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2. Das erschöpfte Selbst

Spätmodernes Leben zwischen Autonomie und Depression

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My thesis is not that depression is caused by capitalism, emancipation, globalization and all the like. It isn't a diagnosis of the causes of the increase of depression, which is a false problem in my opinion. Generally, my goal is not to denounce this or that, but rather to clarify an issue. I made my own Wittgenstein's proposition "philosophy starts when I don't know my way about". Depression is the main clinical entity which led us to a new language, that is of a means of expressing problems, conflicts, dilemmas which have accompanied the process of transformation of norms and values from discipline to autonomy during the last half of the last century. The aim of this speech is to explain this idea by summarizing my book, which is the third one I dedicated to contemporary individualism.

Depression today spells out the different facets of personal distress. In the nineteen forties, it was merely a syndrome recognizable in most mental illnesses. And society paid it no particular attention. In 1970, psychiatrists demonstrated, statistics in hand, that depression was the most widespread mental disorder in the world. Psychoanalysts and other psychological practitioners had noted a significant increase of depressed patients among their clientele. Today, this disorder has captured the attention of psychiatrics just as the psychoses did fifty years ago. This is the success of depression in medicine. At the same time, the news media treat depression as both the latest fashion and the malady of the century. Depression has been transformed into a practical tool for defining various kinds of unhappiness and alleviating them by multiple means. Yet the words anxiety or neurosis could have followed a similar path to success, given the general nature of the conditions they designate. This is the success of depression in the sociological meaning.

In their famous Saturn and Melancholia, Klibanski, Panovski, and Saxl wrote that tracing the history of melancholy overlaps with the history of modern sensibility. Why? Because melancholy is an exacerbation of self-consciousness as an individual. This hypothesis inspired me.

The invention of the antidepressants counts a lot in this history. It gave to psychiatry and, above all, to general practitioners the pharmacological means to treat the problem. Nevertheless, sociological conditions were necessary for depression to occupy a central position not only in medicine, but also in psychoanalysis, in the world of psychotherapies and, more generally, in our societies.

If depression were only the annihilation of the individual described by psychoanalysis, it would interest the sociologist of psychology; if it were a mere public health problem, because it is a disabling, costly and chronic illness, it would interest the sociologist of health; if it were a pipe dream or fantasy invented by pharmaceutical industry, it would interest the sociologist of industry, but in any case it wouldn't have any anthropological interest. By anthropological interest, I mean that its medical and social success is symptomatic of a global change in the representation man has of himself. This is why I have organized my research to answer two questions: How has depression imposed itself as our main form of personal unhappiness? To what extent does depression reveal the transformations of individuality or society, which are according to me two interchangeable concepts, at the end of the last century?

My thesis is that its double success accompanies a global change in the social rule: the anchoring of new social ideals for action which were instituted during the last three or four decades of the twentieth century. That is to say the progressive substitution of a society which referred to discipline, mechanical obedience, etc., with one which refers to autonomy, personal accomplishment, choice and individual initiative.

The history of depression parallels the decline of the style of individual the end of the nineteenth century passed on to us, and which lasted up to the decades 1950-1960. This individual is governed by rules of disciplines, conformity and the forbidden. Neurosis, in the Freudian meaning, is an illness of guilt. On the sociological level, it can be analyzed as the mental expression of problems generated by these rules. Depression starts it's medical and social anchoring during the sixties, at a moment when these rules start to loose their social authority to the benefit of rules urging everyone to individual initiative and personal accomplishment in societies which starts to be characterized by values of choice. Depression can be approached as a means of expression of conflicts, problems and

dilemmas of a society where values of autonomy impregnate the whole of social life. The polarity allowed¬/forbidden is embedded and subordinated by the polarity possible/impossible. Socially speaking, depression presents itself as a disease of responsibility where insufficiency dominates guilt.

Conflict and Insufficiency

The constitution of the notion of neurosis at the end of the nineteenth century offers a grid of reading, which can help to clarify the shift from guilt to responsibility. Two main conceptions brought into conflict: that of Freud (1856-1938) and that of his principal opponent, Pierre Janet (1859-1947). Three oppositions deserve to be mentioned:

1. Freud considers neurosis from the perspective of the conflict: the unconscious guilt arising from a psychic conflict coming from the infancy of the subject characterizes the psychoneurosis of defense. Janet refers to a deficit or, more precisely, to an insufficiency, a weakness he called depressive: the difficulty to act is the fundamental disorder. If there is, undoubtedly, a subject of his own conflicts, for the logical reason that the patient is simultaneously the agent of his own change (the patients does the work), that is, in terms of philosophy of action, the patient is the principal agent, and not only the immediate agent. It is not the case with Janet's concept.
2. The conception of the therapeutics and recovery. For Janet, the goal is to make disappear the traumatizing recollection, which causes the illness, from the memory, as it is never happened. The idea of Janet is to operate a "mental disinfection". It is the doctor who does the job, he is the principal agent of the recovery of the patient. Janet is not preoccupied by the idea, which singularizes Freud, the idea there is a truth for the subject himself in neurotic symptoms and that recovery is the freedom "to decide for this or for that" ("The Ego and the Id", 1923). In a sense, it is to the patient to decide if he has recovered.
3. The conception of the unconscious. Freud's originality is not the discovery of the unconscious, but the discovery of an unconscious that wants something of the individual affected by the symptoms. In those times, the dominant conception of the unconscious, to which Janet refers, is that one of the neurologist John Hughlings Jackson: mental illnesses are dissolutions of the upper areas of the brain: constituted last in the history of human evolution, these areas are more complex, more "willful" and less organized than the lower areas, which are more simple, more automatic and more ancient in the history of the

human specie. The disorganization of the upper areas abolishes the control over the lower centers, which produces the symptoms.

From the invention of electroshock therapy, I distinguish two periods in the contemporary history of depression. From the forties to the beginnings of the seventies, there is a complementarity's between the two models of illness; their disconnection during the seventies led to the domination of the insufficiency model over the guilt model.

Depression as a subfield of neurosis

The contemporary history of depression doesn't start with antidepressants (1957), but with electroshock therapy at the end of the thirties. Why? Because this technical innovation gave birth to a style of controversies which gave a certain form to depression which lasted until the seventies. Those controversies emerged in a social context where families had to be respectable, individuals disciplined and ambitions modest. In the offices of general practitioners, the complaints expressed seem numerous, according to what I read in psychiatric papers published during the thirties, but patients were often considered as "imaginary ills", simulators or individuals observing themselves too much. In such a context, the problem for psychiatrists is to make those complaints recognizable to doctors as genuine pathologies.

The central controversy is about the role and place of affect (or mood, in the psychiatric idiom) in the diagnosis of non—melancholic depressions — keep in mind that melancholic depression is a psychosis characterized by a delirium of guilt, and it is on this type of depression that electroshock works. To "situate" mood is the pivotal issue, because it conditions the choice of the therapy.

In the French context, psychiatrists believe it isn't possible to treat the affect without understanding the place of the conflicts to which the patient is subjected. This is the consensus, which includes the most organicist psychiatrists.

The diagnostic question is: to which underlying pathology the depressive disorder must be linked? The answer implies focusing on the etiology and pathogenesis of the illness, on it's motive and it's causal mechanism. During that period, depression was generally considered not as a clinical entity, but as a crossroad entity that one can find in neurosis and psychosis, which were considered genuine pathologies.

Around the concept of "personality", a tripartition was formed which dominated the nosography and the diagnosis of depression until the end of the seventies: endogenic

depression, exogenic depression, psychogenic depression — in the American context, the last two types of depression were often assimilated with each other. Globally, there are two contrasting models. I call the first one the melancholic-electroshock model electroshock therapy is specifically for a sharply delineated illness. The second model is non—specific: electroshock therapy has a positive, but less efficient, effect on any depression, notably neurotic. This debate continued with the discovery of antidepressants at the end of the fifties, in the niche of controversies elaborated during the forties. It is striking at reading two articles published by the two discoverers a decade later. For the Swiss Roland Kuhn, the antidepressant is effective on endogenic depression mainly, which is caused by biological factors; for the American Nathan Kline, it's effective on every type of depression, because they all have a biological substrate. Kuhn thinks he as discovered a specific, and Kline a non-specific one.

In the years that followed, Kline's vision of depression would predominate.

On the social level, a new horizon appeared at the end of the fifties and the beginnings of the sixties in Europe: liberty for everyone to have a genuine private life with the establishment the well—being as a political operator. Economic growth, the development of welfare state, changes in the educational systems, new possibilities of social mobility, transformations of the family, housing policies (which increased spaces for intimacy), etc. had a decisive consequence: the prospect of a decent private life ease at hand. All of these elements triggered a collective process of material and moral emancipation where constraints were reduced for the benefit of liberty of choice. The possibility of having a more individual life increased, and attention to privacy modified.

The main therapeutic strategy of that period was the following one: by acting on depressive syndromes, the molecule prepares the patients to address his own psychic conflicts. For instance, in France you could find papers by psychoanalysts stating that antidepressant use is necessary in cases of severe obsessional neurosis (OCD), because the reduction of the symptoms allows the patients to undertake a talking cure. Antidepressants are relational substances. Among physicians they are part of a general shift of attention to emotions, feelings, affects, and psychic conflicts. Even at the end of the fifties magazines and popular books reassured readers: depression was not a mental illness —a psychosis—, it can happen to anyone. For instance, Pierre Daninos, one of the most famous French humorists in the sixties, published a book on his own depression in 1965, and Elle, the famous French weekly magazine, published excerpts of the book in six consecutive issues. These mediations stopped people feeling guilty about being interested in their personal problems.

How? By giving common labels to what everybody is personally susceptible to feeling indistinctly. All these elements contributed to giving a social place to psychic life. To recover, included with a molecule, it is indispensable for the patient to think of it. He must not be reduced to an object of his illness, he must be the subject of his conflicts: he is living the modern adventure of individual guilt.

Note that the discovery of antidepressants led medical doctors to pay a new attention to emotions and psychic conflicts. In the first period of modern depression, antidepressants stimulated their listening to the patient.

A diagnosis problem, largely undermined in psychiatric literature as in articles for general practitioners, led to the decline of this approach: the problem is that endogenic depression can resemble neurotic depression, especially for the untrained eyes of general practitioners.

The autonomization of the depressive syndrome

In discussions among psychiatrists, the type of depression at stake is neurotic depression, the most widespread one. Neurosis is the important word: psychic conflict manifest itself in depressive symptoms, and it is this conflict that is the object of the therapeutic action.

Two main solutions have been adopted to make diagnoses more coherent. In a totally different manner, each one contributes to the decline of neurosis. The first solution is centered on the notion of the depressive personality: the depressive symptom is not a symptom of neurosis, but of a narcissistic pathology in which either the patient is unable to get his conflicts to come to consciousness, or, if he is able to do this, it doesn’t help him to heal. The patient feels empty, fragile, and has difficulties bearing frustrations. Hence his tendency toward compulsive behaviors, and his seeking sensations, which abrade the conflicts. The individual is subjected to a feeling of insufficiency.

The second solution eliminates the notion of personality and of the clinical skill of the psychiatrist for diagnosis, thanks to the use of a model of syndromic cutting up: since psychiatrists can’t reach consensus on causes and, consequently, on underlying pathologies, the solution is to get rid the diagnosis of the etiological problem, that is to get rid of the question: to which underlying pathology does a set of symptoms refer? The technical means consists of the elaboration of standardized diagnosis criteria, which describe the symptoms clearly, and so can be accurate guides for the diagnosis of depression. This is the famous DSM, the Diagnosis and Statistical Manual for Mental Disorders, the third version of which was produced by American psychiatry during the

seventies and published in 1980. The medical facet centers on a patient for whom it is no longer necessary to tackle his conflicts to treat him pharmacologically. Consequence: neurosis as a category has become pointless. Its decline was supported by a new question: which antidepressant should the doctor prescribe for which type of depression? This question is also engendered by the growing diversity of antidepressants after 1975, when less toxic and easier to handle new molecules for general practitioners were launched. Psychiatric papers started advising less and less to psychiatrists and GP's to look for the underlying pathology of depressive symptoms, that is, looking for what affects an individual in so far as he is more than a body. The figures of conflicts decline to the benefit of figures which pose deficit or insufficiency as the problem, and well-being as a the solution. Therapy was conceived of as of Pierre Janet's idea of the mental disinfection.

In the medical version, the insufficient individual is no longer the principal agent of his healing; he is reduced to the proper status of patient, the status of an immediate agent of his illness. Depressed people don't need to address their own conflicts anymore. In the psychoanalytical version, the patient doesn't succeed in being the subject of his conflicts, because he suffers from "flaws of the Ego" or from narcissistic deficiencies.

This transformation of the notion of depression occurs in a context of normative and values changes, which became obvious during the sixties. Traditional rules of framing individual behaviors were no longer accepted, and the right to choose the life one wanted to live started entering mores. Following a substantial amelioration of material conditions in Europe and in the US, there were simultaneously new opportunities for social mobility for working class and a new attention to oneself promoted by the media. The perception of intimacy was changing: the idea that everybody can escape from his destiny or social origins, can make his way on his own, and can become someone by himself was democratizing and becoming our supreme value. Hence, of course new hopes, but also new worries.

This period is characterized by a dynamic whose the two facets are: psychic liberation (that is hopes) and personal insecurity (that is worries). In the foreground, the emancipation of mores were taking off: for instance, in 1966 techniques Philip Rieff called "releasing therapies" offered to everybody practical means for building his own path in life independent of any constraint. The new therapies (primal scream, etc.) engendered the feeling that anyone could master a life of choices without having to pay the price: therapists used a deficit model to increase "human potential"; their ideal was an individual without any conflict. In the background, numerous psychoanalysts and psychotherapists

worried about narcissistic-type mental pathologies which seemed much more numerous than before. Their patients were dominated by personal insecurity and feelings of having lost their self-esteem. Psychoanalysts insisted on a neo-traumatology where problematics centered on desire lost ground to problematics centered on object loss and subjective identity (narcissistic pathology and/or borderlines). It seems it is less desire which is at stake, than a need for being, expressing itself by a permanent insecurity. The new typical patient seemed no longer appeared to be neurotic. Actually, this decline of neurosis was discussed, notably in France: for instance, Daniel Wildlöcher, who is the current president of the IPA, wrote that hysterical mostly present symptom of depression, fatigue, and pain. But today, I must say the issue of narcissism is clearly a strong preoccupation.

Parallel to the increasing preoccupation about depression, there was a parallel increase in the preoccupation with addiction. Clinicians emphasized the auto-therapeutic use of drugs or addictive behaviors. Addictive intake seemed the other side of the depressive void. Instead of having symptoms, the patient abraded conflicts through compulsive behaviors (addiction) and impulsive behaviors, with violent or suicidal acting out.

The decline of reference to neurosis overlaps with the decline of a style of a social life, which at once used to express itself in terms of subjection to discipline and of supposedly cut and dry conflicts. Depression, whose main trait is the loss of self-esteem, could be now considered as a pathology of greatness: instead of the old bourgeois guilt and the fight to be freed from the law of the father (Œdipus), the fear of not living up to one's own ideals and the impotence resulting from that fear (Narcissus). Depression is the counterpart to the democratization of the exceptional, of this query to be only oneself, which is the first vector of the redefinition of contemporary individuality.

If personal accomplishment is the first vector, the second is the decline of discipline to the benefit of personal initiative —for instance, in the organization of work, which has developed since 1980. Personal accomplishment and personal initiative are linked in the following manner: on the normative side, personal initiative adds to personal accomplishment, on the pathological side, difficulty in initiating and maintaining action adds to personal insecurity. At the same time, psychiatrists consider more and more that the fundamental disorder of depression is the inhibition, which has become the cardinal concept of depression. It doesn't mean people are more inhibited today than yesterday, but that inhibition is more visible and more disabling in a society of action than in a society of discipline. It is not the lack of discipline which is at stake, but rather the impossibility to live up to one's own ideals.

It is in this context that a new class of molecules was launched on the market: ISSR, of which Prozac is the first kind. Actually, it is the second, because the French launched an ISSR a few years before which seemed to be much better, because it acted more quickly (one week) and, as I read in a paper published in 1982, the patient healed avec plaisir. But the molecule was taken off the market, because deadly neurological syndromes where found among some patients.

In raising hopes of getting over any type of psychic suffering, whether one is sick or not, the new class of antidepressant personifies, rightly or wrongly, the unlimited possibility of manufacturing ones own mind without the dangers of illegal drugs. The previous kinds of antidepressant couldn't help for that task. In a pill-taking society, no one would be able to distinguish between therapeutic goals and performing goals.

Two remarks. First, at the moment when these new molecules were put on the market, depression was redefined as a recurring and chronic illness, and psychiatrists estimated most patients didn't recover completely. During the sixties, psychiatrists used to say that recovery was quite sure. There is no mystery here, because it was the definition of depression itself that has been enlarged: the main reason for this transformation of a curable illness into a chronic one resulted from the integration of neurosis, a notable long-term illness, into depression. The notion of "dysthymy", which designate this type of depression, has replaced the notion of neurosis, and was treatable with antidepressants. The antidepressant has become a medicine for neurosis. The quality of life with comfortable and harmless molecules has replaced the idea of recovery. So, for those who fear our destiny is to be transformed into "neurochemical selves" (Nikolas Rose, 2003), I will say the mastering of the human mind is not going to happen anytime soon. This is why, contrary to the argument of the program, "where the id is, Prozac will not occur".

Second remark. Actually, Prozac and all the like are part of a general shift in the field of medicine which is no longer only a medicine of disease, but also a medicine of health. But the case of psychotropic drugs addresses moral issues, because it is the mind which is at stake, what western societies consider to be the essence of the human. When sociologists or philosophers talk about these topics —mental health, psychotropic drugs, psychotherapies, depression, psychic sufferings, etc.— generally they think that there is a "psychiatrization", a "psychologization" or a "pathologization" of society. This is notably the case of foucaldian approaches, which dominate medical anthropology. If the use of these notions is descriptive, it's of course true, because there is more psychiatry, more psychology, etc. It's true, but pointless. In fact, they are used in a normative meaning. It's

wrong, because theses claims mean the genuine society is what used to be. I think we are confronted with a global transformation of the relationship between the normal and the pathological, and not to a psychiatrization, etc. of society.

I'll conclude with this question.

The transformation of the relationship between the normal and the pathological has accompanied the subsuming of the values of discipline by the values of autonomy, which now impregnates the whole social life. This means everyone is supposed to decide and act in every sphere of life as the actor of … his own work, his own education, his own health, his own illness, etc. Discipline hasn't disappeared, of course. It's a change in hierarchy of values: values of discipline are subordinated to values of autonomy, which are more efficient, have more prestige, and arouse more respect.

The democratization of the exceptional put everyone in the situation of the melancholic of the sixteenth century, as described by the authors of Saturn and Melancholy: the melancholic is the man who has nothing above him to prescribe how he has to live. Melancholy is the price to pay for this enlargement of oneself—"My Joy is melancholy", said Leonardo da Vinci. Through its two facets of personal accomplishment and personal initiative, the demand for autonomy has enlarged the border of oneself at every level of social life. Consequently, the actions you have to consider as yours are so numerous that one can have the feeling we are witnessing a decline of personal irresponsibility. The values of autonomy bring out a personal aspect in every social relationship. The trap is to consider this aspect as meaning we are confronted with a process of psychologization, etc., that compensates for a weakening of social life, a decline of the idea of society. Actually, it is a recurrent and old topic in the history of individualistic societies. Contrary to this idea, it is more a transformation of the concept of social links. A society of generalized individual initiative and of total personal accomplishment renders visible the difficulties of structuring oneself (indispensable to be able to act) that aroused no attention in a society of discipline. These difficulties are expressed by the notion of depression, the psychiatric category which includes the widest variety of symptoms and whose main problematic is self-esteem, without which it is impossible to act.

That is why depressive insufficiency is to autonomy what neurotic conflict was to discipline. In a way of life organized by discipline, the question was: am I allowed to do it? When reference to autonomy dominates the concept of society, the question is: am I able to do it? Depression is a means of expressing and resolving the problems inherent to that question, it is a medium of a genuine social language, and not a symptom of

pathologization, and all the like. The enlargement of the borders of oneself was accompanied by the parallel increase of personal responsibility and personal insecurity. If today depression is considered as a major issue of public health, it is not because people suffer more than before, but because it gives social and medical answers to problems brought out by the generalization of autonomy. Depression is the intermediary entity between the old world of psychiatry and mental disease and the new world of psychic suffering and mental health.