initiate a process of change. She says that in the assessment questionnaires where it says "Was the diabetes school a success?"—the participants write "Yes," but when it says "Have you changed your life?," their response is "No." She shakes her head despairingly. "We teach them all these principles, but I don't think we reach those who are very big." We talk for a while about 'intrinsic' and 'extrinsic motivation,' 'knowledge' and 'learning.' I can clearly feel her frustration about conducting a very fine course, but at the same time having the feeling that it does not initiate changes.¹⁹

Interestingly, the diabetics report that they have benefitted from the course. However, they do not seem to change their lifestyle. The diabetes teacher therefore expresses what to her seems to be a paradoxical experience. The same issue is raised by a nurse, with whom I had an informal and non-recorded conversation during the observations in the out-patient ward, and whose patient consultations I attended. When talking to the nurse after a consultation with a newly diagnosed diabetic, she explains that it is difficult to help the patients who are obese.

Alcibiades I, Socratic Teaching, and Ethics Education," *The Journal of Education*, vol. 187, no. 3 (2007), 103-127. Moreover, Sebastian Harrer discusses central concepts concerning this topic in "The Theme of Subjectivity in Foucault's Lecture Series L'Herméneutique du Sujet," *Foucault Studies*, vol. 2 (2005), 75-96. I find Harrer's argument convincing, and I follow his interpretation of the late practices of the self. See also Christoph Menke, "Two Kinds of Practice: On the Relation between Social Discipline and the Aesthetics of Existence," *Constellations*, vol. 10, no. 2 (2003), 199-210, and Dick Willems, "Managing One's Body Using Self-Management Techniques: Practicing Autonomy," *Theoretical Medicine and Bioethics*, vol. 21, (2000), 23-38.

¹⁷ James P. Spradley, *Participant Observation* (USA: Wadsworth Thomson Learning, 1980).

¹⁸ Harold Garfinkel, *Studies in Ethnomethodology* (Cambridge: Polity Press, 1967).

¹⁹ Observation notes.

However, she is optimistic concerning this patient. She thinks that she has the necessary resources to cope with the condition. She explains that:

‘many of our patients are—how shall I put this in politically correct terms—from a social group that—In any case, they don’t have the same resources available that others do.’

We talk about the difficulties in teaching the patients in the diabetes schools, and that in these cases it can be an ‘uphill journey.’ She refers to a doctor whom she tells me uses the expression,

‘They lack the gene to pull themselves together.’ She tells me, ‘Here in the hospital, we do not see the patients who have social networks, and who have the intellectual and economic resources to manage their situation. Those individuals quickly learn to put to use the principles we teach them. They take care of themselves at home by themselves. It is the complex patients that we see in the hospital. The others, they attend their own general practitioner. We get the cases that have gone wrong, which their GP can’t deal with.’

We talk for quite a long time. The nurse seems to care considerably about the issue of diabetes care. We also talk about the diabetes school, to which the nurse responds that she thinks that the third week is tough, because that is when they talk about disease issues and late complications. She is curious to know what I think about it, and expresses doubts about the effect of the teaching. She feels that it has little effect on the participants. She is concerned about how to get the diabetics to change. ‘Sometimes it is difficult to know why the patients show up for the consultations, since they have to be motivated in order to get anything out of it. If you are not motivated, what’s the point?’ She explains: ‘If you ask a patient why they have come, what they mean to gain from it, then they say: “I don’t know.” They attend because their doctor has told them to. But they don’t seem to know how to make use of our services or why they are here.’

The nurse reflects on the lack of motivation, the unwillingness or incapability of taking care of the self. When perceived with the rationality of the diabetes education field, a rationality which to various degrees is also adopted by the patients, it seems that the health professionals describe the patients, who do not take proper care of themselves, as lacking mental capacities such as motivation, understanding, awareness etc. In light of the experiences reported above I will analyse the specific concept, *stultitia* (madness, foolishness), which Foucault analysed in *The Hermeneutics of the Subject*, to explore this seemingly paradoxical situation.

***Stultitia* and the Care of the Self**

As mentioned above, the prevalent health norms simply render those who are not able to change their bad habits incomprehensible. The teachers in the diabetes school are genuinely frustrated when they feel that their efforts are in vain. The diabetics, who from the perspective of the health professionals are either unwilling or incapable of taking care of themselves, also sometimes express this hopelessness themselves. They report to the health professionals that they understand the gravity of the situation, and they clearly say that they want to live

healthily, but at the same time it is as if they are reluctant or powerless. In the following I want to shed light on this phenomenon, which in patient education research is usually referred to as 'denial,' 'lack of motivation' or 'self-care deficit.' There is a comprehensive literature on diabetes and self-care,²⁰ but in the following I would like to shed light on this phenomenon using Foucault's analyses of the condition *stultitia*.

Foucault began his career with an impressive study of manifestations of madness in *The History of Madness*. He was interested in depicting how the exclusion of madness in the Classical Age (the age of rationalism) had created an object of psychiatric investigation, which we now refer to as mental illness.²¹ Madness, then, was understood as the other side of reason²² and was basically a manifestation of 'a nothingness.'²³ The nothingness of unreason was treated appropriately, simply by making these paradoxical manifestations disappear. It was the nothingness of unreason which Foucault used to perform a critique of reason—a response to the Kantian problem of critique.²⁴ Later, in the seventies, Foucault took up the study of madness in the nineteenth century, where it was constructed as abnormality. In the lectures from 1974-75, published as *Abnormal*,²⁵ he studied how madness was constructed as risk or potential danger, and as abnormal behaviour. This was done analysing penal cases, in which medicine and law tried to establish immanent criteria for distinguishing mad individuals from the normal. Instincts and inclinations to dangerous behaviour was the new sign of madness and the objective for a psychiatric technology.

On the basis of the instincts and around what was previously the problem of madness, it becomes possible to organise the whole problematic of the abnormal at the level of the most elementary and everyday conduct. This transition to the minuscule, the great drift from the cannibalistic monster of the beginning of the nineteenth century, is finally converted into the form of all the little perverse monsters who have been constantly proliferating since the end of the nineteenth century.²⁶

Trouble was that this attempt led to the discovery that we find all the little traces and signs of abnormal behaviour deep in the hearts of ourselves, in our everyday, normal conduct. And consequently, we have to be aware of our selves, because madness is found in the little oddi-

²⁰ Shannon M. Spenceley & Beverly A. Williams, "Self-Care from the Perspective of People Living with Diabetes," *CJNR*, vol. 38, no. 3 (2006), 124-145. See also Sally E. Thorne & Barbara L. Paterson, "Health Care Professional Support for Self-Care Management in Chronic Illness: Insights from Diabetes Research," *Patient Education & Counselling*, vol. 42 (2001), 81-90.

²¹ See for example Nikolas Rose, "Of madness itself: Histoire de la folie and the object of psychiatric history," in A. Still & I. Velody (eds.), *Rewriting the History of Madness; Studies in Foucault's Histoire de la Folie* (New York: Routledge, 1992), 142-149. Moreover, Frédéric Gros has written an inspiring little book on Foucault's concept of Madness, *Foucault et la folie* (Paris: Presses Universitaires de France, 1997).

²² See Shoshona Felman, "Madness and Philosophy or Literature's Reason," *Yale French Studies*, vol. 52 (1975), 206-228.

²³ Foucault, *The History of Madness*, 249-250.

²⁴ See Jason L. Powell "An Enlightened Madness," *Human Studies*, vol. 25 (2002), 311-316.

²⁵ Michel Foucault, *Abnormal: Lectures at the Collège de France, 1974-1975*, edited by Valerio Marchetti & Antonella Salomoni, translated by Graham Burchell (London: Verso, 2003).

²⁶ *Ibid.*, 132.

ties of our own lives when we least expect it. Here, Canguilhem's notion of the normal as a differentiated, polemical notion resonates in Foucault's thought.²⁷

Little crimes, of course, and little mental illnesses; tiny delinquencies and almost imperceptible abnormalities of behaviour essentially constitute the organisational and fundamental field of psychiatry.²⁸

We thus discover that normality and pathology is not an easily differentiable contradiction, but that there are traits of most mental disorders in so-called normal minds, too.²⁹ Madness is deeply embedded in rationality. Subsequently, we learn to suspect that everyone is at least slightly abnormal.

Later, in *The Hermeneutics of the Subject*, madness is taken up again briefly, this time in the context of education and practices of caring for the self. There is a comprehensive literature on this late turn in his literary activities,³⁰ but it will be necessary to focus on a specific detail in these lectures, which is the condition one is in *before* one learns to care for the self. The lectures constitute Foucault's 'legwork' that eventually resulted in volume 2 and 3 of *The History of Sexuality: The Use of Pleasures*³¹ and *The Care of the Self*.³² Importantly, the term *stultitia* allows one to reactivate Foucault's early works on madness. In *The Hermeneutics* Foucault directs attention to Cynic, Epicurean, and Stoic ascetic practices of the self. The pathological vantage point regarding the techniques of life, which constitutes the source of knowledge, is the same as it was for Foucault in the case when madness was used as a vantage point for a critique of reason. In education, the 'pathological' vantage point is the case when an individual is incapable of caring for the self. The notion *stultitia* has not been thoroughly elaborated by Foucault, nor have others, to my knowledge, investigated its role and place in his literary activities,³³ presumably because it is only mentioned briefly in passing. It is mentioned in articles concerned with Foucault's interest in Stoic practices of the care for the self,³⁴ but it is not

²⁷ Canguilhem, *The Normal and the Pathological*, 164-165, 196-200, 239.

²⁸ Foucault, *Abnormal*, 163.

²⁹ Cf. Nikolas Rose, *The Psychological Complex*, on 'the feeble minded,' 98.

³⁰ Tina (A.C.) Besley & Michael A. Peters, *Subjectivity and Truth: Foucault, Education, and the Culture of the Self* (New York: Peter Lang Publishers, 2007). Michael A. Peters, "Truth-Telling as an Educational Practice of the Self: Foucault, Parrhesia, and the Ethics of Subjectivity," *Oxford Review of Education*, vol. 29, no. 2 (2003), 207-223. Peter A. Miller, "The Art of Self-Fashioning, or Foucault on Plato and Derrida," *Foucault Studies*, vol. 2 (2005), 54-74.

³¹ Michel Foucault, *The Use of Pleasure – The History of Sexuality: Volume 2* (London: Penguin Books, 1992 [1984]).

³² Michel Foucault, *The Care of the Self – The History of Sexuality: Volume 3* (London: Penguin Books, 1990 [1984]).

³³ The term is used in Stoic texts by Possidonius, Epictetus, and others to designate the madness or bestial side of the human being, and it is contrasted with the *sapientes*, i.e. the wise. This beast-like nature is what the educational practices are supposed to mend. In contemporary papers about ancient Greek philosophy, the term is most often not mentioned in the Latin form, but translated with the above-mentioned meaning, i.e. the bestial aspect of the human being. See for example Henry Dyson, "The God Within: The Normative Self in Epictetus," *History of Philosophy Quarterly*, vol. 26, no. 3 (2009), 235-253.

³⁴ Ure, 'Senecan Moods,' 47, 51.

the primary target of the analyses. Yet, it constitutes the point of departure for learning to take care of the self, and therefore it is worth reflecting for a moment on this concept. He mentions the condition *stultitia* a couple of times in passing during the lectures.³⁵ It means madness, a condition from which a person must be relieved, a condition in which the individual is not able to care for the self. The first chapter in Foucault that discusses *stultitia* follows the passage in which he speaks of the similarity between the ancient schools of philosophy and the clinic. In antiquity, the doctor cared for the body and the philosopher for the soul. Both offered a kind of treatment (*therapeuein*) for the ills that infect either the body or the soul. The word for this pathological condition is precisely ‘*pathos*,’ referring to both ‘illness’ and ‘passion.’³⁶ The doctor relieves the pain and treats the morbid, bodily condition, and the philosopher, on the other hand, treats the passions, i.e. the morbid condition stemming from bad habits and luxury. ‘A philosophy school is an *iatreion* (a clinic). You should not walk out of a philosophy school in pleasure, but in pain.’³⁷ In the philosophy schools a set of very well-established and elaborated dietetics to treat the passions appeared. It was not just a matter of correcting the thoughts, but rather, through techniques of life, to practise and develop a mastery of the self, to focus attention on the self and to prepare the self for future ills.

In order to demonstrate what the morbid condition, *stultitia*, is about, it will be necessary to carefully go through the chapter in which Foucault sets out the role of the philosopher, the ‘helping hand,’ who aims to help the individual, who is in the grip of bad habits, to care for the self. Instead of marking a transitional passage from ignorance to mastery, the care of the self should be applied to the self by the self for all of life. Thus, pedagogy gains a new meaning. It is no longer just training in adolescence that enables the passage from ignorance to competence. It rather gets a distinct critical function. It becomes a matter of continuous correction. It is no longer a matter of learning a syllabus but a perpetual, ethical process of self-correction coextensive with life by the aid of technologies of the self. The care of the self in the 1st and 2nd centuries A.C. becomes an unqualified principle: a principle of lifelong learning that applies to everyone, but which is always ‘put to work in exclusive forms.’³⁸ One of the many differences between education in the 1st and 2nd centuries A.C. and the modern, or late modern, conditions we face today, is that the person, who is in the grip of bad habits, needed an ideal, a set of truths by which he could exercise a care of the self. The philosophy schools offered precisely that, i.e. abstract and ideal principles of truth. The words of a master were not challenged or doubted. They constituted a truth to be obtained by the student. The function of truths was to change the subject’s mode of being. It was not a matter of philosophy as we understand it today, i.e. the attempt to establish criteria, and explore the limitations, methods and conditions for knowing the truth, but rather a matter of a process of truth-seeking, an ‘ethopoetic’ activity,³⁹ which transforms an individual’s mode of being. The student simply chose to accept the authority of the master and the truth he offered. This is not in the same way an option for contemporary students, or modern man for that matter, who faces a condi-

³⁵ Foucault, *The Hermeneutics of the Subject*, 130-134, 465-467.

³⁶ *Ibid.*, 97.

³⁷ *Ibid.*, 99.

³⁸ Foucault, *The Hermeneutics of the Subject*, 126.

³⁹ *Ibid.*, 237.

tion of contingency of truths. Today, we are constantly on the search for principles or norms to guide us in our attempt to care properly for the self. These truths or norms are constantly contested, and their polemical or political contingency is well-known.

The Roman form of spiritual guidance took an interesting form. The guide ceased being an institutional figure. He became a personal friend or a private counsellor, but the asymmetrical relationship remained. The relationship was based on an exchange of services and very often founded on letter correspondence. The other became a personal friend – someone to whom the individual could entrust himself. The tone between the friend and the individual who asked for advice became more personal and – this point is crucial – more common and ordinary. Typically, someone would send a letter to a trusted friend, explaining carefully about a problem or the state of his life. These letters were about both everyday practical problems and of a moral nature. The objective of learning was no longer that of replacing ignorance with knowledge, but rather to correct bad habits and vices.

The practice of the self is established against a background of errors, bad habits and an established and deeply ingrained deformation and dependence that must be shaken off. What clearly is crucial is that the practice of the self develops more on the axis of correction-liberation than on the axis of training-knowledge.⁴⁰

The individual had to prepare against, not so much external dangers as against the evil within. The correction aims at 'stripping away of previous education, established habits, and the environment'.⁴¹ At the base of this correction of bad habits is found a critical attitude towards culture, civilisation and society, i.e. towards the lives led and values shared by others. An attitude also found in Jean-Jacques Rousseau and later Norbert Elias. At the same time, focussing a corrective practice on oneself is implicitly directing a critique towards others.

The practice of the self will become increasingly a critical activity with regards to oneself, one's cultural world, and the lives led by others. Of course, this is not at all to say that practice of the self only has a critical role. The training component remains and is always present, but it is fundamentally linked to the practice of criticism.⁴²

These networks of friendship, whereby the practice of the self is exercised, these various groups, whose members depend on a relationship to others, either a master or a group of friends, are based on the idea that the subject is 'badly formed, or rather deformed, vicious, in the grip of bad habits.'⁴³ Instead of striving for knowledge to replace ignorance, one should strive towards establishing a:

rational will that defines the morally sound action and the morally valid subject. [...] The individual should strive for a status of subject that he has never known at any moment of his life. He has to replace the status as non-subject with the status of subject defined by the full-

⁴⁰ *Ibid.*, 94.

⁴¹ *Ibid.*, 95

⁴² *Ibid.*, 93.

⁴³ *Ibid.*, 129.

ness of the self's relationship to the self. He has to constitute himself, and this is where the other comes in. I think this theme is rather important in the history of the practice of the self and, more generally, in the history of subjectivity in the Western World.⁴⁴

The theme of non-subjectivity (or nothingness) was also apparent in *The History of Madness*, as well as with the madmen in *Abnormal* (who did not have the status of legal subjects). The person who is in the grip of bad habits, who needs to be corrected, cannot initiate this transformation by himself. The non-subject must constitute himself as a subject with the help of another person. To put it bluntly this is where the need for the special kind of psycho-pedagogy begins. 'The subject can no longer be the person who carries out his own transformation, and the need for a master is now inserted here.'⁴⁵ Foucault takes as an example a letter from Seneca to Lucilius (letter 52) in which they discuss the moral obstacles for achieving virtue, for conducting a proper care of the self, and more importantly, the means to escape the morbid, pathological condition, which we are in, before we start to care for the self.

How, Lucilius, should we designate this impulse which, if we incline in one direction, drags us in another and pushes us in the direction from which we wish to flee? What is this enemy of our soul, which prevents us from ever willing once and for all? We drift between different plans; we do not will with a free, absolute (absolute) will, always firm. 'It is madness (stultitia),' you answer, 'for which nothing is constant and nothing satisfies for long.' But how, when will we tear ourselves free from its grip? No one is strong enough by himself to rise above the waves [...] He needs someone to give him a hand [...], someone to pull him to the bank (aliquis educat).⁴⁶

Stultitia is not just a mental irrationality, a mental illness, or a delirium that can be corrected by rational judgement. Rather, 'a whole therapeutics and dietetics is required in order to dissolve the passions, not just a correction of thought.'⁴⁷ Stultitia is something that is not settled on anything and not satisfied by anything. Seneca says:

This mental restlessness, this irresolution is basically what we call stultitia. Stultitia here is something that is not settled on anything and not satisfied by anything. Now, he says, no one is in such good health (satis valet) that he can get out of (emergere) this condition by himself. Someone must lend him a hand and pull him out: oportet aliquis educat.⁴⁸

Stultitia is a state of madness, and the term directs attention towards Foucault's works on madness in the Classical Age, i.e. the medieval ships of fools, stultifera navis.⁴⁹ There are certain aspects of the early work on madness that correspond with the analysis of stultitia. The stulti are not calm, are not concerned about or attending to themselves, but constantly worry about the future. They do not attend to the present, but are concerned with the future, which

⁴⁴ Ibid., 129.

⁴⁵ Ibid., 130.

⁴⁶ Seneca, cited in Foucault, *The Hermeneutics of the Subject*, 145, note 4.

⁴⁷ Foucault, *The Hermeneutics of the Subject*, 104, note 54.

⁴⁸ Ibid., 131.

⁴⁹ Foucault, *The History of Madness*, part one, chapter 1.

is a nothingness, a non-existence. "Not only are [the stulti] doomed to discontinuity and the flux, they are also doomed to dispossession and emptiness. They exist in nothingness."⁵⁰ The stulti stand out as foolish or even monstrous to others, precisely because they are unwilling or unable to care for themselves. Those who seem to do things that bring their health in danger stand out as mad to others, and their actions are commonly ridiculed, hence the meaning of the word *stultify*. Stultitia does not so much indicate a mental irrationality, and it is not a mental illness. Nor is it a social danger, an abnormality of behaviour, a potential risk, which requires normalisation and discipline. Rather, the behaviour of a person who is in this condition of stultitia is incomprehensible to others, not because their behaviour is deviant or potentially dangerous to others, but rather because the stultus has not established a relationship to himself. The actions of the stultus may very well be unpredictable, but most importantly they are not aimed at the self. The unpredictability is not a warning of danger, but a warning of the lack of care for the self. Stultitia designates a condition of irresolution, of losing focus on oneself, of being confused and bewildered, of not caring for the self properly, of having lost sense of direction, of not knowing how to distinguish between passions and the true will. Foucault paraphrases Seneca by saying:

We are in this condition of stultitia when we have not yet taken care of ourselves. Stultitia is, then, if you like, the other pole to the practice of the self. The practice of the self has to deal with stultitia as its raw material, if you like, and its objective is to escape from it. What is stultitia? The stultus is someone who has not cared for himself.⁵¹

This means that the stultus is someone who is uneducated or uncivilised.⁵² Foucault singles out three characteristics: The first is this: The stultus is someone blown by the wind and open to the external world. He is not capable of discriminating between his own desires, habits, illusions, etc. and what comes in from the outside world. He does not distinguish between his own mind and the external representations. He does not possess the ability to examine his own mind and to determine what stems from himself and what belongs to the external world. Therefore the stultus is broken up in time. He remembers nothing and lets his life pass by, incapable of restoring unity to his life. He does not try to direct his attention and his will to a well-determined end. 'The stultus lets life pass by and constantly changes his viewpoint. His life, and so his existence, pass by without memory or will. Hence, the stultus is constantly changing his way of life.'⁵³ Consequently, the stultus is not able to will properly. Willing properly means willing 'freely, absolutely, and always.'⁵⁴ Willing freely means

⁵⁰ Foucault, *The Hermeneutics of the Subject*, 467.

⁵¹ *Ibid.*, 131.

⁵² On the topic of the uncivilized, see Murray K. Simpson, "From savage to citizen: education, colonialism and idiocy," *British Journal of Sociology of Education*, vol. 28, no. 5 (2007), 561-574.

⁵³ *Ibid.*, 131-132.

⁵⁴ *Ibid.*, 133.

[W]illing without what it is that one wills being determined by this or that event, this or that representation, this or that inclination. To will freely is to will without any determination, and the stultus is determined by what comes from both outside and inside.⁵⁵

Second, the

[S]tultus wants several things at once, and these are divergent without being contradictory. So he does not want one and only one thing absolutely. The stultus wants something and at the same time regrets it.⁵⁶

Third and last, the stultus is someone who ‘wills, but he also wills with inertia, lazily, and his willing is constantly interrupted and changes its objective.’⁵⁷ The will of the stultus is then limited, relative, fragmentary, and unsettled; or, with a reference to his early works on madness, *alienated*.

Learning to Care for the Self—‘Eduction’

Stultitia is thus, according to Seneca, the condition that one must rise above. That entails directing the will towards an object that it can always want, want freely and absolutely. Such an object is the self. The only thing that can be willed freely, absolutely and always, without taking external determinations into account, is the self. According to Seneca, one can will the self without relating it to anything else and without changing it over time and on different occasions. The objective is a firm identity. Bear in mind, of course, that the subject, a firm identity of the self—even as a dialectical striving towards the self as a yet unreached ideal of unity, according to Foucault, is the biggest illusion of modernity. This is seen clearly in *The Order of Things* in which he states in the concluding remarks that ‘man would be erased, like a face drawn in the sand at the edge of the sea.’⁵⁸ That the subject is a construction, shaped by practices (of the self and others), is as evident in his late works as it was in the 1960s.

In stultitia there is a disconnection between the will and the self, a non-connection, a non-belonging characteristic of stultitia, which is both its most manifest effect and deepest root. To escape from stultitia will be precisely to act so that one can will the self, so that one can will oneself, so that one can strive towards the self as the only object one can will freely, absolutely and always [...] Inasmuch as stultitia is defined by this non-relationship to the self, the individual cannot escape from it by himself. The constitution of the self as the object capable of orientating the will [...] can only be accomplished through the intermediary of someone else. Between the stultus individual and the sapiens individual, the other is necessary [...] [This ‘other’ is someone who] has achieved a relationship of self-control, of self-possession, of pleasure in the self [...] The will that is typical of stultitia is unable to want to

⁵⁵ Ibid., 132.

⁵⁶ Ibid., 132.

⁵⁷ Ibid., 133.

⁵⁸ Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences* (London: Routledge Classics, 2010 [1966]), 422.

care about the self. The care of the self consequently requires [...] the other's presence, insertion, and intervention.⁵⁹

This ideal of self-mastery, of self-control, is 'enkrateia,' which is analysed in *The Use of the Pleasures*.⁶⁰ Foucault then goes on to describe the function of this other, on which the union of 'will' and 'self' essentially relies. The other person is not an educator in a traditional sense. He is not someone instructing truths or setting an example ('educare'). Rather, that other person should 'educere' (with an 'e'), which means 'offer a hand,' 'extricate from,' or 'lead out of.' It is an 'operation focused on the mode of being of the subject himself, and not just the transmission of knowledge.'⁶¹ Foucault calls it 'eduction' and not the traditional 'education.' But who is the person capable of teaching the truth? Foucault's Seneca pronounces the philosopher as the individual who has acquired a mastership of the self, a proper relationship to the self. Thus, it is the philosopher to whom one should turn in order to get the directions that one needs in order to reach a fulfilled relationship of self to the self. The philosopher is the *hegemon*, the guide or director, capable of 'governing men, of governing those who govern men.'⁶² Because of the commonplace role of the philosopher, however, he had become a figure integrated in daily life and opinion. The philosopher was no longer a prophet, external to daily life (as for example Heraclitus), but integrated in the decision-making at a secular level, in daily, political, ordinary life (like Seneca). At the same time, the role of the professional philosopher became blurred, because he needed to relate to everyday matters, of social and familial conduct. The role of the professional philosopher became de-professionalised, because people needed counsels of prudence and detailed recommendations. The philosopher could no longer give advice of a very general nature, but instead became counsellors of existence 'with regard to everything and nothing; with regard to a particular life, to family conduct, and to political conduct as well.'⁶³

The de-professionalised role of the philosopher, the philosopher genuinely integrated in the daily mode of being, characterises the 'practice of spiritual direction as a form of social relationship between any individuals whatever outside of the field of philosophers.'⁶⁴ There is a whole array of literature that announces itself when speaking about guiding or motivating: intrinsic and extrinsic motivation,⁶⁵ coaching, counselling, and the like.⁶⁶ It corresponds especially with the modes of government described by Nikolas Rose in *Governing the Soul*.⁶⁷ Nowadays, the 'educator' is represented by motivational therapists, health professionals, teachers,

⁵⁹ Foucault, *The Hermeneutics of the Subject*, 133-134.

⁶⁰ Foucault, *The Use of the Pleasures*, 65.

⁶¹ Foucault, *The Hermeneutics of the Subject*, 134.

⁶² *Ibid.*, 135.

⁶³ *Ibid.*, 143-144.

⁶⁴ *Ibid.*, 144.

⁶⁵ Richard M. Ryan & Edward L. Deci, "Intrinsic and Extrinsic Motivations: Classic Definitions and New Directions," *Contemporary Educational Psychology*, vol. 25 (2000), 54-67.

⁶⁶ Michael A. Peters, "Foucault, Counselling, and the Aesthetics of Existence," *British Journal of Guidance & Counselling*, vol. 33, no. 3 (2005), 383-396.

⁶⁷ For example in Nikolas Rose, *Governing the Soul. The shaping of the private self* (London: Free Association Books, 1989), second edition. See for example the chapter 'The Production of the self,' 103.

health educationists, and others who do not teach in a traditional way, but who operate by letting individuals formulate their wishes, desires, hopes, etc. for a better future, and who then provide the techniques or practices with which these individuals are enabled to work on themselves.

What Foucault found in the ancient practices of the self was precisely a set of precepts and instructions concerning the care of the self that did not focus on the desire of the subject. These practices of the self were instead focused on practical and technical administration. The ascetic exercises were not intended to renounce the desire of the self or to pass a moral sentence on the subject who had acted inappropriately, nor were they to promote an individual's desire as authentic or personal. Rather, they were technical exercises intended to administer the 'use of pleasures.' Foucault refers to Seneca's text *De ira*, in which Seneca examines the errors he has committed during the day. These are not 'moral vices,' but 'should be understood as basically technical errors. He was unable to deploy or handle well the instructions he was using.'⁶⁸ This is what the ancient dietetic instructions were designed to do. They were exercises, practical exercises that transformed the relation of the self to the self. They are everyday rules of conduct, precepts, instructions that direct the practical, everyday being of an individual, changing the mode of being of the subject. They give advice on how to conduct oneself as regards the pleasures of life.⁶⁹

The above elaboration of the *Hermeneutics* shows that Foucault's early works on madness as well as his work from the seventies on abnormality is echoed in the concept of stultitia. In this way madness constitutes a negative experience that provides a foothold for analysing the contemporary. It is the negativity of madness that constitutes the point of departure for analysing the discursive as well as non-discursive practices within a given historical context. Those forms of behaviour that stand out as mad to others constitute the catalyst for understanding the practices established to correct or normalise those mad behaviours. It provides a strategic foothold for thought. The various uses of madness throughout his literary activities could be summarised as such: first, in the Classical Age, it appeared as an incomprehensible, delirious nothingness, being the anti-pole to reason, although his analyses demonstrate that the unreasonable is found firmly within the various forms of rationality. Later, in the middle of the seventies, Foucault analysed madness as abnormality, something which became a part of the normal, only deviant. He analysed various techniques with which to normalise abnormal behaviour, thus identifying madness in all the minuscule, common practices of everyday life. Later, in the beginning of the eighties, he refers briefly to the idea of madness again, only this time as an even more intricate aspect of individual behaviour, i.e. in the relationship of the self to the self. Madness, through Posidonius and Seneca, is analysed as a fundamental condition, which is a prerequisite for entering a learning process.

It is worth for a moment to pause and reflect on the difference between *Abnormal* and the *Hermeneutics*. It is the non-connection of the will to the self, which is at the same time the cause and effect of stultitia, i.e. an internal fraction. The purpose of the process of education is

⁶⁸ Foucault, *The Hermeneutics of the Subject*, 482. See also Michel Foucault, "Technologies of the Self," in L. H. Martin et al. (eds.), *Technologies of the Self: A Seminar with Michel Foucault* (London: Tavistock, 1988), 16-49.

⁶⁹ Foucault, *The Hermeneutics of the Subject*, 236.

to rectify this conflict (cf. Rousseau and Kant's insistence that one is not free if one wants something, which one is not capable of. Therefore the purpose of education is to establish a unity of capability and will, or *pouvoir* and *voloir*). Now, the idea that it is possible to overcome this primordial fraction is the cause of our constant work on the self, our efforts to improve ourselves. But what if it is essentially impossible to ever rectify this distinction—if it is in essence the kernel of subjectivity? The heart of the matter for the late Foucault was therefore to investigate the practices through which we become subjects, i.e. through practices and technologies of the self. It is not a return to the subject or the self as an entity or an inner core of identity, but rather a way of investigating the technologies and practices that we apply to ourselves in a constant modulation, formation and constitution of the self. And the point of departure, the reason for applying these exercises, is the condition *stultitia*.

Possible Interpretations of the Paradox of Patient Education—What Do the Diabetics Say?

One may interpret the paradox of patient education, i.e. the dilemma of the health professionals described above, in various ways. One may say that the diabetes school teachers do not understand what the diabetics really need. It would also be a very plausible conclusion to say that the diabetics do not feel that they have a problem, and therefore do not need to change their lifestyle. Another interpretation could be that the participants think the diabetes school is a success because they get the background information they need in order to introduce changes to their lives accordingly. However, and interestingly, they do not necessarily feel that they need to make any changes. It is just nice to know the causes of one's future agony. They know they are in a risk zone, and they know they will have to take care of themselves, and now they also know how specifically they could do this if they begin to feel the need.

There are different rationalities at play among the diabetics. This is evident from diabetes research in general, i.e. that an elderly male diabetic has a different approach to his condition than a young female diabetic. These differences are visible in the ways the diabetics handle their lives with the diagnosis. Generally, female diabetics try to promote their health through dietary means, whereas male diabetics approach the lifestyle changes through physical activities. The focus group interviews portray these differences through the discussions that the participants have with each other. There are different responses to the question 'Is it difficult to live with diabetes?' Some say it only requires that a person get used to the rules that one must obey, that one makes a habit out of it, and that one does not think about the condition once this new state of life has been instated. Others find it tremendously troublesome to follow the rules of healthy living, and blame themselves for not trying hard enough. A male interviewee, for example, describes diabetes, not as a disease, but as a 'vice' or a 'flaw.' It is not the disease that is the problem. The disease is only a consequence of the real problem, which is obesity or even laziness, as a female diabetic exclaims. Others regard the rules as a challenge, an opportunity to experiment, through which they can personalise the rules to make them fit into their situation. Others will just ignore certain recommendations and follow the ones that make sense to them. The recommendations are sometimes seen as instruments for a regulation of the self. 'I can have a few pieces of dark chocolate, not milk chocolate' or 'If I stay on the diet all the weekdays, then I can have a cheat day on Saturday.' As such there are

different motifs, different rationalities, and ways of practicing a care for the self among the diabetics.

Another possible interpretation is that some of the diabetics have not fully understood the situation they are in. This interpretation touches upon Leriche's claim, mentioned at the beginning of the paper, i.e. that health is life lived in the silence of the organs. When asked if he feels ill (Danish: *syg*)⁷⁰ this 37 year old male diabetic says:

No, not really I think—well—I think things are going well, really well. And perhaps I make light of the situation, that I have a condition [*sygdom*], but I can't tell myself that I am ill [*syg*]—I can't, because then I would become even more ill [*syg*]. I have to be positive, you know, and laugh about it all—I think.

He feels that it is necessary not to accept the story presented in the diabetes school, because otherwise he would feel seriously ill. It is important that he keeps saying to himself that things are going very well. And they probably are on many accounts. Here, he touches on the rationality of the diabetes school. The purpose of the school is to make the diabetics aware that in fact they have a disease, and that they should not take their condition too lightly. A teacher in the diabetes school explains that she used to tell the participants that diabetes is 'dead serious,' but that she has changed her choice of terms, as she feels no need to scare them. The purpose is to let the participants know that they have a serious condition, but at the same time in a constructive way so that they do not despair, but actually acquire some skills with which they can manage the situation, to cope with their condition. When asked about his own goals or aims the above patient explains:

Well, the aim is to realise that I have a disease, right, and take it seriously. I probably don't do that, that is—I probably haven't understood the situation. Once in a while I... Well, I think I still take it too lightly.

But what will happen if one does *not* care properly for the self (disregarding for the moment the disputes about how one ought to take proper care of the self)? This shared negative image is often described in horrifying terms. Some interviewees refer to relatives, some to friends or acquaintances, some to information they have received from the hospital or media and some to the experiences they had from the wards when they were long ago diagnosed with diabetes and hospitalised. This elderly woman explains:

My father had diabetes and that is... is a nightmare to think about. He had both his legs amputated, and... During all the years he lived he was really ill [*syg*], and it was really horrible, and... Thinking back when I saw that as a child... [...] Having a father who is just ly-

⁷⁰ The distinction between illness and disease does not exist in Danish. Therefore the context decides whether one uses one or the other word in the interpretation of the quotes. This is possibly the reason why the interviewee seems to be undecided with regards to his own condition, because he uses the same word in Danish ('*syg*,' English: ill, sick, diseased) or variations on this word ('*sygdom*,' English: disease, illness, a condition).

ing there, totally handicapped, angry and bitter that he had no legs, right. That was not a very pleasant experience.

She moves on quickly to explain the causes of this horrible condition:

But he didn't know... I can't remember that we ever had vegetables at home, because it wasn't part of... [...] We had fatty food. Fried pork and so on. They thought that was really delicious, right. And I don't think they knew anything about vegetables and exercise being healthy. I can't remember my father being active at all. It kept getting worse. They didn't know what to do about the diabetes. He didn't even get insulin.

She then explains: 'That is probably why to some people I stand out as more extreme compared with others when it comes to treating my own diabetes—because I have that scary example on my mind, right.' This woman is not a special case. We know of many stories regarding what happens if one does not take care of oneself. People in general use these ideas of risks as a vehicle for working on themselves. The thirty-seven year old man quoted above says that if he had been asked about his attitude towards diabetes before he was diagnosed, he would have said the following:

It is only old people and people who eat fast food all day and stuff themselves with sweets and Coca Cola, who are diabetics. It is their own fault—it is their problem. I don't think like that anymore. But I see that attitude everywhere. It's because you're fat, they say, that you're a diabetic. But they just don't know enough about it. And I think that's the opinion in all of society: that if you're overweight and you've got diabetes, then it's your bloody own fault.

He furthermore suggests that in order to educate people how to take proper care of themselves, they would have to start very early in the schools.

Then they could bring in some people like me. In five years from now, my legs will probably have been amputated—in worst case, that is. Bring these people, who don't have their legs anymore, into the schools. And say: 'If you don't eat properly and stay active, you're going to end up like that guy,' right. But I don't know if that would help. If I were a primary school kid, I wouldn't listen anyway.

The various educational and medical institutions as well as the practices that the diabetics subsequently apply to themselves make sense in light of this negative image. The person we all know, but with whom we rarely identify: the mad person who does not want to care for him or herself, or who is incapable of doing so. The practices around diabetes have this common denominator, and allude to this negative experience. It constitutes the purpose of and the reason for, and permeates the various health education practices and the practices of self-care.

An obese female diabetic (age 62) during a focus group interview says the following when asked what the informants thought about the diabetes school:

I knew most of the things we were told [in the Diabetes School], I was very well aware of those things. And that has only confirmed my own thoughts that 'you know it all, so why don't you just do it,' right? That is... I've used the information to kind of whip myself [Danish, meaning 'blame myself'], that is, when I already know, why don't I just do it? That is, why don't I just take some long walks, why don't I run, why don't I do more than I do? And why don't I stay away from red wine, cheese and cakes—It's a mystery! But I don't. I haven't properly understood that that is what I ought to do. And you can wonder why I'm like that—I do, anyways—I wonder why I'm like that [laughs a bit].

I'm a mystery to myself! Why do I have this enigmatic character? I want to live healthily, but I don't. Why is that? I don't want to desire the things that I desire. The woman blames herself, and she looks at herself through the eyes of society. She stigmatises herself by internalising a cultural, economic, political, and medical exigency or norm. She thus becomes a stranger to herself—'I wonder why I'm like that.' It is as if she characterises herself with the properties of 'stultitia.' I want to care about myself, but at the same time I can't—I want to, but only fragmentarily, relatively, in a limited and unsettled manner. Why can I not will myself properly?

Conclusion

The main difference between current lifestyle changes and the Hellenic and Roman practices of the self is that the truths guiding the Hellenic work on the self were established by an unquestionable authority, a master. There were, of course, competing schools of thought in the Hellenic and Roman world, but the individual-to-be-corrected would choose a master, and subsequently follow his words as truths. The master was, undisputedly, a hegemon, but he operated as a counsellor, a guide, or an 'educator,' i.e. someone who would 'lend a hand' rather than instructing technical principles of truth. The truths, then, had a pragmatic function. By applying the truths to the self, the very being of the subject changed. As such, the truths and the master enabled this transformation to occur. To some extent the same is probably true for the rules of healthy living with which the diabetics are met. The difference, however, is the relationship to the master or expert. Neo-liberal modes of government have installed a self-limitation of power,⁷¹ i.e. modes of governing that transfer the responsibility from a state level to the individual. The individual is conceived as a free agent on a market, an entrepreneurial self, and the health professional as a supplier of health services. There have been several attempts to situate these changes within the health care sector in a wider historical-political context, for example the commodification of the public sector, the privatisation of health care, and in the general development of the welfare state throughout the twentieth century. Annemarie Mol's *The Logic of Care. Health and the problem of patient choice* from 2008 elegantly depicts how a logic of care has been replaced by a logic of choice, which means that the patient has no authority on which to rely, to appeal to, when making decisions about healthcare and treatment. Making decisions about how to conduct one's life vis-à-vis an endless flood of statistically generated knowledge about how different kinds of lifestyles and behaviour affect our health

⁷¹ Michel Foucault, *The Birth of Biopolitics – Lectures at the Collège de France, 1978-1979*, edited by Michel Senellart, translated by Graham Burchell (New York: Palgrave Macmillan, 2008), 20, 63-64.

and wellbeing is a complex task. Instead of indisputable truths we therefore have health norms to guide our choices, norms that are constituted through an increasing awareness of pathological conditions. Norms reduce the complexity of choice, and normalise behaviours. Caring for the lives of citizens by constructing a politics of life (Vitalpolitik)⁷² is achieved through enabling citizens to care for themselves within a welfare state that provides social care and security. This is an important premise for civil society's self-regulation. Because of this self-limitation of governmental reason, this reluctance of experts to appear as authorities, 'education' becomes an important mode of governing in liberal-democratic societies.

Obviously the condition of *stultitia*, the relationship of the self to the self, which is unsettled, fragmentary, and irresolute, is conditioned by the logic found in society, the media, in public health policy recommendations, and in the diabetes education activities more specifically. The diabetics appear stultified vis-à-vis the prevalent health and lifestyle norms, and more specifically in light of the practices with which diabetics are supposed to practice good self-care. In light of these norms and practices they at times and in various ways and degrees appear incomprehensible to health professionals, to people more generally, and importantly, to themselves. By elaborating the concept of *stultitia* this, perhaps parenthetical aspect of Foucault's work, which has not been elaborated theoretically nor used empirically before, I hope that I have been able to shed new light on the condition, which sometimes causes health professionals and patients alike to despair. The aim of the paper was to elaborate the concept of *stultitia* in Foucault's work and moreover to apply the concept by trying to make sense of the sometimes paradoxical experiences in a diabetes education setting.

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⁷² *Ibid.*, 148.