On Depression Considered as Acephalic Melancholia

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"Pain and suffering begin with existence and end when it ends, and this end gives pain and suffering to those who survive." — Jean-Luc Nancy

This statement by Nancy opens a subsection of his book entitled "Pain, suffering, unhappiness," (1977:143) in which the question of art necessarily arises, and arises necessarily because of modern art's integral link to aesthetics, the science of feeling. Aesthetics, since at least the latter part of the eighteenth century, functions as a theory of the threshold between sense and sensibilia (to cite J.L. Austin), in which the pleasures and pains of a person's particular body are bound up with a problem of a universal thought that is neither moral nor cognitive. Both passive and active, aesthetic judgements about art become part of the making of art itself, and these aesthetic judgements are ultimately founded in nothing other than pleasure and pain. Everything else is derivative. Yet it is also true that such derivatives are immensely valuable, the indices of a properly human life.

But aesthetics immediately raises the problem of anaesthesia, anaesthetics: neither pleasure nor pain, neither pathos nor passion. A classical tradition denominated varieties of anaesthesia under such headings as ataraxia, apatheia, adiaphora and so on; such rubrics were philosophically valuable insofar as they designated the achieved detachment of the sage from the derisory quotidian concerns of the world. Among the less elevated conditions afflicting humankind which nonetheless also bespoke something of this detachment, without, of course, a consonant value being attached to them, was melancholy. Melancholy did, in fact, acquire a peculiar value: to the extent that it participated in a detachment from the things of the world in a way that was similar to that of the philosopher, it was worthy of respect; to the extent, however, that this detachment was suffered as an immensely painful, manifestly undesirable complaint, it was considered a failing or a sin. Melancholy has thus been considered, to parody Kant, a suffering without suffering. Hence the ambivalence of a figure such as the ancient atomist Democritus (notoriously joyful), whose ethics were easily inverted by Robert Burton, who published, in an early modern England itself notorious for its melancholics, his encyclopaedic Anatomy of Melancholy under the pseudonym Democritus Junior. One can see why Slavoj Zizek, though denouncing the garden-variety cultural studies
valorisation of "melancholia" over "mourning," can still end up affirming that "melancholy (disappointment at all positive, observable objects, none of which can satisfy our desire) effectively is the beginning of philosophy (2000: 660).

Melancholia, moreover — as the invocation above of Democritus Junior might suggest — is also consistently linked to materialist philosophies. Such a materialism is itself paradoxical. On the one hand, melancholy is utterly detached from the things of the world, and hence seemingly anti-material, anti-materialistic. On the other hand, melancholy is immured absolutely in the things of the world — there is no other world but this — to the point where the world itself has lost all sense. The world dissolves into objects-without-possible-relation. Albrecht Dürer’s etching of the melancholy angel is exemplary in this regard. As Giorgio Agamben writes, in the course of a gloss on Dürer’s image:

The troubling alienation of the most familiar objects is the price paid by the melancholic to the powers that are custodians of the inaccessible...Since the lesson of melancholy is that only what is ungraspable can truly be grasped, the melancholic alone is at his leisure among these ambiguous emblematic spoils. As the relics of a past on which is written the Edenic cipher of infancy, these objects have captured forever a gleam of that which can be possessed only with the provision that it be lost forever (1993: 26)

Such paradoxes of melancholia, which reveal unexpected bonds between matter, aesthetics and philosophy, have been almost entirely reduced in the diagnosis of depression, melancholy's contemporary avatar. Indeed, corporate, governmental and medical institutions are currently obliterating every trace of melancholia from depression other than the medical. As the Honourable Jeff Kennett, Chairman of the Australian foundation beyondblue (one word, all lower-case) declares in the foundation’s annual report 2001-2002: "The World Health Organisation predicts that unless we take appropriate action, depression will be second only to heart disease as the leading cause of death and disability within the next two decades." (2000-2002:2).

Indeed, depression in contemporary first-world societies has now reached, as doctors, academics, journalists, politicians, multinational governmental agencies and pharmaceutical companies agree, "plague proportions." The easy journalese of the phrase "plague proportions" should not prevent us from wondering as to the work being done by this metaphor: depression is not a transmittable disease, like SARS, for instance, one that might be contained through quarantining its victims and developing an easily-administered cure, although one might certainly still wish for genetic therapy (The Weekend Australia, June 21-2. 2003: 13). Then again, it's also tempting to suggest that such metaphors still unconsciously govern a great deal of medical practice that prides itself on its own "materialism."

Certainly, the current overwhelming dominance of medical technologies, personnel, and institutions over the bodies of those who are the world’s richest people, that is, those who live in the first world, is not simply linked to its effectivity or scientific foundation. This is a fact at once acknowledged and camouflaged in the literature, which often literally sparkles with statistics and desperation. The hallucinatorily named "Centre of Excellence in Depression and Related Disorders" (a beyondblue initiative) is self-confessedly concerned with publicising depression and with offloading government costs of specialists onto GPs and community organizations (its other major concern is with insurance claims). In order to do this in any economically- and publicly-viable way,
however, it needs to make depression not a mental health issue but a health issue, i.e., on the level with bowel cancer and heart disease. If such an ideological operation seems doomed to failure on its own terms, it is calibrated to exclude all questions of a sense of depression; therapies such as psychoanalysis, which depend on language having a symbolic efficacity for human life, are a priori excluded from the realms of genetics, physiology and neuroscience. "Depression," we might say, is what happens to melancholy when the sufferer’s words are considered absolutely meaningless or, at best, mere reports of affect. Depression is a literally mindless melancholy, an acephalic melancholy.

This project is implicitly flagged by beyondblue’s "Principles for action," among which we discover: "Respect for human rights and dignity," "A population health approach," "An evidence-based approach" and "Sustainable action." The logic underlying these principles was a volatile issue during the discussion at the Australian Freud Conference 2 May 2003, where most of the analysts were complaining bitterly that they had been cut out of beyondblue and other governmental psychiatric initiatives on depressive disorders. In the place of psychoanalysis, of course, we find drug therapies and CBT. So the great medical opposition between "listening" and "dispensing," psychoanalysis versus Prozac, seems today to be on the side of dispensing. The great early paean to Prozac was issued by Peter Kramer, *Listening to Prozac* (1993), a massive bestseller. Note how Kramer’s title attempts to reconfigure the distinction between "listening" and "dispensing," in the favour of dispensing: Prozac is a wonder drug precisely because it is the drug that *overcomes the very distinction — to the point that one now listens to it as if it were the true subject of depression.*

It is more than possible that depression has a physical aetiology (brain lesions, genetic predispositions, etc.) and that such a disease ought to be treated physically. Tests carried out at Massachusetts Mental Hospital during the 1970s showed that the crude anti-psychotic drugs then available were far more effective than any analysis. But in the long term? Who knows? As Mikkel Borch-Jacobsen notes: "Under the impact of antidepressants, not only was the distinction between the psychoses and the neuroses (and, by the same token, the professional niche of psychoanalysts) erased, but also that between psychiatry and general medicine. Everything has become depression, because every condition responds to antidepressants, the new panacea." (*The London Review of Books*, 11 July 2002). "So," Borch-Jacobsen notes, "farewell Kierkegaard and Heidegger." Or as Kramer puts it, "Perhaps what Camus’s Stranger suffered — his anhedonia, his sense of anomie — was a disorder of serotonin. Kierkegaard’s fear and trembling and sickness unto death are at once spiritually significant and phenomenologically unremarkable, quite ordinary spectrum traits of mammals, affects whose interpretation in metaphysical terms is wholly arbitrary" (1993:296).

Yet, if pharmacology has made great advances in treatment, the causes of depression seem to have become even more opaque. As David Healy remarks in one of his groundbreaking studies of the psychopharmacological era:

> There has been astonishing progress in the neurosciences but little or no progress in understanding depression. The fact that the SSRIs are no more effective than other antidepressants questions the idea that depression is the kind of target that a specific magic bullet will someday hit dead centre. The fact that both specific norepinephrine reuptake inhibitors and specific 5HT reuptake inhibitors may cure it points strongly to the fact that it is simply
So if even the new-generation SSRIs (Selective Serotonin Re-uptake Inhibitors) are not any more effective than their cruder pharmacological ancestors, among the most notable of their so-called "side-effects" (a term I deeply loathe, given that effects are effects and calling them side-effects seems to me nothing more than a self-deluding nominalism), include a suppression of libido, often to the point of functional impotence. An anecdote: a patient, Dr D., was prescribed Prozac by his psychiatrist; when he complained of "loss of libido," he was told that he clearly wasn’t depressed, as any truly depressed person would be only to happy to sacrifice their sexual desire functions on the altar of Prozac. In this context, one could note Lewis Wolpert’s apparent serenity in the face of a loss such as this (2001)

But there is another interesting fact about depression that is relevant here. It is that a number of reproducible laboratory tests suggest that depressives are in fact significantly more accurate in describing their capacities and situations than non-depressed people.

If Aaron Beck, the father of cognitive therapy and ex-psychoanalyst himself, spoke of all depressive and many anxiety "disorders" as characterised by a "negative cognitive shift," the depressive’s "shift" would itself be more accurately characterised as an "accurate cognitive shift." Normal people are demonstrably more self-deluded than those who are depressed. One doesn’t need to invoke Hegel’s famous "patience, labour and suffering of the negative" to see how an inability to listen to the content of the depressive’s utterances can end in a frustrated technicist fatuity.

Given the failures of pseudo-scientific psychology and current neuroscientific explanations, unbridled speculation as to the true causes of conditions such as depression remains, as ever, rife amongst humanities academics (such as myself). Oliver Bennet, for example, writes:

"a disposition towards negative cognitions could be attributed to one or more of four main factors: genetic inheritance, bio-chemical dysfunction, 'life-events,' and psychological tendencies formed in childhood. Although long-term historical trends were impossible to establish, there was evidence to suggest that there had been a significant increase in the incidence of depressive and anxiety disorders during the second half of the twentieth century. In Oliver James’s view, this was due to the social impacts of the 'new' capitalism, which was producing an epidemic of 'learned helplessness,' 'maladaptive social comparison' and 'anxious attachment,'" (2002:192).

Numerous studies have now established that "normal" (that is, non-depressed) people exhibit three main tendencies: first, they tend to maintain unrealistically positive views of themselves, persistently overestimating their strengths and discounting their weaknesses; secondly, they tend to have an exaggerated belief in their ability to control their environment; and, thirdly, they nurture a view of the future that is unrealistically optimistic, believing that it will bring what is personally or socially desirable rather than what is objectively likely (2000:184).
It is a profound paradox of our age that the huge strides in scientific research — especially in the fields of psychology, neurology, pharmacology, and genetics — have only had the effect of making more pronounced the intractability of the human mind…This paradox is only heightened when it is noted that cases of depression are now reaching epidemic proportions, threatening society’s de facto ideal of a smooth and efficient wealth-creating power house. And this in the most affluent societies — in those societies where, it is claimed, people have never had it so good" (2002:1).

But that desire and depression seem to be inversely related seems to me a matter of interest, as is the striking linkage between apparent truth-telling about self and depression. Neither of these relations would have been surprising to Sigmund Freud, who noted both in his classic 1917 essay "Mourning and Melancholia" (note the date, during WWI). As Freud sardonically notes: "When in his heightened self-criticism he describes himself as petty, egoistic, dishonest, lacking in independence, one whose sole aim has been to hide the weakness of his own nature, it may be, so far as we know, that he has come pretty near to understanding himself; we only wonder why a man has to be ill before he can be accessible to a truth of this kind." (Freud, 1991: 255).

Freud draws a crucial distinction between "mourning" (a natural process of grieving for a lost object, and an attempt to come to terms with this loss) and between "melancholia" (a refusal to give up on the lost object). For Freud, melancholia has many possible triggers, but it essentially revolves around the loss of a loved object. This loss creates extreme difficulties for the subject:

the distinguishing mental features of melancholia are a profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment (258).

In mourning, which shares, at least superficially, many features with melancholia, there is a conscious recognition of the loss of the loved object. Recognising the loss consciously, the mourning ego struggles to withdraw its libidinal investments from the object. However, this struggle is not easy, and is usually accomplished only in stages, bit by bit. This is what Freud refers to as the "work of mourning" (my emphasis); the mourning or grieving person literally works through the pain of their loss in an attempt to come to terms with its necessity, and with their own incapacity to restore the loss in reality. For the mourner, a loss in reality cannot be made good, nor ignored, repressed or repudiated — but it can be accommodated.

Although, as noted, melancholia exhibits similar symptoms to those of mourning, it differs from mourning in a number of crucial ways. Whereas the lost object is always consciously recognised by the mourner, the melancholic’s lost object is sometimes unknown or unconscious — they do not know what they have lost. This unconscious status of the lost object proves extremely problematic, and in a number of senses. For Freud, the overwhelming sadness of melancholia cannot be worked through insofar as the object remains unconscious. Furthermore, the psychic energy or libido freed by the loss of the object is thereafter withdrawn into the ego itself by a thoroughgoing
identification with that object. In melancholia this terrible sequence — loss, repression, egoic identification with the loss — entails that the melancholic person constantly persecutes him, or herself, turning against their own ego their ambivalence about the loss. As Freud notes, whereas mourning recognises the loss of an object that was "good" and "loved," the melancholic’s relation to the lost object is necessarily more ambivalent, i.e., a dense complex of love and hate. For Freud, the bitter recriminations that a melancholic typically turns against him- or herself are rather more appropriate to the lost object itself:

Thus the shadow of the object fell upon the ego….In this way the loss of the object became transferred into a loss in the ego, and the conflict between the ego and the loved person transformed into a cleavage between the criticizing faculty of the ego and the ego as altered by the identification (1991: 258).

In a way, the melancholic refuses to mourn, incorporating and preserving the lost object unconsciously within his or her psyche — a self-torturing denial of loss. Paradoxically, as Maria Torok and Nicholas Abraham have memorably phrased it, melancholy can proffer the odd equation: The Lost Object = Me. For Freud, the three major "conditioning factors" in melancholia are: 1) object loss; 2) ambivalence; 3) the regression of the libido into the ego itself. The melancholic is eviscerated by an inadmissible rage against loss.

Yet there is another point to be made here, precisely about the apparent asociality considered characteristic of melancholy: that is, the tendency of the depressive person to exhaustion, sluggishness, withdrawal from the world. Such features are very often noted in the literature about depression, from personal accounts to governmental documents; sometimes these features are understood as causes, at other times as symptoms. Yet Freud emphasizes that the melancholic is prone to all sorts of externalised self-reproaches which are performed before others — whether those others are family or friends, medical professionals, or even fantasmatic figures. As Judith Butler has noted, "the performance of melancholia as the shameless voicing of self-beratement in front of others effects a detour that rejoins melancholia to its lost or withdrawn sociality."(1997: 181). What this means, among other things, is that the melancholic retains a link to the society from which he or she simultaneously withdraws by showing, in one way or another, that they are no longer able to perform (as expected) in that society. If "shame" is one of the very important social emotions (shame is, by definition, shame before the eyes of others, crucial, among other things, in instilling a sense of prohibited/correct behaviour in infants), there is then something about the overwhelming sadness and enervation of melancholy that can be considered an attempt to evade and incarnate shame. Melancholy would then be an ambivalent defence against shame, which encrypts, retains the shame of the other within. Depressives begin to act in ways that they would never countenance when well; or, to put this differently, they patently expose themselves as acting in ways that "well" people would never countenance. And because Freud considers that melancholia is integrally constituted by rage at other(s) turned back upon the self, it is then possible to consider melancholia a peculiarly self-lacerating and unconscious form of social revolt. Many sufferers have themselves noted that, along with Lewis Wolpert, although being "totally self-involved" in their sickness they would suffer "panic attacks if left alone."(2001: xv). And sufferers constantly speak of the peculiar shame that attaches to their disorder. As the French novelist Marie Cardinal puts it: "I was ashamed of what was going on inside
of me, of this uproar, of this disorder, of this agitation." (2000:3). Almost every writer on the topic notes — not always consciously or explicitly — the close link in depressives between their feelings of shame and their "shameless" actions. Cardinal herself, noting that madness doesn’t seem so shameful among the impoverished or aristocracy, gives an explanation based on socio-economic class: "When the madness comes from inbreeding or poverty, it may be understood. But when it comes out of a comfortable life where there is good health and that poise conferred by money decently earned, in such a case, it is a disgrace," (14). For Freud, however, sufferers can be so shameless because it is not really themselves that they are addressing — it is the other encrypted inside them.

To return to the metaphors of depression-as-plague already briefly noted above: if Freud’s account retains any pertinence, it is possible that the widespread hope for magic bullets and isolation of plague-vectors in relation to depression may be, in a particular but unexpected way, essentially correct. Depression is transmitted in the form of shame before others, to the extent that it has now become so fearful it can only be publicised as an entirely-normal physiological possibility. On the basis of the preceding remarks, my own speculation is therefore that the attempt to normalise and control depression and the effects of depression through public ventures such as beyondblue will not work. On the contrary, depression will continue to flourish, suddenly striking anyone, anywhere. This is not simply due to the familiar paradoxes of definition, performative creation, competing specialisations or causal overdetermination characterized in the following. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Diseases (Fourth Edition) aka DSM-IV, requires that, for a clinical diagnosis of depression to be made, five or more of the following symptoms must be present over at least a two-week period: depressed mood most of the day; diminished interest or pleasure; significant gain or loss of weight; inability to sleep or sleeping too much; reduced control over bodily movements; fatigue; feelings of worthlessness or guilt; inability to think or concentrate; thoughts of death or suicide. But that leaves a lot out, such as the problems of the relationships between anxiety and depression, or the relationships between "postnatal depression" and depression "proper." The abiding mutability and fuzziness of the category leads to genuine problems in diagnosis, treatment and prognosis. Is depression a single disease or a complex of diseases? If a complex, then how should it be diagnosed and treated? Are there differences in degree or in kind between forms of depression? What sort of diagnostic criteria can be applied to separate out the various elements of the disease? Is there more depression about these days, or is it just that our diagnoses have become more nuanced? Is it under- or over-reported? How is it linked to other diseases, some which seem to have a clear organic causality, some of which don’t (hypochondria or chronic fatigue syndrome, for instance)?

Having indicated problems associated with the paradoxical nature if how it is understood and defined, the most debilitating obstacle for the depressive to overcome is the social structure of depression itself. The shame of depression will never be overcome, precisely because depression is integrally bound up with shame; this shame is only intensified by advertising claims that there should be nothing shameful about depression; after all, if Freud still has something to contribute to this debate, for a depressive there may well be something (unconsciously) enjoyable about their shame.

It is also crucial to note the non-neurotic structure of melancholy, which is more akin to perversion than to neurosis or psychosis. Almost every psychoanalytically-inflected
theorist agrees on this. Freud, Kristeva, Butler, Agamben all suggest that the perverse disavowals of melancholy function similarly to the disavowals of the fetishist. But if the fetishist fixates on a particular kind of object, the melancholic’s problem is precisely the loss of object or, to use more Lacanian terms, the loss of the object-cause of desire. These psychoanalytic writers imply that any overcoming of melancholia requires a certain imaginative invention of solutions for and by each particular sufferer. Although they are certainly interested in discerning regularities in the symptomatology and theory of the disease, these regularities by no means have the status of biophysical laws. Their work suggests that medical difficulties in clarifying the fuzziness of the category of depression — not to mention the often wildly divergent responses of sufferers to medication and therapy — are absolutely irresolvable. Because melancholy is precisely an intense affective rejection by the sufferer of his or her contemporaneous technologies and modes of life, i.e., the lack that founded their objects, the sufferer cannot simply be treated by those very technologies which he or she is (unconsciously) rejecting. Language necessarily fails in talking about melancholia, as symbolic bonds are central among the “things of the world” which the melancholic resists. This is why the title of Cardinal’s account of her recovery from depression is so significant: The Words to Say It. This state of affairs renders many of the supposed “treatments” part of the problem itself.

On such accounts, melancholy — to the very extent that it seems to be bound up with a loss it cannot abandon — is at the same time an unconditional demand for something new. The depressive is typically obsessed with everything that he or she cannot bear about the world, which suggests also that he or she will not put up with fake solutions. In this sense, melancholy is not backward-looking, but rather authentically forward-looking, or, more precisely, subsists in a temporality skewed between already-over and not-yet. Its cure would then be at least partially dependent on the sufferer’s ability to reinvigorate both self and world by an imaginative solution (and not just a chemical solution). This solution involves the creation of new objects. Despite all appearances, then, melancholy would be a necessary stage in the invention of new possibilities for life; it might even, unexpectedly, as Burton’s Democritus Junior suggests, provide the indispensable underlining of joy.

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