Science and the 'Ideal' of Mental Health

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'We are all born mad. Some remain so.' (Samuel Beckett - *Waiting for Godot*)

The spirit of the current age is heavily scientific and we are deluged by a will to measure everything, to quantify it and to know it so that soon, we are told, all of the mysteries of the universe and of human desire will be understood by facts and figures. Producing ever more increasing levels of knowledge statistical calculations and evaluative methodologies have lead to the identification of regularities and patterns from which conclusions and treatment approaches are supported. Larger bureaucratic mechanisms are required to manage this knowledge and we don't have to look far for evidence of this. In the field of health for example, we know that administration costs far outweigh clinical costs. Science and medicine have come together in unprecedented ways and the body itself is now industrialised, a commodity to be diagnosed, treated and regulated with the aid of medicine, gene therapies, even the production of new organs and bodies through cloning. In the field of mental health, the dominance of the scientific method has led Le Blanc to note that the approach to mental life is considered similarly to brain function and as a function of biological life,[1] and for Eric Laurent, this has led the reduction of the patient's history to the role of genes and to environmental factors.[2]

The premise of scientific knowledge is as Rik Loose puts it 'the observation, registration and the systemisation of this "order of things."'[3] The end result of this scientific knowledge accumulation is the production of universal norms that can be applied to populations of people.[4]This has led to a standardisation of care, supported by ever-increasing levels of testing and evaluation that tends to make everything conform and be homogenous. Under this 'one size fits all' model, the predominance of drug therapies and educational training which

[1] G. Le Blanc, 'The Unevaluable: the Timelessness of Canguilhem,' in *Psychoanalytical Notebooks*, Vol. 17, 2007, pp. 81-82.
[2] E. Laurent, 'Blog Notes: The Psychopathy of Evaluation,' *Psychoanalytical Notebooks*, No. 16, 2007, p. 59.
[3] R. Loose, *The Subject of Addiction: Psychoanalysis and the Administration of Enjoyment*, Karnac Books, London, 2002, p. 196.
[4] This is based on the empiricism of questionnaires and the data accumulation of the interview conducted by the research worker pursuing a particular hypothesis.

is meant to arm the patient against his/her historical reality means that patients are medicated and educated into better mental health.[5]

The dominance of science has not happened by chance and has precise historical, intellectual and socio-cultural foundations that I won't elaborate in this short article. It is however important to note that psychoanalysis emerged at the beginning of the twentieth century against the backdrop of what can be described as the confident consolidation of science in the field of intellectual knowledge. In this, Freud, who founded psychoanalysis as a way of re-resituating the citizen through an act of speech, recognised that there are no guarantees that generalised knowledge and truth coincide and in fact, they rarely do. The fundamental truth that science tries to overwrite with knowledge is that there are forces that drive and impact upon us that can never be fully known (e.g. birth, death and trauma) and what really drives us originates from a time before we had access to speech and language.[6]

The enormity of science's impact on the field of mental health is borne out in treatment approaches to symptoms. Dominated by a masterful gaze which is directed at the passive objectified, the patient who is expected to conform and submit to treatment. This gaze reaches a zenith in dominant models that strenuously assert the subjectivisation and even eradication of symptoms by cognition (i.e. thinking and willing them away) and behaviour (i.e. the correct training) and this is based on the idea or rather, the ideology of adaptation. Psychological symptoms are taken as the measure for diagnosis that must be reduced or eliminated, and are thus treated similarly to how one might transform unacceptable social conditions. Mental health treatment in this sense is broadly premised on getting the individual to buy into the 'need' to eliminate their symptoms and make the proper adaptation. This approach taken to its end point implies the mythological homologous citizen who is happy in his/her symptom-free existence.[7] Many readers will recall the Irish Times report of the latest Gallup global well-being survey, published earlier in April 2011 which claims that the Irish are "among the most fulfilled and optimistic in the world". Ireland came in 10th in this league table of nations, with 62 per cent of the 1,000 Irish people surveyed describing themselves as

[5] Scientific conclusions are based on a perception of reality as referring to a particular reality and particular objects in a straightforward unproblematic objectified way and this is based on the idea that nature contains laws and an order which exists independently of the researcher.

[6] The paradox of the scientific method is that in creating ever-more concepts and facts, it seeks to overwrite the abstraction and indefinateness of its own beginnings, i.e. science itself is not built on clear and sharply defined basic concepts.

[7] 'Normality' satisfies the socio-cultural domain and sometimes it even satisfies the subject.

thriving. Yet Ireland has the fourth highest rate of suicides amongst young men in the EU, behind Lithuania, Finland and Estonia.

To leave behind these statistics for now, let us turn to what is involved in the mental health clinician of today prescribing or teaching the patient to get better. The clinician must buy into the norm or 'ideal' that is mental health and support the idea that the patient's symptoms, suffering and disordered life should be eliminated. But what is this norm or ideal? It is based on an average, what the very statistical figures themselves appear to reveal. As J.-A. Miller recently noted, the normal has become the average and the pathological is the deviation in respect of the average.[8] We can describe this as the rise to power and the triumph of average values[9] in order to control symptoms and disorders. Let's look at Prozac, which as you know is prescribed in cases of depression. While Prozac does produce a chemical reaction that sometimes temporarily lifts an individual's mood, it cannot explain why some people suffer from depression and others don't.

In contrast to science, psychoanalysis takes into account the question of cause, which for each person is unconscious *and* it takes into account a person's relation to the cause which is characterised by alienation and separation. It stresses the importance for an individual of the impact of their confrontation with the real, with the tragic and inescapable consequences of his/her lived life and history. In operating in this way, psychoanalysis treats a person as a subject rather than as an object.[10]Thus, psychoanalysis approaches mental life and symptoms differently. It understands neurosis to be on one level a reaction of dissatisfaction against norms. As a clinic of the symptom, psychoanalysis recognises a symptom as both a refusal of norms, of averaging and conforming social ideals as well as a particular solution to the existential dilemmas and traumas of life. Symptoms express in disguised and highly individual ways the impossibilities of life. They are noisy nuisances that won't stay put, won't be told what to do and cannot be willed away and are messages that reflect not only human desire but also the conditions of life. So the idea of removing symptoms, so important to the field of medical science, is impossible from the perspective of psychoanalysis as

[8] J. A. Miller, 'The Era of the Man without Qualities' *Psychoanalytical Notebooks*, No. 16, 2007, p. 21.
[9] ibid. p. 23.
[10] This is not as easy a task as collecting and organising data but it is complicated by the fact that speech, the psychoanalytic instrument, is nuanced, riven and swollen with multiple meanings and when we speak, try as we might otherwise, our words are filled with ambiguity and a multiplicity of meaning. So when someone speaks to an analyst, the analyst does not take it for granted that what the patient says means only one thing but rather that it refers to a range of things at once. When we speak, we have already mediated between what we want to say, what we don't want to say, who we want to be, what is the truth and what is falsehood.

symptoms perform the crucial function of giving voice, is a peculiarly successful way, to what has not yet been said and beyond that, what is unspeakable for a patient.

To illustrate some of these points, let's turn briefly to the DSM IV Diagnostic Criteria for Depression, which beings a standardised approach to the treatment of depression[i] (see endnote below).The diagnostic criteria indicated are applied regardless of the causative factors present in a particular individual.[11]I'd like to draw your attention to Criteria 7. This is the presence of what is described as 'excessive or inappropriate guilt,' an idea that brings into focus the question of normal/average levels of guilt. You can't measure inappropriate until you have established what appropriate levels are. But psychoanalytically, guilt is understood as arising from giving up on one's desire, as being a crucial indicator that that the psyche is discontented. It is as impossible to give up on guilt as it is impossible to not desire. Its effects can be diminished and that can lead to great psychological relief, but we should bear in mind that the very idea of appropriate levels of guilt suggests appropriate kinds of human desire and that ought to cause us cause for concern. Moreover, depression is also understood psychoanalytically as arising as a conflict in respect of a total contradiction between reality and an ideal. To enforce an ideal in treatment is to eliminate the possibility of working with the ideal as a disposing factor in the illness.

When we speak out against the universal application of standardised treatments we give a dignity to human suffering as an expression of profound social and personal discontent, as well as an expression of hope for extraction out of overwhelming conflict and life-crises. The predominance of medical models in the treatment of mental ill-health closes off the space of the subject which psychoanalysis asserts inhabits another 'scene,' a scene structured like a language and approached via the act of speech. Far from being a place or time, the subject is already in our linguistic formations and psychoanalysis permits the subject to speak, it speaks ('*ça parle*').

The outcome of mental health's engagement with psychoanalysis is unknown and their engagement is not likely to go smoothly as psychoanalytic critique is akin to the resistance of the individual against the absolute supremacy of the collective, modelled on the principles of uniformity, invariance and reductionism. That being said, all movements begin with one

[11] Factors that can be as different as for example an incapacitating bereavement, the loss of the identificatory mark such as a job loss or an ambition fails to be realised, early stages of dementia, the experience of or the re-awakening of a trauma, the life cycle and aging process, the end of a love relationship and the experience of profound disappointment.

individual challenging the absolute might of the Other – think of the Tunisian self-immolator, Mohamed Bouazizi who ignited the Arab Spring revolutionary movement in December 2010, a movement still gaining momentum in the Spring of 2012. Regarding psychoanalysis, we stress thatit functions like a neurotic symptom in the field of science and mental health, bespeaking the malcontent of the human subject in the modern world. This means that psychoanalysis takes up a position that facilitates a critique of norms and ideals and their function in the psychological health of the subject. For the sake of the modern speaking subject, it is vital that psychoanalysis continues to be a noisy nuisance in the contemporary world and its scientific-dominant discourse.

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[i] **Criteria for Major Depressive Episode (DSM IV)**

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either
(1) depressed mood or
(2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruentdelusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
(4) Insomnia or Hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode (see p. 335).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.