P.L.A.C.E

Depression: The Democratic Symptom

By Robert Groome

In these series of articles we have begun to address the problem of normality as itself involved in the causality of depression. By normal we understand not someone who knows what s/he wants and follows a process of accumulating wealth and health countering death and insanity, but that peculiar modern normality discovered by Freud in a society of consumption where the ego, in its claim to 'good sense' and 'life', becomes auto-destructive of its health, wealth, and others. Although the clinical problems of the normal have been long known among psychoanalysts, they are just beginning to enter into popular psychology: in a new book, *The Price of Privilege*, the American psychologist Madeline Levine claims that affluent children, with parents earning more than $130,000 a year, have "three times the rate of depression and anxiety disorders as ordinary teenagers, as well as substantially higher rates of substance abuse, cutting and suicide". The popular psychologist Oliver James, who is set to publish in January a new book, *Affluenza*, about the mental cost of wealth, warns that it is not affluence alone that "translates into greater happiness or mental health", but the quality of early parental care. *The London Times*, psychology investigator John Cornwall writes:"Depression in children, it is becoming increasingly clear, is not only a consequence of family dysfunction, marriage break-ups, child abuse, and combinations of genetic and environmental disadvantage. Depression can lurk and flourish in the minds of "normal" children whose parents deliver them to £5,000-a-term day schools in top-of-the-range 4x4s. Childhood psychological misery can be found in an ambience of back-to-back improving activities – from flute lessons to tennis training to private maths tuition; in the pony club and on the junior ski slopes. When such children falter and fail, turning to forms of self-hatred and self-harm, will their striving, over-anxious parents wake up to their own failings and inadequacies?"[11/12/06]. No doubt, these short internet articles are not exhaustive, but can only claim to inform beyond the current confusion reigning on the subject.

The symptom dominating our modern democracies is depression, specifically manic depression, more commonly known as bi-polar disorder. Suspended in the oscillation from apathy to impulsiveness, the sadness of being out of place and out of time, the shame of a liberty which would only recognize itself in abuse, many have been left fixed in imperatives to merely calm the symptom through the use of a substance (legal or illegal medications), forms of relaxation (hot tub therapy, spiritual retreats, sleep therapy, etc.) or physical doping (spinning, boot camp therapy, coaching, and so forth). In spite of the tranquility imposed by such measures, a recent World Health Organization study estimates that over

eleven million people have this illness and concludes that by 2020 the leading cause of disability and death will be depression. What then, does contemporary psychoanalysis have to tell us about the 'illness' of depression? And how does its entry into the problem differ from the imperatives of calm?

Beginning with Freud's *Mourning and Melancholia* (1917), psychoanalysis has taught us to consider that "When in his exacerbation of self criticism he describes himself as petty, egoist, dishonest, lacking independence, one whose sole aim has been to hide the weakness of his own nature, for all we know it may be that he has come very near to self-knowledge; we only wonder why a man must become ill before he can discover the truth of this kind."

Our purpose here is to introduce without vulgarizing, while saving the Lacanian mathemes and jargon for a later publication. We begin by briefly examining how depression has been medicalized in the psychiatric and therapeutic literature and to what extent, if at all, such explanations are adequate. In conclusion, we will introduce a more precise psychoanalytic explanation that both responds to Freud's pondering on the causality of depression and indicates a practice that goes beyond the mere management of symptoms.

Overview of the Psychiatric Explanations

Though related to the ancient term of melancholia (literally meaning 'black bile'), the modern term, manic depression, was first established by Emil Kraepelin in a 1913 study which tried to distinguish its internal causes (largely hereditary) from its external causes (those acquired by circumstance and cultural influence). The modern revolving door introduction to depression, and mental illness in general, is polarized by this opposition of internal and external causes. For if modern psychiatry defines internal causes as 'natural' and the most fundamental in the explication of depression, it is because the more a state of grief cannot be put into correspondence with an external cause (the death of a spouse, the loss of a job, etc.), the more a symptom becomes incomprehensible. Consequently, what is called major, or clinical depression, is assumed to be caused by the internal traits of the individual's innate biological development. In 1952, an article appeared in The *Journal of Nervous and Mental Disorders* postulating that the genetic causes behind the disorder lie in nature, and that there is the likelihood that manic depression ran in families already stricken with the disorder. In 1980, bi-polar disorder replaced manic-depressive disorder as the diagnostic term found in the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-III).

Without denying the influence of Kraepelin's research and the psychiatric tradition in the analysis of depression, neither he, nor psychiatry can claim to have resolved the problem or produced a cure. They do, however, give an indication of the direction in which a resolution may be found — though often without recognizing it. For if it is tempting for the psychiatrist to make depression correspond to a personality type — the depressive constitution as it is determined by heredity for example — one must not forget the extremely problematic value of such definitions. Indeed, if innate genetic differences are incontestable, in the last analysis they cannot be admitted as what determines a particular constitution until they are integrated as a function of the individual's experience and education. Does it then become a question of leaving room for other causes of depression — cultural influences for example — which complement and modify the fundamental constitution of the individual as it is defined in terms of genetics and neurophysiology? Or again, is it a question of complementing a treatment of depression by referral to a psychotherapist who would then use myth and suggestion to educate and modify the

personality of the individual after it has been primarily defined in psychiatric terms?

Introduction to a Psychoanalytic Theory

Psychoanalytically speaking, the answer to both of these questions is no, for it is not a question of determining the proportion by which natural or cultural influences cause depression. Neither is it a question of abandoning those searching for an answer to their questions to the circular responses of psychiatry and therapy. On the contrary, it is a question of recognizing to what degree the causes of depression are completely lacking in reference to an internal innate nature or an external acquired culture.

Beginning with the work of Abraham (1911), Freud (1917), and Melanie Klein (1935), the causality of depression was discovered as not resulting from an exterior reality, as psychiatry had already observed. Rather such exterior causes, such as the loss of a loved one or a job, only produce states of mourning which are, properly speaking, not to be confused with melancholia or depression. Yet, unlike psychiatry, psychoanalysis did not postulate that the cause of clinical depression was due to an interior natural cause either — that is, a hereditary trait or chemical imbalance. On the contrary, depression resulted in the impossibility of referring to exterior cultural influences as well as the interior natural ones — an impossibility which lead Freud to postulate that this internal loss is unconscious and has its origin in fantasy.

This early discovery of the discontinuity of the representational space of nature and culture is not so odd, in fact it is a rediscovery of the apparent absurdity of anything called a 'mental disorder' — the strange apparition of crying for no reason, sleeping when one is not tired, waking up when one is; eating when one is not hungry, starving oneself when one is, and so forth. It is in beginning to listen to these symptoms, and not simply in suppressing them, that psychoanalysis founded a new place for the treatment of depression — a clinic, which would not reduce its theory or practice to that of the hospitals or asylums.

Psychoanalytically speaking, a clinic discovers that the cause of depression does not correspond to the rupture of a continuous development of the individual, but in a rupture, pure and simple, of any attempt at comprehending or representing it. A psychoanalytic theory of this pure rupture is not, however, as paradoxical as it sounds, as it confirms the common and pre-scientific idea that depression, and mental disorders in general, deviate from the norms of everyday understanding and appear 'cracked' or irrational. Psychoanalysis does not attempt to understand depression, nor does it try to cure it by presupposing a norm — a socialized and functional nature — which existed before the outbreak of the illness and which it hopes will return as the result of the treatment. On the contrary, psychoanalysis explains a discontinuity that is constantly misunderstood in diagnosing symptoms, a discontinuity that has a specific causality irreducible to a deviation from the norm of nature or culture. Further still, psychoanalysis has shown, since Freud, that to avoid listening to and working with this discontinuity by negating the symptom risks throwing the baby out with the bathwater.

Problems with the Current Approaches

One then, may begin to recognize the psychoanalyst's critique of any treatment which would merely seek to reduce depression to a chemical imbalance or attempt to cover over a void of desire through the

use of drugs and suggestion. Indeed, in attempting to trivialize a reading of the symptom, either by 'calming' or 'enhancing' the mood of the subject, such therapies are forced to import characteristics into a treatment which oddly begins to resemble the very symptoms of depression and mania they are attempting to cure. For if in a more naïve time the individual romanticized depression by joining the French foreign legion, practicing Zen, or going on jungle safaris, with the invention of modern designer drugs such as Prozac, one is left in a void of desire maintained in a technological imperative 'to be calm'. A treatment which itself results in manic depression — or at the limit, begins to induce psychotic episodes — is an indication that the problem is wrongly formulated in the first place. Thus the sterility of a search to explain the causality of manic depression, or any other mental disorder, through the circularity of what is a natural or cultural cause. By systematically trivializing the singularity and discontinuity of the symptom to the same biological entity one shares with every other John Doe, then assimilating it to a cultural identity which tries to dramatize the individual's difference in a few archetypal myths (the child within you, the artist you are, your Buddha nature, etc.), an effective entry into the causality of depression is avoided at the moment it claims to calm.

Being abandoned at the serene divide between nature and culture — between psychiatric pharmacology and psychotherapy — results in the production of two groups in the consumption of the cure: (1) those with a negative reaction to treatment, who have been left in a depressive therapy, and have resigned themselves to a disbelief in getting any help whatsoever; and (2) those with a positive reaction to treatment, who, by covering over and calming the discontinuity of the symptom through the use of drugs, relaxation techniques, and suggestion, have succeeded in maintaining their job, educational, or familial relations — yet at the price of conforming to a reduced form of reality bordering on induced psychosis. It is this latter 'successful but psychotic treatment' which is the most difficult to analyze insofar as a proper definition of a psychotic structure is not merely, or even fundamentally, a form of mental illness found behind asylum walls, but includes modern forms of 'hyper-normality' and 'hyper-functionality' which are typically fragile and disintegrative. Witness the panoply of so-called 'mindless' and 'irrational' crimes plaguing our modern societies, presumably committed by normal people — police assisted suicide, psychiatric assisted suicide/homicide, exam suicide, suburban school murders, road rage, etc. Without denying the effectivity a drug may have in calming the subject, or the consequence an anthem or myth may have in leading one into a normative identification with the group, or even, the inadequacy any of this may have in a cure — the question of a true theory of manic depression and the causality of desire lies elsewhere.

Misunderstanding Depression

In reformulating the problem as laid out by psychiatry, psychoanalysis does not discount that there is an interior organic origin to the symptoms of depression. On the contrary, it agrees that nature can be used to justify all those internal causes of grief that do not appear to have an external or circumstantial cause. Neither does psychoanalysis claim that exterior cultural influences cannot modify the instincts, as there is a reactional structure to the natural instinct which has the potential to educate. However, psychoanalysis also recognizes that nature and culture have always been used to fantasize origins, or to originate fantasies, which go beyond their strictly biological or sociological function.

The position of psychoanalysis consists initially in introducing the patient's speech and thoughts into the analytical situation, not merely as someone being observed and judged, but as observing, judging, and indeed, fantasizing. In analysis properly speaking, there are no patients or clients, only

psychoanalysts and analysands. Moreover, from the viewpoint of language, they both are on the same side of the wall: the fantasies, symptoms, and transfers of the analyst are never neutral in this regard. As a consequence, an initial response to the question of whether the cause of depression is natural or cultural becomes clear insofar as such explanations amount to the same thing: they are both incomprehensible and incongruous to the personality of the individual who is depressed. What does the patient really understand when told by a psychiatrist that they have a “hard-wired genetic disease” and are then told by a psychotherapist that “their child within” is trying to realize a new form of self-expression? The reasons for this obscurantism are complex, but can be stated briefly in an abbreviated form. The psychiatric explication occupies and silences the body of the patient through a hypothesis of biological heredity bordering on a fantasy, just as in psychotherapy the patient’s mind is said to be occupied with irrational thoughts and deeds through a hypothesis (whether by therapist or patient is inconsequential) of a cultural heredity bordering on fantasy. In both cases, the subject is inhabited by an incomprehensible other, while his or her speech, as instructive as it is in directing the cure beyond the fantasy, goes unaddressed or is merely reduced to that of a suggestion.

In beginning to listen to the fantasy and determine its causality in the production of the symptom — its mis-comprehensions, debilitations, and mis-recognitions — psychoanalysis introduced a more true theory of depression; one in which the modern individual emerges not as the object of a technological application, but as the subject of this discontinuity and its fantasies. Instead of adopting a continuous notion of the development whereby the individual is both presumed to be genetically predisposed to adapt to its natural environment and socially predisposed to adapt to its social surroundings, psychoanalysis reveals how the individual is predisposed to neither: rather, that there is a natural biological mis-adaptation and a cultural reaction inherent to the human subject which is covered over in a fantasy. Unlike an animal, for whom the biological type and instinct suffices to integrate it into its environment, the identity of the human individual is in conflict with its species and instinct, views it as an imposed constraint, and reacts against the type with a fantasy. Further still, for human nature a symbol is not merely a contingent cultural acquisition, but something *innately acquired* : a representative of the drive (not an instinct) that is necessary to the well-being of the subject. The difficulties of the current depressive treatments stem from trying to simultaneously reduce the individual to an innate biological entity and an acquired cultural identity, while mis-recognizing an analysis of what is crucial to the subject: a construction of the drives and *the innately acquired*.

The difference between a continuous thesis that identifies the individual with an innate biological entity (psychiatry) and acquired cultural virtualities (therapies), and a discontinuous one that explains a biological and cultural lack as what is *innately acquired* by the modern subject is crucial to a psychoanalytic clinic of depression. For psychoanalysis reveals how the human subject is not only maladapted to its nature, but is depressed by cultural identities and norms that attempt to repair it. By foregrounding the *innately acquired*, psychoanalysis replaces a theory of abnormality (such as psychiatric theories of the ‘depressive personality’) with a theory of the drives and desire. The stability of desire is unquestionably involved in the establishment of a position (that of mother or father, for example), but the connection between the subject and the world is not simply a question of 'reality', but a question of a 'normativity' : not merely in the sense of a cultural norm (expressed as a bourgeois family, for instance), but in the sense of a symbolic law (such as one expressed in a system of kinship or language). Indeed, one of the most depressive representations of a symbolic position is to consider it in terms of cultural ‘role models’ — the artist, successful businessman, sports figure, war hero, working mother, and so forth — all of which reduce the problem of the stabilization of desire to fantasy. For

instance, one need only think of the depression encountered by an aspiring art student who, upon graduating from art school, finds he must wait tables or compromise his desire in the business of art to earn a living; or the young woman who aspires to be the bride of a Mr. Marvelous, only to learn after some years of marriage that he has become a so-and-so, and she must reinvent or imagine a Mr. Marvelous number two; or the woman who, in the lack of family recognition, strives to be recognized as someone in the business world, only to find her career success has compromised her position as a mother. It is not only that the subject is irreducible to the biological type, but that the moment the subject has been identified with a cultural role, it has essentially been mis-recognized, for in reducing a symbolic function to a mere cultural model one simultaneously introduces a fantasy and a prospective depression in its place.

Psychoanalysis constructs a clinic whose logic is robust enough to analyze what is normally kept apart — innate and acquired, nature and culture, interior and exterior — thereby adhering to its clinical findings, and not to the preconceptions of the natural and human sciences. Indeed, should this real and symbolic not be given an adequate place or clinic, or should their discontinuity be constantly assimilated to fantasies of nature and culture, then one is dealing with a structure which is itself un-sane.

The Reality of Depression

We are now in a position to begin to respond to Freud's question as to why the truth revealed by a depressive symptom can induce illness.

Before responding however, one should recognize that psychoanalysis does not reduce psychic suffering to an unreal mental symptom or imaginary effect of a natural or cultural cause. Consequently, depression is not considered a myth or psychosomatic illness, but something very real. Yet, the discovery that this reality does not exist in nature either, but engages a properly psychic reality — a fantasy, hallucination, delirium, and so forth — in isolating a particularly psychoanalytic conception of causality.

By implication, psychoanalysis shows that what is referred to as 'mental' cannot be reduced to an imaginary psychological introspection or a real psychiatric observation of a brain scan, but is itself an event having its own causality and reality. Indeed, the fundamental psychoanalytic rule of 'free association' has the effect of establishing a place for the interpretation of psychic causality by bracketing not only a reference to nature or culture, but also the sensible reflections of the speaking being. In examining depression the same bracketing occurs: the loss of work, friendship, health, or sexuality, caused by a depression does not fundamentally indicate the failure of the individual to achieve a norm of nature or culture but reveals a real discontinuity in regard to this norm. Clinically speaking, in psychoanalysis a real cause is no longer the silent cause following the laws of nature or codes of culture, but a cause which is actually written through symptoms according to something like the laws of language. To determine this causality is not to try make sense out of the symptom through the mere use of metaphor and myth, as psychotherapy might, but to construct a nonsense revealing a problem of identity and difference. Who is writing or trying to speak in a depression? What is being expressed when a six year old threatens to cut hereself, or the ego in general discovers a sense of self only in disintegrating ?

Let us agree to call a symptom what figures this difference of identity. Consequently, a manic-

depressive symptom emerges in scenes where the emperor discovers he " has no clothes" – instead of giving place to this loss of identity and the imaginary it implies, the common mistake is to view the problem as nothing more than a socio-biological difference: a 'hyper-active' child, 'mid-life crisis', an 'out of placeness', an 'out of time and out of mind' . Such normative classifications only identifies this difference – or symptom – as an 'exception to the rule' and in comparison with the norms of 'others' without giving a place to the symptom as such. Consequently, psychoanalysis opens the question differently: how does one recognize an emergence of Difference without having it systematically trivialized and assimilated to the Same ? What is the necessity for the recognition of a pure Difference – and the anxiety it provokes – that would not be reduced to the differences of the group ? How can we construct a *place of the subject* that would not be confuse its desire with a deviance from a *conception of Man* ?

That it would be possible to construct a fantasy and a void of desire seriously, and not merely as a rupture of the ideals of nature or culture, is the first step in acknowledging the reality of a depressive structure clinically. For, if there is a reality to depression itself, if it is a psychic event that has its own structure and truth, then it becomes necessary to isolate the causality of its Difference in a way that is less scientifically and moralistically severe than assimilating it to the norms of the group. Indeed, in order to make a progess psychoanalysis gives the symptom a place and makes room for a practice that is uniquely constructed to listen and construct what is singular to its subject – without trivializing either the speech or language of the individual to the prejudgements of normative behavior.

In order to follow this questioning, psychoanalysis not only separates the real of the subject from its biology, but the symbolic of the subject from culture, and, in this clearing, discovers a reality of psychic suffering which is the incontestable place of the psychoanalytic clinic. It is precisely in the promotion of the autonomous individual “free, but alone” that the modern subject is left 'ill' not because the manic-depressive alternates between a fantasist or negative relation to nature or culture, but because the psychic reality that such fantasies and loss reveal goes unaddressed and is constantly reduced to a mere disorder of the individual in relation to the norm — the losses of sleep, concentration, sexual or family relations, eating, and so forth.

A psychoanalysis of the causality of depression, then, is not an explanation of the genesis of a positive individual which then exhibits negative symptoms, but the examination of its inherent reality — the discontinuity it reveals in the real, symbolic, and imaginary formations of the individual. That manic-depression would be one reactional mode (paranoia, neurosis, and perversion are others) of accounting for this discontinuity attests to the need for a more robust research into these structures. By rethinking the relation between nature and culture and the negativity that separates them from the psyche of the modern subject, psychoanalysis restores an analysis of depression to its proper dimensions. What is real in manic depression is not merely a physical cause, and what is symbolic is not merely a cultural influence, just as what is fantasy is not merely the imagination of the individual. Consequently, one discovers the numerous possible misunderstandings of the reality of depression and the need to situate its causality in a way that does not reduce it to a mere 'illness' or 'ab-normality'.

From Meta-Analysis to Meta-Psychology: Redefining the Problem

Today, the misunderstanding of depression and the burgeoning deficit of its treatment costs our

mental-health care systems forty-four billion dollars a year (per a 1990 World Health Organization study). Our democratic leaders have attempted a *meta-analysis* of the problem in an effort to bring together the best various therapies have to offer: psychodynamic, cognitive, psychiatric, behavioral, and spiritual healing; each with their own empirical or cultural agendas, their risks, and each either dismissing the evidence of the other or claiming to complement what the other fails to treat. More productively, one can begin in the manner of Freud with a *meta-psychology* that... [To be continued]

top of page

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