Sovereignty, Security, Psychiatry: Liberation and the Failure of Mental Health Governance in Iraq

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This article examines how psychiatry has been used as a technology of security in post-'liberation' Iraq. Drawing on Foucault and Foucauldian work on the history and sociology of medicine, it begins by tracing how, from the 19th century onwards, psychiatry has instantiated its authority through a claim to provide social security within national spaces, both through methods of sovereign confinement and through liberation and governance. Arguing that the various 'psy' disciplines – and medicine more generally – are increasingly used as technologies of security internationally, the article examines psychiatric practice in Iraq, where patients in the Al Rashad psychiatric institution were accidentally liberated from their confinement by US Marines in 2003. Iraq's 'mentally ill' were initially considered a manageable security threat and thus subject to liberal community governance efforts. Yet, after the so-called suicide bombing of two pet markets in 2008, reportedly by former Al Rashad patients, those deemed 'mentally ill' and others associated with them were once again made subject to sovereign confinement, marking a failure in liberal governance. Thus, this article seeks to explore some of the complex lines connecting sovereignty, security and psychiatry in post-'liberation' Iraq, and in global politics more generally.

Keywords Iraq • psychiatry • medicalization • sovereignty • governance

SCHOLARS WORKING IN THE FIELD of the sociology of medicine have long since probed how psychiatry and psychology have been deployed as technologies of liberal governance aimed at providing social security within national spaces. Yet, little has been said about how the various 'psy'

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disciplines[1] are also increasingly harnessed in international security imperatives. This article begins to trace out some of the complex ties that bind security, sovereignty and psychiatry in the contemporary conduct of international affairs, focusing on a specific investigation of psychiatric practices in post-2003 Iraq. The story of psychiatric practice in post-'liberation' Iraq begins with a rather contingent event on 8 April 2003. As US forces were taking Baghdad, US Marine Corps tanks knocked down a wall of the Al Rashad hospital, Iraq's main long-term psychiatric institution, with the Marines reportedly believing that they were entering a prison (Arnold, 2003). Some of those confined at the institution reportedly fled immediately, only to be killed in the battle outside the institution's walls (Tyler, 2003). Others left in the following days, after looters raped some of the female patients and stripped the hospital of anything of value (ICRC, 2003). Still others chose to stay on at the institution (Tyler, 2003; Glauber, 2003).

The US Marines' unintentional 'liberation' of the approximately 1,400 Iraqis institutionalized at Al Rashad came to be understood as a symbol of anarchy and a source of danger in multiple media reports. The *New York Times* ran a cover story entitled 'In Baghdad's Anarchy, the Insane Went Free' (Tyler, 2003), which described how 'the Marines broke the door down on the maximum security wing, and in no time the patients were gone, untethered from the antipsychotic drugs that stabilized many of them'. The escaped patients were portrayed as dangerous, dark, violent, and murderous. One psychiatrist associated with the institution asserted that 'there are quite a few human time bombs out in the community', while another lamented the lack of laws for involuntarily committing patients. Part of the disorder of the invasion of Iraq, then, was tied up with the 'liberation' of these mad men and women: that the mad were left free to roam – ungoverned – came to be emblematic of anarchy, insecurity and the absence of the rule of law.[2] In short, Baghdad's liberated mad became representative of a vacuum of governance. This article traces a series of attempts by aid agencies, the World Health Organization, the US Department of Health, as well as psychiatrists and other mental health authorities to submit Al Rashad's patients to renewed forms of governance after their unintentional liberation. Such attempts have ranged from governmental and disciplinary to sovereign: the Al Rashad patients have been positioned as pitiable subjects and as sources of humanitarian concern, but also as sources of danger requiring containment and re-institutionalization. In the liberation/liberalization of Iraq, this varied treatment of the patients – their

[1] The 'psy' disciplines include all those sets of knowledge that take the psyche as their object, including psychology, psychiatry, their subfields and cognates. Treating these varied disciplines under the unified term 'psy' is not to say that such disciplines should be treated as monolithic, coherent or undifferentiated (see Rose, 1998: 2). Yet, what they all share in common is a belief in the psyche and its problematization through various diagnoses.

[2] In an article co-authored with Andrew Neal, we explore how the liberty both of the escaped 'mentally ill' from Al Rashad and of the escaped lions and other animals from the Baghdad zoo came to be prominent in a symbolic economy representing post-liberation Iraq as an anarchic space; see Howell & Neal (2010).

liminal position within liberal order – sheds light on some of the intricate ways in which liberal governance works in tandem with sovereign and disciplinary power in international relations.

The activity surrounding the Al Rashad psychiatric hospital and its patients can tell us much about the uses of sovereign power and confinement in contemporary global politics, and about the deployment of the psy disciplines as technologies of security. Foucault and Foucauldians writing on the history and sociology of medicine have been central to explicating how the psy disciplines have been constituted as technologies of the defence of society within national settings (Foucault, 1988, 2006; Castel, Castel & Lovell, 1982; Miller & Rose, 1986; Rose, 1998, 2006), though less has been done to trace the place of the psy disciplines as technologies of security in managing the threat to global stability purportedly posed by the 'mentally ill', with the notable exception of Vanessa Pupavac's (2001, 2004) work on post-traumatic stress disorder and therapeutic governance in Bosnia. In conceptualizing the psy disciplines, and medicine more broadly, as technologies of security, I follow from Duffield's formulation of development as a technology of security that is central to liberal forms of governance (Duffield, 2007: viii, 216–217).[3] Technologies of security work to contain and manage the populations that they target, whether these be the 'underdeveloped', the ill, the contagious or the disordered. Then, just as we have seen the securitization of development and the developmentalization of security, so too are we witnessing the securitization of medicine and the medicalization of security in contemporary global politics (see also Elbe, forthcoming).

In order to illustrate how psychiatry is harnessed as a technology of security, the article begins by placing the psy disciplines in historical perspective, focusing on how psychiatry has instantiated its authority through its claim to provide public safety. In this context, spaces of confinement have had a particular role, as the psy disciplines have shifted from operating primarily through sovereign confinement to more disciplinary and governmental tactics. Here, Foucault's reconsideration of the legacy of Philippe Pinel provides critical insights into narratives of liberation surrounding spaces of confinement, and into the psy disciplines more broadly. The second section turns to the case of the unintentional liberation of the mad at Al Rashad. Here, I trace the ways in which Al Rashad's liberated patients became 'problem' subjects in attempts to liberalize and secure Iraq. Third, the article examines renewed sovereign interventions that have been exercised on the bodies of those deemed 'mentally ill'. Following their accidental liberation, many of Al Rashad's former patients were originally deemed subjects suitable for liberal community governance. Yet, with the bombing of two pet markets in 2008, purportedly by two former female patients, Baghdad's mad, homeless and vagrants were again deemed dangerous and subjected to forced sovereign

[3] On technologies of security, see also Foucault (2007), particularly pp. 8 and 59.

confinement. This return to post-libera(liza)tion sovereign confinement suggests that mental health activities have been marked by a failure of liberal governance. Such failures are not often so stark, and yet at the same time many have noted that the literature on governmentality has tended to overemphasize the success of governmental programmes at the expense of considering instances wherein such programmes fail or falter (O'Malley, Weir & Shearing, 1997). The article concludes by disentangling some of the complex lines that draw sovereignty, security and psychiatry together in the practice of contemporary international relations.

Governing the 'Liberated' Mad: Psychiatry and Security in Historical Perspective

In *Madness and Civilization*, Foucault argues that in the 19th century the mad were (partially) liberated from sovereign power only to be governed anew through disciplinary power. Foucault reconsiders the legacy of Philippe Pinel in this context. Pinel has been regarded as a father of psychiatry and a liberator of the mad. He famously unchained the mad confined at the Bicêtre and Salpêtrière hospices in France, instituting new techniques of close observation and lengthy conversations (in addition to the sovereign use of chains and straitjackets when deemed necessary). Foucault's innovation is to argue that Pinel's 'liberation' of the mad signals the emergence of a new kind of purpose for confinement: 'madness, liberated, is obliged to submit' (Foucault, 1988: 195). Confinement is henceforth not merely repressive, but 'endowed with a positive efficacy' (Foucault, 1988: 196). Then, 'the absence of constraint in the nineteenth-century asylum is not unreason liberated, but madness long since mastered' (Foucault, 1988: 252). In this sense, madness moves from sovereign capture to discipline and governmentality, which make more strategic recourse to outright confinement, force and other sovereign measures.

New psychiatric practices in the early 19th century also became important in situating the madman within the realm of the medical. This is a historical feat, not a natural fact. The mid-19th century 'conquest of madness by medicine, which in psychiatric hagiography is recounted as a heroic saga, was in reality no more than a thin patina of modern innovations laid over the surface' of longer-standing methods for dealing with deviance, poverty and illness (Castel, Castel & Lovell, 1982: 5). For Foucault (1988: ix), this discovery by science and philanthropy of madness as a positive truth divided madmen from reasoned men in the name of public order, often confined those deemed mad to carceral sites, and established codes of respectability and discipline for all subjects.

In *Madness and Civilization*, Foucault appealed to a notion of violence that he asserted still permeated the asylum. In his recently translated 1973–74 lectures on 'Psychiatric Power' and his 1974–75 'Abnormal' lectures, Foucault shifts away from this concept of 'violence' because of its 'connotation of physical power, of an unregulated, passionate power, an unbridled power' (Foucault, 2006: 14). This notion is dangerous, he argues, because it leaves power that is not laden with direct physical violence unexamined, and implies that it is not also physical. Rather, Foucault suggests that all power is physical in that it is applied to the body (see also Philo, 2007: 152). As an alternative, Foucault advances the notion of a microphysics of power in operation in the asylum and in psychiatric practice more generally: one that is meticulous, calculated, and marked by a series of strategies and tactics (Foucault, 2006: 16).

In the 19th century, the madman was constituted as a social danger, which transformed the psychiatric enterprise from one of assistance into a phenomenon of protection (Foucault, 2006: 220). Psychiatry then began to take up its position as a technology for the defence of society. To shore up the power and utility of their discipline and to position psychiatry as a science of social defence, psychiatrists increasingly took an interest in crime. 'The determination to pin madness on a crime, even on every crime, was a way of founding psychiatric power . . . in terms of danger: We are here to protect society, since at the heart of every madness there is the possibility of crime' (Foucault, 2006: 250). The binding together of madness, danger and crime should be viewed as a historical achievement, requiring continuous reproduction. For its authority to hold, psychiatry must reproduce itself not only as a helping discipline, but also as a tool of public safety by continually seeking out new criminals and other security threats. Thus, in order to exist as an institution of medical knowledge, psychiatry had to undertake two simultaneous codifications: first, it had to codify madness as illness; second, madness had to be codified as a danger.

From this point forward, psychiatry has positioned itself as an authority in managing public order and safety, and quashing the possibility of disorder and danger. Psychologists have also increasingly become implicated in the project of managing the risk to public security that the mad purportedly pose. When the 'mentally ill' are deemed to be a threat to collective security, it falls on psychologists, among other psy experts, to manage the risk that arises from this security threat: 'to tame uncertainty and master hazard' (Rose, 1999: 260). The psy disciplines have also grown more diffuse, so that any behaviour potentially comes under their purview: 'there is nothing in human conduct that cannot, in one way or another, be questioned by psychiatry' (Foucault, 2004: 160). Psychiatry also binds with other professions and sites of disciplines and governance: 'it is eventually found wherever there is power: in the family, school, workshop, court, prison, and so on' (Foucault, 2004: 276). At the same time, given biomedical models of mental illness, the psychiatric

is now increasingly molecular (Rose, 2006: 199). The psychiatric gaze is thus simultaneously 'drilling deeper' and increasingly diffuse. I argue that this diffusion of the psy disciplines is also progressively more international. The activities surrounding the Al Rashad psychiatric hospital in Baghdad illustrate how the psy disciplines are no longer positioned solely as technologies for managing social danger confined within national spaces, but also increasingly operate as technologies of national and international security.

To summarize, narratives of liberation surrounding the mad should be viewed critically. First, as Foucault's account of Pinel illustrates, historically the mad have been 'liberated' from sovereign confinement only to be subjected to disciplinary and governmental measures (as well as sovereign force for the incorrigible, the dangerous, the criminally insane or patients who otherwise resist). Claims concerning the humane treatment of the mad by medical authorities should be met with scepticism: though such efforts are often made in the name of liberation or benevolence, all too often they are also implicated in renewed forms of governance. Second, psychiatry and the psy disciplines in general are heavily implicated as technologies of governance used to manage the social danger purportedly posed by the untamed mad. The psy disciplines have long claimed to provide social security in domestic settings. Increasingly, I argue, they are also called upon in the international realm to provide global security, order and stability. The frenetic activity of mental health experts in the wake of the unintentional liberation of those incarcerated at Al Rashad during the 2003 invasion of Iraq forms a case in point illustrating this trend.

Al Rashad: Liberation and Community Governance

In Foucault's account of Pinel's legacy, he illustrates how madness, liberated, was made to submit to emergent forms of liberal discipline and governance. In the case of Al Rashad, the unintentional liberation of the institution's patients was not immediately followed by such governmental programmes. When the US Marines accidentally 'liberated' the patients, they were simply and unintentionally let loose. This apparent vacuum of governance did not last long: psychiatry stepped in to once again fill this supposed void, to manage the purported disorder and insecurity posed by the ungoverned mad.

In order to quell this threat, psychiatry was reasserted anew on the bodies of the escapees, alongside and as part of military and humanitarian intervention in Iraq. It should be noted that this occurred in the context of the broader targeting of the Iraqi population as a whole as a 'traumatized' population. Post-conflict populations have increasingly come to be subject to a kind of therapeutic governance that treats trauma with the aim of restoring stability

and thus international security (see Pupavac, 2001, 2004). In Iraq, the World Health Organization and the Ministry of Health of Iraq have been particularly active in this regard. Recently they conducted a mental health survey (which was also supported by four pharmaceutical corporations, among other organizations) in order to assess the prevalence of mental illness in Iraq (see Alhasnawi et al., 2009), while Iraqi refugees in Jordan and Lebanon have been targeted as especially in need of this kind of therapeutic governance (see IOM, 2008). These efforts are aimed at monitoring the psyches of the entire Iraqi population. 'Mental illness' is then generalized across the national population, and medical solutions are positioned as the appropriate response to conflict. These expansive programmes target the Iraqi population as a whole, in ways that are also meant to ensure future peace and security. This forms part of the broader context in which the accidental liberation of the patients at Al Rashad comes to be seen as a particular kind of 'problem' for mental health experts.

Two-thirds of the Al Rashad patients were re-institutionalized after being returned by families, religious leaders, neighbours or the police (SAMHSA, 2005; WHO & Ministry of Health of Iraq, 2006: 11). Of the one-third not returned, Al Rashad's former director Dr Muhammad Lafta lamented: 'we lost them' (SAMHSA, 2005). Some reportedly died in the conflict outside the institution's walls, while the majority had refused or escaped being returned. The question remained of what to do with those who had been re-institutionalized, given Iraq's libera(liza)tion. The answer was to assemble mental health expertise in order to determine how best to govern the returned patients. As part of the broader reconstruction efforts in Iraq, the US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) programme, along with the World Health Organization (WHO), funded a conference bringing together Iraqi psychiatrists with US and British mental health experts, in order to create a Mental Health Plan for Iraq (Clay, 2005). In line with WHO's theme for 2001, 'Mental Health: New Understanding, New Hope' (see WHO, 2001), these experts decided that Iraq's mental health model should shift from institutionalization to community-based care, and that Al Rashad would be transformed into an institution only for forensic patients (i.e. the criminally insane) (SAMHSA, 2005). This shift to community-based care signals the introduction of a new form of governing Iraq's mad: from sovereign incarceration to governance through community (Rose, 1999), except for the 'forensic patients' who would remain at Al Rashad.

Nikolas Rose (1999: 173–176) has argued that, since the early 1990s, 'community' has emerged in Western liberal democratic market-based societies as a central technique of governance: government through community. 'Community is emerging both as a means of problematization and as a means of solution', and one valorized as the primary alternative to centralized inter-

vention aimed at the 'social'. The emphasis on 'community' as a resource for mental health care provision is not, however, limited to liberal democratic market-based societies. For example, development discourse has increasingly emphasized 'community care' as a solution not only to mental ill-health in the context of so-called developing countries, but also as a resource in development writ large, because mental ill-health has been identified as a barrier to national development. The World Health Organization's Mental Health Improvements for Nations Development (MIND) Project (see WHO, n.d.) is an example of this trend. This form of governing through community is also making an appearance in mental health programming in Iraq. Rose's analysis of community as governance thus also becomes useful in questioning such programmes outside of Western contexts, particularly when they form part of Western interventions.

As Rose (1999: 187) points out, although 'community' originated as a strategy of resistance, it has increasingly been transformed into an expert discourse and professional vocation: community is now something to be programmed. Community becomes governmental when it is rendered technical: when it is made an antidote to social ills (Rose, 1999: 175; see also Li, 2007). The shift to community governance enlists all citizens, and particularly those in the voluntary sector, in ways that make them responsible for the moral training of community members (such as the mad) so that such members of the community take up responsible citizenship (Ilcan & Basok, 2004).

In Iraq, efforts to move towards community governance in mental health care delivery gathered steam by 2004. At this time, mental health was deemed one of the three top health priorities in Iraq, along with oncology and infectious diseases (see Goodman, 2004: 1). With the financial support of Oxfam, the global health NGO Medact (2004: 4) released a report that identified a lack of 'community services or community-based interventions' in the mental health field in Iraq. A Behavioural Health Care Task Force was set up with the support of the US Department of Health and Human Services, tasked with building 'a community-based mental health care system from the ground-up' (Goodman, 2004: 1). In order to carry out this transformation in mental health service delivery from hospital-based to community-based governance, a range of training and knowledge transfer activities were instituted.

Starting from 2005, a series of annual conferences on mental health in Iraq were organized, the first held in Amman, Jordan, the next in Cairo, Egypt, and the next in Baghdad. The aim was to plan the shift to community-based care through the creation of the Iraq Mental Health Action Plan. According to one international officer for SAMHSA, 'the Iraqis had a very medicalized, institution-based model of mental health care in the past, but there was clear agreement at the conference that the country would now prioritize the development of an integrated, community-based care model' (quoted in Goodman, 2004: 1). At the Amman conference, the possibility of closing Al

Rashad emerged. An article in a SAMHSA newsletter described the reaction of Al Rashad's director:

> [He] didn't believe it was possible. But after exploring the idea further at a recent conference, he's now committed to closing the mental hospital as soon as possible – even though it means putting himself out of a job. . . . 'It's not unusual for patients to spend 20 years in the hospital,' explained Dr. Lafta. 'These are people without rehabilitation, without goals, without human attachments. They have nothing to do. They spend their days waiting for pills. I'm now convinced that a better way to treat patients is to let them live in the community. Instead of just being left in the hospital, they should be treated like human beings' (Clay, 2005).

Ten Iraqi psychiatrists, including Al Rashad's director, received three months of specialized training in the UK, focused on community-based care provision. The training was conducted by Dr Sabah Sadik, then director of the West Kent National Health Service and Social Care Trust in the UK, and national adviser for mental health to the Ministry of Health of Iraq (he later left his post in the UK to become the Iraqi minister of health in 2007) (Clay, 2005). As another SAMHSA (2005) newsletter trumpeted, 'now that Dr. Lafta has seen community-based services in England and the United States, he's convinced that's the model to use. . . . And Al Rashad would be transformed into an institution serving only forensic patients'.

US health officials in particular seem naive in viewing their activities in terms of the humane and benevolent export of progress, despite the context of the US-led war. SAMHSA's chief administrator put the organization's activities in these terms: 'Our compassion and our shared humanity dictate the necessity and the value of assisting other countries. But beyond that, we have a responsibility, as a leader among countries with the most advanced services for mental health care, to share what we know and help others create better mental health services' (Curie, 2004). One American Psychiatric Association publication ran an article under the title 'Americans Help Iraqis Build Community Mental Health System', again identifying a shift from hospital-based to community-based care as the model to follow (Lehmann, 2004).

Through the Mental Health Plan for Iraq devised by the US, SAMHSA and the WHO, in consultation with Iraqi psychiatrists, community was established as the primary alternative to institutionalization. This is positioned as a more progressive, humane and efficient way of treating the 'mentally ill'. Indeed, psychiatric survivors/consumers and those who identify as mad have fought for human rights and de-institutionalization for well over three decades (Crossley, 2006; Morrison, 2005; MindFreedom International, 2009). This does not mean, however, that alternatives to sovereign institutionalization – such as community governance – are not also fraught. That the mad need to be governed at all is at question, particularly when such governance is positioned as a security measure in the defence of a society, nation or international stability.

First, such forms of governance continue to rely on the exercise of sovereign power. Those deemed mentally ill are not all targeted equally in programmes of liberal (community) governance: some mad – those deemed dangerous, criminal or incorrigible – remain under the remit of sovereign power and institutionalization. In 2005, a study was conducted at Al Rashad in order to determine what proportion of the patients could be released into community care (Humaidi, 2006). The study excluded forensic patients – that is, those already deemed criminally insane, and therefore not even considered fit for rehabilitation or anything short of sovereign incarceration. In the words of Al Rashad's director at the time of the patients' escape, the forensic inmates were 'exceptionally dangerous and volatile patients' (Muhammad Lafta, quoted in Arnold, 2003). I use the term sovereign incarceration, it should be noted, to denote a form of institutionalization that is marked by the absence of a will to improve. Rehabilitation is not the central aim of sovereign incarceration: rather, its aim is the capture and containment of those deemed incorrigible and dangerous. Guantánamo and other detention centres in the 'War on Terror' are also examples of this kind of incarceration. At Al Rashad, the forensic patients were not considered fit for improvement, and have thus been subject to this kind of sovereign confinement in the name of security. Yet, confinement can also be undertaken with a will to improve and to rehabilitate.

Of the 723 patients included in the study, 474 or 65% were deemed 'ready to be rehabilitated outside the hospital' (Humaidi, 2006: 179), while 249 were determined to be not yet ready for non-hospital rehabilitation (i.e. for liberal governance of the self and through community). These patients would be subject to disciplinary incarceration: that is, a kind of confinement that is coupled with the will to improve. Various barriers to releasing the patients were identified, including the absence of family or other support networks available to patients. It is notable that one factor was never mentioned in the study: the ongoing conflict in Iraq. It seems implausible that community-based governance would be deemed an option at all given the massive disruption to communities in the context of war. In any case, the means for determining which patients were or were not ready for non-hospital governance were left largely to their psychiatrists, who determined their level of 'independent functioning' according to whether they were on drug-therapy programmes that involved 300mg of chlorpromazine or the equivalent (Humaidi, 2006: 181). The mad, then, are not just divided from the sane, but also subject to internal division between those considered ready for community governance, those not yet ready (but potentially ready in the future), and those who are simply removed from such consideration (the forensic patients). The Al Rashad patients were divided in these ways and then governed according to their ability to self-govern or to integrate into community governance, or according to their purported inability to govern themselves. The Al Rashad patients have thus been subject to a range of strategies: some governmen-

tal, such as community and self-care, some disciplinary, such as rehabilitative institutionalization, and some sovereign, including the captivity of those deemed violent and incorrigible. These strategies are not so much contradictory as complementary.

Mitchell Dean (2002) has considered how spheres of government categorize individuals differently according to the capacity for self-governance that they are deemed to exhibit. Dean outlines how individuals are roughly separated into groups according to their capacity for autonomy, from those who self-govern, to those who need training or assistance, to those who are delinquent or disruptive and may thus be subject to authoritarian measures, such as incarceration. The psy disciplines remain authoritative in such dividing practices, which deem some populations pathological and others normal, thus calling up various forms of sovereign, disciplinary or governmental interventions.

The treatment of the escaped patients at Al Rashad forms one of those instances wherein sovereignty, discipline and governance are articulated together. Some (notably Deleuze, 1992) interpreted Foucault's understanding of these forms of power as a successive chronology, with disciplinary power replacing sovereign power in the 18th century, and governmental power replacing disciplinary power in the 20th century. This, however, is not a fruitful interpretation, as it does not allow for examinations of how such forms of power may be articulated simultaneously. As Beaulieu (2006: 24) has put it, this is not a matter of succession or sequence, but of transversal and overlap. Agamben makes a similar argument in *Homo Sacer*. He asserts that the points of convergence between sovereign and biopower remain unclear in Foucault's work, and that these two types of power are dissociated through their historicization in Foucault's account, when they are instead best understood in their relation to one another (Agamben, 1998: 6; see also Montag, 2006 for a discussion).

Singer & Weir (2006) have argued that those writing histories of the present – including, to some extent, Foucault – have often conflated all of politics with governance owing to an inability to sufficiently account for sovereign power. Sovereign power has largely been theorized as displaced by governance, and thus considered both residual and anachronistic when it appears in the 19th and 20th centuries. With the recent publication and English translation of Foucault's *Security, Territory, Population* lectures, more can be gleaned about Foucault's formulation of the relation between sovereignty, discipline and governmentality. In the fourth lecture, previously translated into English in 1979 as the lecture on governmentality (and also reprinted in Burchell, Gordon & Miller, 1991), he asserts that the emergence of the art of government eliminates neither discipline nor sovereignty, but in fact makes the problem of sovereignty and the development of discipline more acute (Foucault, 2007: 107). The newly translated balance of the *Security, Territory, Population* lectures

also bear this out in the empirical material that Foucault presents. As Singer & Weir (2006: 448) point out, Foucault never maintained that governmentality had abolished sovereignty (see also Dillon, 1995). Further, they challenge those (notably Rose, 1999) who figure governance as a superordinate term to refer to all forms of power, including sovereignty. This is conceptually incoherent, because sovereign power – with its emphasis on the obedience rather than the administration and optimization of subjects – cannot be subsumed under governance. To attempt to do so is to reduce all politics to governmentality, to fail to see any exteriority to governance, and 'to blind oneself to the discursive construction of power with all its possible, present effects' (Singer & Weir, 2006: 459). Accordingly, Singer & Weir (2006: 443) seek to highlight a more robust conception of sovereignty in order to introduce a more nuanced and heterogeneous account of power. Sovereignty should be considered not only in its difference from governance, but in the way in which they are both articulated together: 'articulation suggests many different, possible relations, and many different possible meditations' (Singer & Weir, 2006: 459).

In this sense, the dividing up of the Al Rashad patients and the subjection of the forensic patients to sovereign confinement should not be viewed as anachronistic, but as a simultaneous articulation of sovereign, disciplinary and governmental measures together. This kind of simultaneous articulation is common in contemporary politics. The ability of the psy disciplines to divide up the mad – to assess who can be governed through community, who will be rehabilitated, and who is dangerous and thus subject to sovereign incarceration – functions to continually shore up the authority of the psy disciplines as technologies for the defence of society and, increasingly, security in the international realm. Accordingly, continued expressions of sovereign confinement should not be viewed as anachronistic or as vestiges of Iraq's sovereign psychiatric system under Saddam Hussein,[4] but as integral to liberalism and to the continued production of the psy disciplines as technologies of security.

What we have in Iraq is a series of attempts to assess who is sane and who is mad (i.e. to measure the prevalence rates of 'mental illness'), and then to further divide up the mad between those who are truly dangerous and those who are only potentially dangerous. Then, determinations are made concerning what forms of governance or discipline or sovereign intervention are appropriate for each, while 'community' is rendered a technical solution to the 'problem' of the liberated, ungoverned mad. And, yet, all these attempts to fill a post-liberation void of governance were ultimately never fully realized.

[4] It should be noted that, from 2001, the International Committee of the Red Cross (ICRC) had been heading a CHF 3.6 million project to improve the conditions at Al Rashad. The project included not only the improvement of facilities but also training of all staff in the 'humane' treatment of patients and the provision of journals for the doctors. At the time of the invasion, the ICRC's Psychiatry Project Manager stated that 'when we came here two years ago the staff were treating the patients like animals – they weren't cruel to them, but failed to understand that they were fellow human beings' (quoted in Arnold, 2003: 1).

Security, Sovereignty and Failed Governmentality

By 2007, cracks in the enthusiasm for community governance began to appear. One article in an American Psychiatric Association publication put it simply: 'Iraq . . . has failed to establish community mental health centres' (Hamid & Everett, 2007: 1355). In accounting for this failure, the authors went on to state that the 'deinstitutionalization movement . . . has particular ideological, social, financial, and political significance in the United States and the United Kingdom, which may not be applicable to Iraq's current circumstances. . . . Iraq has essentially no community health centres, vocational or rehabilitative services, homeless shelters, or residential mental health programs, and it has fewer than 100 psychiatrists to serve 25 million Iraqis' (Hamid & Everett, 2007: 1356). Strangely, in this account of 'Iraq's current circumstances', the ongoing conflict in the country fails to be addressed, much as in the 2006 study described above. Again, community governance seems implausible in a context of massive disruption to communities caused by the ongoing use of force in Iraq.

Undoubtedly, this failure of liberal governance may also be due in part to the resistance of the Al Rashad patients themselves. It is difficult to account for such resistance, however, because few narratives from the perspective of those incarcerated at Al Rashad exist. These patients are almost universally represented as either pitiable or dangerous, a dynamic that is not unique to those incarcerated at Al Rashad. Indeed, this is common in global politics, for instance in the representation of populations such as refugees (Nyers, 1999), women trafficked as sex workers (Aradau, 2004) and Guantánamo detainees (Howell, 2007), among others. The *New York Times* cover article on Al Rashad (discussed above) opened with this assertion:

> The only mental patient left behind at the high security ward of Al Rashad state hospital is a killer . . . with jet black hair and dark, searching eyes. He is off his medications, the door to the ward is wide open and shards of glass lie everywhere as potential weapons. . . . He stalks the looted corridors inside the 15-foot-high wall that once provided maximum security to restrain 120 patients who were committed for murder and rape while in the throes of mental disorder (Tyler, 2003).

And, yet, in the very next paragraph, the article describes 'six women among the patients who were raped by looters' and who receive special attention from the nursing staff: 'Some spend their days curled under blankets, others have ventured out to squat in the light where there are no chairs, but where cigarettes can be smoked. The nurses whisper that one rape victim is pregnant.' These passages ask the reader to see the Al Rashad patients as both sources of danger and as pitiable subjects, as victimizers and as victims. This is deeply bound up with both race and gender. The description of the 'killer' is notably marked by reference to his 'black' hair and 'dark' eyes: danger

here is racialized. Victimhood is feminized: the reader is invited to pity the female patients, especially those who have been raped. Elsewhere, one female patient is described as having a face 'frozen in a mask of permanent terror' (Ghosh, 2003: 42). It is in part through such representations that the 'problem' of Al Rashad comes to be positioned on the cusp of security and humanitarianism: governing the mad of Al Rashad ostensibly becomes necessary both as a security measure and as a measure of humanitarianism. These accounts also fail to tell us anything of what the patients themselves think about their incarceration, their 'liberation', or what kinds of services (if any) they may be interested in accessing as Iraq rebuilds. In the activities of those experts planning Iraq's shift to community-based mental health services, it is sometimes acknowledged that consumers of psychiatric services should be involved in the process of shaping these shifts, and that the establishment of community-based programmes should be 'consumer-driven' (Charles Curie, quoted in Goodman, 2004). Yet, little has been done to actually ensure consumer/survivor participation in these processes, because the patients have not tended to be seen as able to contribute. One report, for instance, described Al Rashad's patients as 'baffled' by 'therapeutic choice', given that they were 'used to being told what to do' (Feinmann, 2007: 17; see also Black, 2008). Because so few accounts from the perspectives of the patients exist, it is difficult to account for what role they may or may not have had in resisting efforts to govern those deemed mentally ill in Iraq through the liberal shift to community governance.

Yet, the failure of liberal mental health governance in Iraq culminated with a rather contingent event. In February 2008, two pet markets in Baghdad were bombed. Ninety-nine people were killed. The bombings were blamed on two female 'suicide bombers'. On the basis of photographs of their detached heads, Iraqi authorities said the so-called suicide bombers had Down's syndrome, then later asserted that they had been treated for depression and schizophrenia at Al Rashad (Lannen & Khadim, 2008). In news reports covering the incident, the women were repeatedly described as 'unwitting' (see Holden, 2008), and it was emphasized that the bombs were exploded by remote detonation (see Fletcher 2008). Despite this, strangely, the women were still designated as 'suicide' bombers. In the aftermath, Al Rashad was raided by Iraqi security forces and US soldiers, and its director at the time was detained for nearly two months on suspicion that he had 'supplied' Al-Qaeda in Iraq with the so-called suicide bombers.

Evidently, the Al Rashad patients were constituted as a particular threat to order and security, because they were considered vulnerable to being used in insurgent attacks (Kenyon, 2008). Their very vulnerability was positioned as a source of danger. Pity and danger were collapsed into each other, as those associated with Al Rashad were deemed to be either at risk, risky, or both. In response, Iraq's interior minister ordered police to round up Baghdad's

homeless, vagabonds, beggars, mentally disabled and mentally ill in order to place them in institutions (Lannen & Khadim, 2008; Kenyon, 2008), including, in particular, Al Rashad. Here we see a failure in dividing up, a feature so intrinsic to governmental efforts. As described above, psychiatry historically achieved its authority through its division of the madman from the idiot, its codification of the madman as a social danger, and its claim to be able to manage this danger. With the bombing of the pet markets, there is confusion over whether the two female 'suicide' bombers had schizophrenia coupled with depression, or whether they had Down's syndrome (or both). Additionally, a whole set of 'abnormals' – from the mad, to vagabonds, to the homeless and the mentally disabled – were associated together, in a totality. Sovereign control over the bodies of Baghdad's mad and homeless was reasserted when they were constituted – in their supposed totality – as security threats. In this sense, efforts to govern liberally, to govern through community, failed: the bodies of the mad (and those associated with them) were subject to indiscriminate, sovereign confinement. This kind of confinement seeks not to improve or rehabilitate its inmates, but to contain the dangerous and disorderly in the name of security. This kind of re-institutionalization and resort to indiscriminate force does not represent a resurgence of psy power, but signals its limits and undermines its authority as a technology of governance and security, able to divide up and manage human life. As Foucault's account of Pinel demonstrates, the psy disciplines are at their most powerful when they are tasked with the diffuse governance of those deemed mad in the name not only of security, but also of liberal and humane treatment. Sovereign confinement, when it extends beyond the incorrigibles – in this case, beyond the forensic patients – is no longer used strategically. It becomes disarticulated from governance and overtakes it. When the vulnerable are made indistinguishable from the dangerous, this signals a failure in the liberal deployment of the psy disciplines and an erosion of psy authority. In this sense, efforts to establish the liberal governance of Al Rashad's patients failed.

And, yet, a governmentality of psyches is still emerging in Iraq, and planning activities for liberal mental health governance continue to take shape. Efforts to calculate the prevalence of mental 'disorders' in Iraq continue apace (see Alhasnawi et al., 2009). As Li (2007) has argued, governmental assemblages are often marked by efforts to manage failure. Such failures are often presented as the outcome of rectifiable deficiencies, and new sets of techniques are then called forth to address such deficiencies. It is likely that this will be the case with efforts to govern the mental health of Iraqis: the psy disciplines would not be so ubiquitous if they were not resilient and adaptable. As the situation in Iraq evolves, it will be important to see whether and how the psy disciplines are enlisted in renewed governance strategies.

Conclusions: Sovereignty, Security, Psychiatry

The activities surrounding Al Rashad tell us something about the simultaneous articulation of sovereign and disciplinary measures with liberal governmentalities in the international realm. Indeed, the interface between sovereignty, discipline and governmentality is a subject best answered in empirical terms. Questions about whether authoritarian practices are internal or external to governmentalities or to liberal governance – in other words, whether liberalism functions by necessity through strategic recourse to sovereign measures – tend to be less productive when posed only in theoretical terms. The site of Al Rashad reveals that sovereign or authoritarian measures have been both internal *and* external to the liberal governance of Baghdad's mad. Sovereign measures were integral to the push towards liberal community governance in the sense that this kind of governance relies on a division of subjects – not only of the mad from the sane, but also of the mad among the mad. Some of the Al Rashad patients were deemed able to be governed in and through community, while others were subject to a kind of disciplinary incarceration coupled with the will to improve, and still others (the forensic patients) were subject to the kind of sovereign incarceration that seeks only to contain, and not to rehabilitate. In this sense, sovereign measures were integral to moves towards the liberal governance of the mad in Iraq: it was only by separating out those 'not yet ready', as well as the incorrigibles, that community governance could be contemplated as a possibility. And, yet, with the bombing of the pet markets, these kinds of divisions collapsed. The separation between the mad and the 'idiot', so foundational to the authority of the psy disciplines, evaporated with the confusion about whether the female 'suicide' bombers had either Down's syndrome, or schizophrenia with depression, or both a mental disability and mental illness. The division between the mad, vagrants, the homeless, beggars and others also collapsed, as all were subject to (re)institutionalization. Sovereign force came to be used in ways that were less discriminate, more total and less strategic. This use of force was not marked by the kind of finesse intrinsic to governmentalities. This indiscriminate use of sovereign confinement, I have argued, forms part of a governmental failure wherein the psy disciplines did not adequately manage the danger purportedly posed by the mad (or those associated with them), because the mad were seen either as intrinsically dangerous or as dangerous in their vulnerability. This kind of indiscriminate sovereign force operates, in this case, as exterior to governance, and indeed as one marker of its failure.

The activities surrounding Al Rashad thus also tell us something about governmentalities and failure. Often, studies of governmentality are focused too tightly on governmental rationalities or on problematizations at the expense of assessing the 'messy actualities' of the implementation of governance

projects (O'Malley, Weir & Shearing, 1997, see also Larner, 2000; Li, 2007). This tendency has meant that moments of governmental failure are often ignored or underestimated. The failure of the move towards community governance in the management of Al Rashad's patients forms a case in point for assessing how programmes of governance can falter or collapse. This failure occurs in the context of war and the ongoing use of force in Iraq, a context that strangely seems to have not been fully accounted for in the instituting of community governance programmes. While there is a mounting literature that traces the biopoliticization of security and war-making, especially in the context of the 'War on Terror' (Dillon & Reid, 2001; Reid, 2006; Dillon & Lobo-Guerrero, 2008; Bell, 2009), perhaps less has been said about how war sometimes poses a particular kind of challenge to biopolitical projects, such as the community governance of Iraq's so-called mentally ill.

Finally, the activities surrounding Al Rashad illustrate some of the tight connections between psychiatry and security. While Foucault and Foucauldian historians of the present have focused on how medicine and the psy disciplines have come to be used as technologies of public safety in domestic settings in Western liberal democracies, little has been said about how psychiatry and psychology are deployed as technologies of national and international security in the conduct of global politics. The psy disciplines have historically been both diffuse and generous (Rose, 1998), in the sense that they have been taken up in a wide swath of institutions (schools, workplaces, militaries), and by a diverse number of experts (teachers, self-help gurus, aid workers). This diffusion is also international in that the psy disciplines and psy experts not only are increasingly called upon to provide security in domestic settings, but also have been called upon in national and international security imperatives. Security is thus becoming increasingly medicalized and psychiatrized. Efforts to secure Iraq as a liberal space have been undertaken in part through attempts to govern Baghdad's so-called mentally ill. The escaped patients of Al Rashad were deemed to be both sources of humanitarian concern and security threats, either because they were deemed intrinsically violent and risky or because their very vulnerability made them risky/at risk of becoming 'unwitting' suicide bombers. Psychiatry has been deployed in Iraq as a technology of security in order to manage these apparent risks. This is just the tip of the iceberg. For instance, this article has set aside the ways in which the psy disciplines are used to manage soldiers in those militaries deployed in Iraq, among the myriad of other spaces in global politics wherein the psy disciplines are called upon (see Howell, forthcoming). What is clear in the activities surrounding Al Rashad is that security and psychiatry are entwined in complex ways in the contemporary practice of global politics.

What is at stake here is the disruption of the notion that those deemed 'mentally ill' represent some kind of security threat. This notion is a historical achievement of the psy disciplines, and not a natural fact. Madness, instead,

should be viewed as a form of difference along the same lines as race, gender, sexuality or ability. Just as the 'queer' moniker has been reclaimed by those who identify as such, mad/ness is undergoing a process of reclamation in ways that challenge processes of medicalization and psychiatry, for example through Mad Pride movements (see Parr & Philo, 1995; Crossley, 2006). Alongside these efforts, and in tracing out the shaky ground upon which psychiatry has been deployed as a technology of security in Iraq, this research is aimed at challenging the authority of the psy disciplines, the constitution of madness as threat, the medicalization of security and the securitization of medicine. The deployment of the psy disciplines as technologies of security – wherever such technologies crop up (in this case, in Iraq) – should thus be viewed with great scepticism.

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References

Agamben, Giorgio, 1998. *Homo Sacer: Sovereign Power and Bare Life*. Stanford, CA: Stanford University Press.

Alhasnawi, Salih; Sabah Sadik, Mohammad Rasheed, Ali Baban, Mahdi M. Al-Alak, Abdulrahman Yonis Othman, Yonis Othman, Nezar Ismet, Osman Shawani, Srinivasa Murthy, Monaf AlJadiry, Somnath Chatterji, Naeema Al-Gasseer, Emmanuel Streel, Nirmala Naidoo, Mohamed Mahmoud Ali, Michael J. Gruber, Maria Petukhova, Nancy A. Sampson & Ronald C. Kessler, on behalf of the Iraq Mental Health Survey Study Group, 2009. 'The Prevalence and Correlates of DSM-IV Disorders in the Iraq Mental Health Survey (IMHS)', *World Psychiatry* 8: 97–109.

Aradau, Claudia, 2004. 'The Perverse Politics of Four-Letter Words: Risk and Pity in the Securitisation of Human Trafficking', *Millennium: Journal of International Studies* 33(2): 251–277.

Arnold, Catherine, 2003. 'Looters Destroy Iraq's Only Secure Mental Hospital', *Baghdad Bulletin*; available at http://baghdadbulletin.com/pageArticle.php?article_id=84 (accessed 3 March 2009).

Beaulieu, Alain, 2006. 'The Hybrid Character of "Control" in the Work of Michel Foucault', in Alain Beaulieu & David Gabbard, eds, *Michel Foucault and Power Today: International Multidisciplinary Studies in the History of the Present*. Lanham, MD: Lexington (23–34).

Bell, Colleen, 2009. 'From Empire Lite to Post-Interventionary Governance: Counter-

insurgency and the Problem of Population in Coalition Interventions', paper presented at the 50th Annual Convention of the International Studies Association, New York, 17 February.
Black, Phil, 2008. 'Doctors Work To Rescue Patients in Iraq's Mental Health System', *CNN*, 28 October; available at http://www.cnn.com/2008/WORLD/meast/10/28/iraq.mental.health/index.html (accessed 25 March 2009).
Burchell, Graham; Colin Gordon & Peter Miller, eds, 1991. *The Foucault Effect: Studies in Governmentality*. Chicago, IL: University of Chicago Press.
Castel, Robert; Françoise Castel & Anne Lovell, 1982. *The Psychiatric Society*. New York: Columbia University Press.
Clay, Rebecca A., 2005. 'Helping Iraq Restore Its Mental Health System', *SAMHSA News* 13(3); available at http://www.samhsa.gov/samhsa_news/VolumeXIII_3/index.htm (accessed 13 April 2010).
Crossley, Nick, 2006. *Contesting Psychiatry: Social Movements in Mental Health*. London: Routledge.
Curie, Charles G., 2004. 'From the Administrator: Mental Health in Iraq', *SAMHSA News* 12(3); available at http://www.samhsa.gov/samhsa_news/VolumeXII_3/index4.htm (accessed 12 April 2010).
Dean, Mitchell, 2002. 'Liberal Government and Authoritarianism', *Economy and Society* 31(1): 37–61.
Deleuze, Giles, 1992. 'Postscript on the Societies of Control', *October* 59 (Winter): 3–7.
Dillon, Michael, 1995. 'Sovereignty and Governmentality: From the Problematics of the "New World Order" to the Ethical Problematic of the World Order', *Alternatives: Global, Local, Political* 20: 323–368.
Dillon, Michael & Luis Lobo-Guerrero, 2008. 'Biopolitics of Security in the 21st Century: An Introduction', *Review of International Studies* 34(2): 265–292.
Dillon, Michael & Julian Reid, 2001. 'Global Liberal Governance: Biopolitics, Security and War', *Millennium: Journal of International Studies* 30(1): 41–66.
Duffield, Mark, 2007. *Development, Security and Unending War: Governing the World of Peoples*. Cambridge: Polity.
Elbe, Stefan, forthcoming. *Security and Global Health: Towards the Medicalization of Insecurity*. Cambridge: Polity.
Feinmann, Jane, 2007. 'It's Another Goal for Iraq: Amid the Carnage, a Little-Reported, High-Quality Mental Health Service Has Been Established', *New Statesman*, 6 August.
Fletcher, Martin, 2008. 'Hospital Boss Arrested over Al-Qaeda Attack by Human Boobytraps', *The Times*, 12 February; available at http://www.timesonline.co.uk/tol/news/world/iraq/article3353482.ece (accessed 25 March 2009).
Foucault, Michel, 1988. *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard. New York: Vintage.
Foucault, Michel, 2004. *Abnormal: Lectures at the Collège de France, 1974–1975*, eds Valerio Marchetti & Antonella Salomoni; trans. Graham Burchell. New York: Picador.
Foucault, Michel, 2006. *Psychiatric Power: Lectures at the Collège de France, 1973–74*, ed. Jacques Lagrange; trans. Graham Burchell. Basingstoke: Palgrave Macmillan.
Foucault, Michel, 2007. *Security, Territory, Population: Lectures at the Collège de France, 1977–78*, ed. Michel Senellart; trans. Graham Burchell. Basingstoke: Palgrave Macmillan.
Ghosh, Bobby, 2003. 'Forever a Prisoner', *Time* , 5 May; available at http://www.time.com/time/magazine/article/0,9171,1004760,00.html (accessed 12 April 2010).
Glauber, Bill, 2003. 'Mentally Ill "Have No Place To Go"', *Chicago Tribune*, 23 April.
Goodman, Deborah, 2004. 'Across Borders: Reaching Out to Iraq', *SAMHSA News* 12(3); available at http://www.samhsa.gov/SAMHSA_News/VolumeXII_3/index2.htm (accessed 13 April 2010).

Hamid, Hamada I. & Anita Everett, 2007. 'Developing Iraq's Mental Health Policy', *Psychiatric Services* 58(10): 1355–1357.

Holden, Michael, 2008. 'U.S. Raids Iraq Psychiatric Hospital over Attacks', *Reuters*, 10 February; available at http://in.reuters.com/article/worldNews/idINIndia-31863420080210 (accessed 25 March 2009).

Howell, Alison, 2007. 'Victims or Madmen? The Diagnostic Competition over "Terrorist" Detainees at Guantánamo Bay', *International Political Sociology* 1(1): 29–47.

Howell, Alison, forthcoming. *Madness and International Relations: Therapeutic Interventions and the Global Governance of Disorders*. London: Routledge.

Howell, Alison & Andrew Neal, 2010. 'Madness, Animals and Anarchy in Liberation Baghdad', paper presented at the 51st Annual Convention of the International Studies Association, New Orleans, February.

Humaidi, Naama Shlaba, 2006. 'Resettlement Prospects for Inpatients at Al Rashad Mental Hospital', *Journal of Muslim Mental Health* 1(2): 177–183.

Ilcan, Susan & Tanya Basok, 2004. 'Community Government: Voluntary Agencies, Social Justice, and the Responsibilization of Citizens', *Citizenship Studies* 8(2): 129–144.

International Committee of the Red Cross (ICRC), 2003. *Iraq Bulletin – 17 April 2003*; available at http://www.icrc.org/web/eng/siteeng0.nsf/htmlall/5lpgf8?opendocument (accessed 25 March 2009).

International Organization for Migration (IOM), 2008. *Assessment of Psychosocial Needs of Iraqis Displaced in Jordan and Lebanon*. Amman & Beirut: IOM.

Kenyon, Peter, 2008. 'Bombing Probe Leads to Iraqi Psychiatric Hospital', *National Public Radio*, 27 February; available at http://www.npr.org/templates/story/story.php?storyId=28891288> (accessed 10 April 2008).

Lannen, Steve & Hussein Khadim, 2008. 'Siege Mentality at Baghdad Hospital', *Seattle Times*, 20 February; available at http://seattletimes.nwsource.com/html/iraq/2004191006_iraq20.html (accessed 3 April 2008).

Larner, Wendy, 2000. 'Neo-Liberalism: Policy, Ideology, Governmentality', *Studies in Political Economy* 63: 5–26.

Lehmann, Christine, 2004. 'Americans Help Iraqis Build Community Mental Health System', *Psychiatric News* 39(21): 19.

Li, Tanya Murray, 2007. 'Practices of Assemblage and Community Forest Management', *Economy and Society* 36(2): 263–293.

Medact, 2004. *Enduring Effects of War: Health in Iraq 2004*. London: Medact.

Miller, Peter & Nikolas Rose, eds, 1986. *The Power of Psychiatry*. Cambridge: Polity.

MindFreedom International, 2009. 'MindFreedom Brochure'; available at http://www.mindfreedom.org/brochure/mindfreedom-brochure-2009.pdf (accessed 5 May 2010).

Montag, Warren, 2006. 'The Immanence of Law in Power: Reading Foucault with Agamben', in Alain Beaulieu & David Gabbard, eds, *Michel Foucault and Power Today: International Multidisciplinary Studies in the History of the Present*. Lanham, MD: Lexington (13–22).

Morrison, Linda Joy, 2005. *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-Patient Movement*. New York: Routledge.

Nyers, Peter, 1999. 'Emergency or Emerging Identities? Refugees and Transformations in World Order', *Millennium: Journal of International Studies* 28(1): 1–26.

O'Malley, Pat; Lorna Weir & Clifford Shearing, 1997. 'Governmentality, Criticism, Politics', *Economy and Society* 26(4): 501–517.

Parr, Hester & Chris Philo, 1995. 'Mapping Mad Identities', in Steve Pile & Nigel Thrift, eds, *Mapping the Subject: Geographies of Cultural Transformation*. New York: Routledge (182–207).

Philo, Chris, 2007. 'Review Essay: Michel Foucault, Psychiatric Power: Lectures at the Collège de France 1973–74', *Foucault Studies* 4 (February): 149–163.

Pupavac, Vanessa, 2001. 'Therapeutic Governance: Psycho-Social Intervention and Trauma Risk Management', *Disasters* 25(4): 358–372.

Pupavac, Vanessa, 2004. 'International Therapeutic Peace and Justice in Bosnia', *Social & Legal Studies* 13(3): 377–401.

Reid, Julian, 2006. *The Biopolitics of the War on Terror: Life Struggles, Liberal Modernity, and the Defence of Logistical Societies*. Manchester: University of Manchester Press.

Rose, Nikolas, 1998. *Inventing Our Selves: Psychology, Power, and Personhood*. Cambridge: Cambridge University Press.

Rose, Nikolas, 1999. *Powers of Freedom: Reframing Political Thought*. Cambridge: Cambridge University Press.

Rose, Nikolas, 2006. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Cambridge: Polity.

Singer, Brian C. J. & Lorna Weir, 2006. 'Politics and Sovereign Power: Considerations on Foucault', *European Journal of Social Theory* 9(4): 443–465.

Substance Abuse and Mental Health Services Administration (SAMHSA), 2005. 'In Transition: Al-Rashad Mental Hospital', *SAMHSA News* 13(3); available at http://www.samhsa.gov/samhsa_news/VolumeXIII_3/index3.htm (accessed 13 April 2010).

Tyler, Patrick, 2003. 'In Baghdad's Anarchy, the Insane Went Free', *New York Times*, 12 May.

World Health Organization (WHO), 2001. *The World Health Report 2001: Mental Health – New Understanding, New Hope*. Geneva: WHO.

World Health Organization (WHO), n.d. 'Mental Health Improvements for Nations Development: The WHO MIND Project'; available at www.who.int/mental_health/policy/en/index.html (accessed 31 December 2007).

World Health Organization (WHO) & Ministry of Health of Iraq, 2006. *WHO-AIMS Report on: Mental Health System in Iraq*. Baghdad: WHO & Ministry of Health of Iraq.