Short Communication

iMedPub Journals
www.imedpub.com

ACTA PSYCHOPATHOLOGICA
ISSN 2469-6676

2017
Vol. 3 No. 5: 55

DOI: 10.4172/2469-6676.100127

The Failings of Depression: A Review of Lacanian Psychoanalytic Critiques

Derek Hook*

Department of Psychology, McAnulty College and Graduate School of Liberal Arts, PA, USA

***Corresponding author:**
Derek Hook

hookd@duq.edu

Associate Professor, Department of Psychology, McAnulty College and Graduate School of Liberal Arts, Duquesne University, 600 Forbes Avenue, Pittsburgh, PA 15282, USA.

Tel: 412-396-6513

Citation: Hook D (2017) The Failings of Depression: A Review of Lacanian Psychoanalytic Critiques. Acta Psychopathol. Vol. 3 No. 5: 55.

Abstract

Despite that it is cited the leading cause of disability in the world, the notion of depression is not accorded the status of a diagnostic concept in Lacanian psychoanalysis. The wide-ranging reasons for this 'ex-nomination' provide the basis of an informative critique of how the concept functions in both the clinic and in much contemporary Western culture today.

Keywords: Psychoanalysis; Depression; Psychiatry; Clinical observations; Neurosis

Received: July 14, 2017; **Accepted:** August 26, 2017; **Published:** September 01, 2017

Introduction

What might a Lacanian psychoanalytic perspective have to offer regards the topic of depression and culture? At first glance, the answer seems simple: not much. The term is not included in the *Dictionary of Lacanian Psychoanalysis* [1], and it is only very rarely indexed in the Lacanian literature (for insightful exceptions to this rule [2-4]). The infrequent reference to depression in the Lacanian literature is striking, particularly given the overwhelming prevalence of the concept in clinical discourse, and it is not incidental. This virtual absence has, paradoxically enough, something important to offer contemporary debates on depression and culture.

There are at least two reasons that depression is not accorded the status of a diagnostic concept in Lacanian theory. Firstly, the notion of depression is considered to be both under-defined and over-used. As Hill stresses, "the 'depression' of ordinary language and psychiatry is too vague a term" [5]. Or, in Skriabine's opinion: The notion of depression "covers certain particular sufferings with…[a] non-differentiating cloak" [6]. So, not only is the notion of depression lacking in conceptual clarity and clinical refinement, it also obstructs the work of more careful clinical observation. For instance, as Leader notes, what is sometimes labeled depression is often far more akin to a state of nervous agitation, indeed, to a pronounced condition of anxiety [7].

The ever-expanding use of pharmacological medication has much to answer for in the massive increase in diagnoses of depression, and, by extension, in the over-use of the concept of depression. It is also, arguably, a factor in the associated decline of rigorous clinical observations regards what underlies the symptoms of depression. As Etchegoyen and Miller argue, the utilization of drugs to alleviate symptoms results in the erosion of clinical phenomena, which disappear without ever having been properly understood [8]. The end result of this is, invariably, the conflation of different symptoms, most typically "under the name of "depression"" [8].

A second crucial reason why Lacanians avoid the use of depression as a diagnosis is that, as they claim, depression is not a discrete *structure*. It refers instead to symptoms that can occur in any of the major diagnostic structures recognized by Lacanian theory (neurosis, psychosis and perversion).

Review of Lacanian Psychoanalytic Critiques

As Lander argues: From the point of view of psychiatric nosology, depression is a definite clinical entity. It is conceptualized through a group of phenomenological data that constitute a diagnostic clinical entity. Lacanian psychoanalytic clinical practice, on the other hand, sees depression in a different way–as a symptom that is instated in any clinical structure. Depression is not an unconscious structure in itself [9].

As Skriabine [6] more bluntly asserts: "The [Lacanian] psychoanalytic clinic refutes any idea of an entity that could be named "depression"" [6]. The sounds like a radical and perhaps not entirely helpful position, especially given today's many calls to recognize the disabling and often under-reported effects

of depressive sufferings globally. Nevertheless, this seemingly antagonistic stance to the commonplace use of depression as an all too ready-to-hand descriptive label has much to teach us.

What exactly then might be informative about this apparent Lacanian dismissal of the concept of depression? Well, for a start, the Lacanian critique of the notion of depression expands into an important social critique. Fink clarifies: The fact that people are increasingly diagnosed as depressed may…reflect the simple fact that pharmaceutical companies have concocted ever more antidepressants, and when you have a "cure" you have to find a "disease" that can be treated with it–this is a…widely documented problem in modern American culture…. If doctors are convinced by pharmaceutical company representatives that they can cure depression with a pill, then doctors will be more inclined to label patients as depressed than as…conflicted with themselves about love and hate they feel for one parents, for example… But drug companies have no pill for "intrapsychic conflict" so it isn't likely doctors would be tempted to list it as a diagnosis [10].

Depression as a diagnostic label then, following this logic, is more a construction of pharmaceutical companies than a precise or particularly useful concept of psychotherapy. Given the widespread medical and pharmacological use of the concept, it is unsurprising that people go on to experience various difficulties in their lives in the terms of depression. As we will go on to see, the labeling of experience as depression might itself be a means of aggravating ostensibly 'depressive' symptoms.

Two further components of Fink's commentary on depression are worth noting. The first targets the idea of symptom reduction as a prime agenda in mental health. Now while the reduction of painful symptoms is obviously a worthwhile goal–especially in the long term–the stress placed on the immediate elimination of symptoms often occurs at the expense of properly investigating underlying structural causes. Depression, Fink avers, is more often than not the effect of longstanding neurotic conflicts. Accordingly, it is the neurotic conflicts that should be focused on, "not the affect, which may even at times be a…smokescreen…behind which the conflicts disappear from sight (*Affect is an effect, not a cause*" [10]). To avoid giving the wrong impression: Fink is not suggesting that *what appears* as depression is not clinically serious. He is–and this is a hallmark of Lacanian approaches more generally–suggesting that clinical diagnosis and conceptualization should dig deeper than affect, should explore structure rather than behavioral/affective symptoms. Clinicians should avoid seeing affective states as indicative of either structure or diagnosis, and instead focus on exploring the conflicts or structures that underlie such affective states. Verhaeghe [11] extends this point, noting also how, from a Lacanian perspective, issues of identification are typically more *structurally* important than are questions of surface affects:

Contemporary popular approaches focus on the affect, and people quickly come to associate depression with certain negative emotions. But this is not the crux of it, quite the opposite in fact… feelings-are deceptive. At the heart of depression, as is clinically not hard to see, is a lack of emotion, and a confrontation with emptiness and the loss of meaning…. Depression can thus be conceived as the reverse of identity acquisition, the loss of an identificatory anchoring point… In this way, depression is an essential possibility for every subject [11].

We should pause here to qualify a little more carefully the Lacanian critiques of pharmacological intervention in apparent instances of depression. It is true that many Lacanians take a dim view regards what they would consider the over-prescription of medications for depression. "I see plenty of patients who come to me after having been diagnosed with depression and placed on a half-dozen different medications", says Fink [10], adding that "They usually get off the majority of medications fairly quickly…[when] it becomes clear that the depression is the effect of longstanding neurotic conflicts". While Skriabine in apparent contrast to Fink, stresses that there are times when pharmacology is indispensible, he nonetheless shares the more general Lacanian view that "pharmacology…works only on somatic processes" The particularities of a subject's personality and the unique historical conditions of their life are all too often lost when it comes to pharmacological interventions. It is for this reason that the refutation of the popular notion of depression–as a malady to be treated by medications–has become tantamount to an ethical issue for Skriabine [6]. The contemporary extension of the term of depression can thus be seen as a symptom of discontent *within contemporary Western culture*, an idea I will elaborate upon as we continue.

Leader similarly dismisses the idea that depression is a unique disease, and in fact argues that the term should be jettisoned as a technical or diagnostic term, used merely as a descriptive term to refer to *surface features* of a behavior Part of what drives Leader's critique of contemporary notions of depression is his concerns over a culture that medicalizes solutions to problems of human suffering. In contemporary treatments of depression, he contends:

The interior life of the sufferer is left unexamined…Depression… is conceived of as a biological problem like a bacterial infection, which requires a specific biological remedy. Sufferers have to be returned to their former productive and happy states…the exploration of human interiority is being replaced with a fixed idea of mental hygiene.

There is an important humanistic dimension to this argument, which clearly prioritizes subjective meaning and the role of inter-subjective relations over the reduction of apparent instances of depression to a biological or neurological state. Leader's argument, however, goes one step further. The objectifications of a biological/medicalizing approach can, in effect, be an exacerbating part of the problem itself. Or, to word things in slightly stronger terms, today's conceptualization of depression could itself be considered to be iatrogenic. How so? Here it helps to cite Leader at length: As so many different aspects of the human condition are explained today in terms of biological deficits, people become emptied of the complexity of their unconscious mental life. Depression is deemed to be the result of a lack of serotonin rather than a response to experiences of loss and separation. Medication aims to restore the sufferer to the optimal levels of social adjustment and utility, with little regard for the long-term causes and possible effects of their psychological problems.

Viewing depression as a localized disturbance that can-and should-be removed with targeted interventions overlooks the fact that such forms of suffering involve the whole of a given person's existence. Depression is not, as such, extricable from the domain of human (and unconscious) meaning. Separating 'depression' from the everyday realm of lived experience, and objectifying it in terms of medical language (as bio-medical condition) undercuts the subject's own attempts to make sense of it, or to investigate the multiple facets of their personal history that may underpin it.

Added to this is the 'quick-fix' problem so evident in today's popular culture. Rather than spending countless hours in a therapist's office, conducting the work of self-exploration, many would opt rather to assume the label of depression and the relatively effortless routine of taking the daily medication thought to remedy this ailment. We return here to the ethical quandary noted above–the problem of losing sight of the texture of individual subjectivity–which becomes more pronounced the more individuals are subjected to socio-medical norms:

the more that society sees human life in…mechanistic terms, the more that depressive states are likely to ramify. To treat depression on the same model as, say, an infection requiring antibiotics, is…dangerous. The medicine will not cure what has made the person depressed in the first place, and the more the symptoms are seen as signs of deviance or unadapted behavior, the more the sufferer will feel the weight of the norm, of what they are supposed to be [12].

Depression as a discourse engenders societal norms that many individuals fail to live up to. Similarly, depression approached along the lines of medical and neurochemical interventions–without the accompanying exploration of the patient's internal life–leads to expectations of a direct solution. In both such instances, the concept of depression can be said to be introgenic, to increase the sufferings of those who are unable to meet such social norms or such expectations of recovery.

This provides us with the opportunity to introduce a series of apparently scandalous comments that Lacan makes on sadness and depression. Sadness, says Lacan, which is often qualified as depression is simply a moral failing, as Dante, and indeed Spinoza, put it…a moral weakness, which is ultimately located only in relation to thought, that is the duty of speaking well, to situate oneself in relation to the unconscious [13].

Factors for Lacan's Controversial

We need to take into account several factors in weighing up the value of Lacan's controversial remarks. There is, firstly, his deliberate wish to be provocative, to challenge his audience with something so counter-intuitive and shocking that it may result in a reassessment of what they–and we-take today as accepted wisdom (namely that depression is a type of illness). Along with this, we need to bear in mind Lacan's preference for consulting philosophical, literary and religious texts from earlier eras to those of the scientists and psychiatrists of his own time. Doing so brings an important historical dimension into play.

The description of depression as moral failing has a clear precedent in Christian and medieval thought. The crucial idea there is that sadness can be thought of a sin once we have realized that we are called by God, firstly, and that hope and joy are duties that stem from this calling, secondly. As Leader observes in his commentary on the above passage: Sadness becomes a sin when opposed to the duty of rejoicing in God, and can hence be categorized as sinful alongside hatred, envy, pride and anger [14].

Lacan's use of this idea from Christian ethics is of course re-inflected: the duty of which he speaks is neither a duty to God or to the life of a Christian. It is instead a duty to speaking, to put one's life and troubles into speech, a duty furthermore, in relation to the unconscious. Or, as we might put it, depression can indeed be a moral failing, if we shirk the responsibility of responding ethically (that is, *clinically*) to 'depression', and doing this by encouraging speech and the exploration of the unconscious conditions of subjectivity (that is, ideally, psychotherapeutically). This apparently shocking set of comments then can be read as an insistence on the need to explore–via the modality of the speaking cure–the specificity of a given manifestation of depression, which is always particular to a given individual's history, embedded within the culture and society of which they are a part.

Conclusion

If we are to agree to such an–admittedly charitable–interpretation of Lacan's words, we are nevertheless left with a question of responsibility. Exactly *whose* moral failing are we concerned with? A first reading of Lacan's words suggests that it is the sufferer of sadness/depression themselves that is responsible for this shortcoming. This is an irreducible aspect of Lacan's comments, one which cannot be denied, certainly so given that a central facet of Lacan's clinical ethics [15] is to *avoid* a renunciation of responsibility for one's own subjective position–however terrible it might be Neill [16]. We might expand upon this point of responsibility, however, and, circling back to some suggestive comments noted above, suggest that the moral failing and responsibility in question concerns–at least in part-our own current medicalizing, quick-fix cultural milieu. This is perhaps one way of critically re-contextualizing and helpfully applying Lacan's comments today: A culture that invariably biologizes and medicalizes sufferings of loss, conflict and bereavement fails us by not considering these sufferings within the broader ambit of the subjective, psychological and interpersonal factors which underlie its particular manifestations.

Why, we might ask, is a given person unhappy, 'depressed'? Perhaps they lost a loved one before a longstanding conflict could be resolved; maybe they have been subject to a life-time's worth of racist degradation; possibly they are dealing with chronic pain on a daily basis; or they have experienced an inexplicable malaise of personal value and meaning, despite that everything else in their life seems–at a surface level at least-to be running smoothly. There are then an infinite number of–often very complex-causes of the symptoms and experiences that we label as depression. What is to be stressed then, from a Lacanian position, is that there is not one biological/neurological entity called 'depression', but multiple historical, subjective and unconscious antecedents to the sufferings of loss, bereavement and 'depressive' suffering, all of which should be approached via attention to the mediums of human experience, subjective meaning, and inter-subjective speech.

References

1 http://www.davidbardschwarz.com/pdf/evans.pdf

2 Vanheule S (2004) Neurotic depressive trouble: between the signifier and the real. J Lacanian Stud 2: 34-53.

3 Moncayo R (2008) Evolving lacanian perspectives for clinical psychoanalysis. London: Karnac.

4 Svolos T (2016) 21st century psychoanalysis. London: Karnac.

5 http://www.philiphill.com/

6 http://www.lacan.com/depression.htm

7 Leader D (2008) The new black. London: Penguin.

8 http://www.ascodocpsy.org/santepsy/index.php?lvl=publisher_see&id=264

9 Lander R (2006) Subjective experience and the logic of the other. New York: Other Press p: 124.

10 Fink B (2014) Against understanding: cases and commentary in a Lacanian key (Volume 2). London: Routledge p: 246.

11 Verhaeghe P (2004) On being normal and other disorders. New York: Other Press pp: 274-275.

12 http://universa.filosofia.unipd.it/index.php/Universa/article/viewFile/93/130

13 https://monoskop.org/images/f/f2/Lacan_Jacques_Television_A_Challenge_to_the_Psychoanalytic_Establishment.pdf

14 Leader D (2015) The specificity of manic depressive psychosis. In: Gherovici P, Steinkoler M. Lacan on Madness. London: Routledge.

15 http://www.lacan.com/seminars1a.htm

16 Neill C (2014) Without ground: Lacanian ethics and the assumption of subjectivity. London: Palgrave.