cinemas of therapeutic activism

DEPRESSION AND THE POLITICS OF EXISTENCE

adam SZYMANSKI

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Perceiving the Pandemic

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The Pandemic

A depression pandemic is sweeping the globe and its end appears nowhere in sight. Study after study confirms skyrocketing diagnostic rates: now about ten times more prevalent than it was only a few decades ago, depression has become the world's leading cause of disability. Approximately 350 million people live with a depressive disorder and over 800,000 people commit suicide every year.[1] This startling statistical trend has politicians and public health officials scrambling to mitigate a crisis that deepens with every moment by increasing the resources allotted to public mental health services.[2] However well-intentioned these institutional efforts may be, their attempts to quell the depression outbreak have proven largely inept because they are grounded on the credulous presupposition, which has also now become a hallmark of liberal democratic ideology, that increased access to mental health services will actually translate into improved mental health.

Studies on dominant treatment methods are showing their benefits to be as modest as ever, and broad-based initiatives to administer "evidence based treatments" to the public have yielded underwhelming clinical results.[3] To

1 For more statistics on depression see the World Health Organization's factsheet (2016a).

2 Politicians are increasingly making mental health a policy priority. Take for example the UK secretary of health Jeremy Hunt's recent admission that mental health services are the NHS's greatest area of weakness, and his subsequent announcement of £1.4 billion for children and young people's mental health care (Campbell 2016: n.p.). In Canada, mental health funding has become a hot-button issue in failing budgetary negotiations between the federal government and the provinces, due largely to Federal Health Minister Jane Philpott's insistence "that billions in new federal money be devoted specifically to mental health care" (Curry 2016: n.p.).

3 A recent meta-analysis published in the American Psychological Association's *Psychology Bulletin* shows that Cognitive Behaviour Therapy is proving less and less effective as a treatment for depression (Johnsen and Friborg 2015). In the UK, more than a million people have received

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make matters worse, no curative breakthrough lies on the horizon since the basic research on depression has long resigned itself to the search for topical solutions. Martin Seligman, a depression researcher and former president of the American Psychological Association, has outed the "dirty little secret" that biological psychiatry and clinical psychology have totally abandoned the search for a cure. "The road has come to a dead end at symptom relief," he writes. "Every single drug on the shelf of the psychopharmacopeia is cosmetic. There are no curative drugs and no drug is in development that I know of that aims at cure" (46). Even after having abandoned the loftier goal of cure to settle for mere symptom suppression, clinicians are witnessing relapse after relapse. Access to first-rate treatment has done little to change the unwavering fact that once someone has been diagnosed with severe depression, it is typical for them to battle with a high risk of relapse for their entire life.[4]

The crisis has gotten so out of control that even the world's financial elite have started to worry about the economic consequences. "This is not just a public health issue—it's a development issue," says Jim Yong Kim, a former President of the World Bank. "We need to act now because the lost productivity is something the global economy simply cannot afford" (World Health Organization 2016b). In support of the World Health Organization's

free CBT as part of a public health inititative that economist Richard Layard launched with the help of Oxford psychologist David Clark (Burkeman 2016; Department of Health 2012). Despite these massive governmental efforts, rates of mental illnesses such as depression are still higher than ever in the UK (Campbell 2016).

There is also a mounting body of literature that questions the effectiveness of psychotropic drugs prescribed in treating depression and points to the economic incetives in place for maintaining their primary role in treatment programs. One of the best summaries of this literature comes from Marcia Angell, the former editor of the *New England Journal of Medicine*. In "The Epidemic of Mental Illness: Why?," a lengthy 2011 review of three authoritative books, she makes echo the criticisms found in Irving Kirsch's *The Emperor's New Drugs: Exploding the Antidepressant Myth*; Robert Whitaker's *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*; and Daniel Carlat's *Unhinged: The Trouble With Psychiatry—A Doctor's Revelations About a Profession in Crisis*). She describes the books as "powerful indictments of the way psychiatry is now practiced" and she recounts in some detail how they "document the 'frenzy' of diagnosis, the overuse of drugs with sometimes devastating side effects, and widespread conflicts of interest" (Angell 2011b: n.p.).

The criticisms that Angell shares is corroborated by trends in the medical literature. For a recent patient-level meta-analysis that has raised doubts about the effectiveness of SSRIs for "milder forms" of depression, see Fournier et al. 2012.

4 Depression recurrence statistics show "50 percent of those who recover from a first episode of depression having one or more additional episodes in their lifetime, and approximately 80 percent of those with a history of two episodes having another recurrence" (Burcasa and Iacono 2007: 960)

For depression recurrence statistics, see Burcasa and Iacono's "Risk for Recurrence in Depression."

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call for increased government investment into mental health services, Jong Kim underscores the economic advantages of treating depression and anxiety disorders, citing a "fourfold return." Without delving into how destructive this free marketeering of life really is, his statement harbours a telling contradiction that begs to be teased out. By framing the mental health epidemic as a development issue, Jong Kim unconsciously infuses the discourse on depression with a political-economic dimension that psychiatry is wont to conceal, and points to one of the reasons why psychiatry's dominant methods have proven so unsuccessful at alleviating the crisis, to the degree that they could even be considered an aggravating factor. For if psychiatry was really concerned with intensifying health, and not just suppressing the symptoms of mental illness, then it would be obliged to put neoliberal hegemony (and its deleterious effects on the bulk of the world population) into question, and develop a critical auto-reflexivity about its own relationship to power. Instead, psychiatry not only leaves the status quo uncontested, but is instrumental in its reification. The financial elite represented by Yong Kim just "couldn't afford" to have it any other way.

Psychiatry's naturalization of asymmetrical power dynamics is as notable today as it was when Foucault gave his lectures on psychiatric power at the Collège de France in 1973-1974. Foucault refers to a number of historical examples whereby psy-professionals are brought into schools, the army, or the prison in order to reinforce the order of the institution, and these lead him to conceive of psychiatric power as an "intensification of reality" that "is found wherever it is necessary to make reality function as power" (Foucault 2006: 189). One of Foucault's many insights is that there is a fundamental complicity between the discipline of psychiatry and society's dominant institutions, however unconducive to mental health or overall well-being that they may be. The intensification of reality that Foucault describes, whereby psychiatry reifies the power dynamics of society at large, is enacted through psychiatry's diagnostic practice of identifying an individual subject with a mental illness. In the diagnostic scene, an "individual" is clearly demarcated from "society," and as a result of this distinction, society is normalized (no matter how cruel or unjust it may be), and the individual is pathologized (no matter how understandable their suffering may be given the circumstances).[5]

5 For more on moving past the binary between "culture" and the "individual," a true "chicken and the egg problem," see Brian Massumi's chapter "The Political Economy of Belonging and the Economy of Relation" in *Parables for the Virtual*. Massumi explains, "it is an absurdity to speak of them as if they were discrete entities that enter into extrinsic relation to one another, let alone to wonder which term takes precedence over the other in determining stasis and change. […] In

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Psychiatric power renders depression a personal problem that someone "has," and must assume responsibility for managing, thereby intensifying and subtly absolving the neoliberal reality through the act of medical diagnosis.

Psychiatry's awesome power to produce subjectivity is wielded through a perceptual apparatus that Foucault calls the "clinical gaze"—"a way of seeing, saying, and doing in relation to illness, the body, [and] life itself" (Rose and Abi-Rached 79).[6] Based on the research of their "Brain, Self and Society" project, Nikolas Rose and Joelle M. Abi-Rached have identified three dimensions to the clinical gaze: the spatio-temporal, the technological and the institutional (Rose and Abi-Rached 79-80), each of which are operative in the medical perception of depression. In the diagnostic scene, the clinical gaze transforms the patient into a spatio-temporal matrix that allows the doctor to perceive clinically significant patterns and influences (the persistence of symptoms over a set period of time, family history, environmental factors, etc.); diagnostic technologies such as standardized questionnaires and brain scans can be used to glean the targeted symptoms; and mental health institutions and networks of social legitimization (the hospital, the media, the university) provide resources and infrastructure to make the gaze's conclusions operative on a mass scale.

Institutions of medical perception have certainly developed to embrace new (mostly neurological) theories and technologies over the last two centuries, but they have retained the core function that Foucault ascribes to the clinic: that is, they extract the person who is ill from the illness. "In the rational space of disease," Foucault writes,

> doctors and patients do not occupy a place of right; they are tolerated as disturbances that can hardly be avoided: the paradoxical role of medicine consists, above all, in neutralizing them, in maintaining the maximum difference between them, so that, in the void that appears between them, the ideal configuration of the disease becomes a concrete, free form, totalized at last in a motionless, simultaneous picture, lacking both density and secrecy, where recognition of itself opens onto the order of essences. [...] If one wishes to know the illness from which he is suffering, one must subtract the individual, with his particular qualities (Foucault 2003: 9, 14 translation modified).

other words they might be seen as differential emergences from a shard realm of relationality that is one with becoming—and belonging" (71).

6 In *The Birth of the Clinic,* the term "medical gaze" (*regard médical*) is sometimes translated by A.M. Sheridan as "medical perception," as an acquiescence to the unprepared reader (2003: vii).

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The clinical gaze neutralizes the patient, whose presence could only introduce possible distortions or variations, and unnecessarily complicate a neatly classifiable and ideal disease with essential qualities.

By constructing an autonomous disease as object of its perception, the clinical gaze subtracts the individual. Yet rather than amount to its overcoming, the individual's subtraction marks its very production.[7] This may seem counterintuitive, but medical perception's subtraction of the individual is at the same time a privileging of the individual—a privileging of what to subtract. The individual's subtraction is made to stand in for the erasure of everything else that disappears in the diagnostic scene, like the plethora of affective ties and libidinally significant relationships which are systematically obscured by the clinical gaze. In search for an autonomous disease, medical perception occludes all that the depressed person brings into the diagnostic encounter, effectively denying their complicated presence—the multiplicity of relations that encompass the individual and are irreducible to it—in the name of scientific objectivity. These relations are swept outside of the clinic's walls and labelled "society." What remains is a standardized shell, a clinical individual, whose role is to play host to an alien disease living inside of it. By bringing disease under the regime of medical perception, the diagnostic scene ritually performs this separation of individual from society, exemplifying Foucault's assessment that "medical authority functions as power well before it functions as knowledge" (2006: 3).

A more contingent theory of subjectivity is warranted if the experience of being profoundly unwell is to be reinfused with an existential and political dimension that allows for escape from the essentialist confines of the "individual," "society" and "depression" triad that psychiatric power reifies so efficiently. A theory of subjectivity-in-the-making is exactly what militant psychoanalyst Félix Guattari proposes through his theory of "assemblages" which he develops in collaboration with Gilles Deleuze. Assemblages are "set up at the intersection of meaning, material and social facts, and, above all, of their transformation" (Guattari 2009d: 209) and they comprise "actions and passions, an intermingling of bodies reacting to one another" as well as "acts and statements" and "incorporeal transformations" (Deleuze and Guattari 1987: 88). The metastable manner of the assemblage, or the way that it tentatively stages the mobile relations between its component parts, articulates a dramatically expanded sense of the term "subjectivity." In "Subjectivities, For Better or for Worse," an essay that Guattari wrote near the

7 Foucault clearly writes: "It seems to me that insofar as power is a procedure of individualization, the individual is only the effect of power" (2006: 15).

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