Escaping the Stain of the Real: the Biopolitics of Trauma

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Mr. R. has been diagnosed at different times with schizoaffective disorder and PTSD and has been medicated with large amounts of psychotropic drugs for almost 20 years. His chart contains a list of his many hospitalizations, changes in medication, and suggestions that non-compliance has been a factor in his many readmissions. When I met him for an interview to teach psychiatry residents about psychoanalytic principles in treatment, I was greeted with a firm handshake and direct eye contact by a man who was pleased to have the opportunity to talk, which he said had been denied him because psychiatrists regarded his ideas as paranoid delusions he needed to relinquish. He explained that his treatment was focused upon helping him with "reality" and titrating his medications. While he realized that he sounded paranoid (this was indeed the case), he urgently wanted to convey what was truly bothering him, which he was able to do quite coherently.

In our time together, Mr. R. described escaping a brutalizing home situation in which he had been beaten and humiliated by older brothers and abused by an alcoholic father. As a young man he had enlisted in the military with the dream of becoming an elite Navy Seal, alluding to concerns that suggested a preoccupation with his manhood. After enlistment, he trained to qualify as a medic for the Seals. His goal was to fight in a combat unit, but also to help people. Unfortunately, a violent incident on his first mission abroad led to hospitalization and a series of orthopedic surgeries that dashed all his hopes. In a knife attack during a demonstration, major vessels in his leg were severed. As a result, he was reassigned to a menial job and eventually given a medical discharge. During the same year, he had been having trouble performing sexually with his fiancée, who was his first love. After learning of his attempt to have relations with another woman to prove his manhood, she broke off their engagement, which was another crushing blow. Mr. R's ensuing delusions revolved around the notion that all these setbacks were the fault of the Navy, which he believed was engaged in a cover-up by labelling him mentally ill. They thus appeared to represent rather obvious attempts to project blame and thereby compensate for an unbearable sense of failure and defeat that might otherwise have led to suicide. All the same, various events continued to stir intrusive memories of the incidents that had shattered his life, hence his diagnosis with PTSD. During our discussion, the residents were impressed with Mr. R. as a person with complex feelings and ideas, suffering from a set of traumas, who sought our help. Should some form of psychoanalytic listening be part of his treatment, I asked?

The Psychiatric Context

According to a report of the United States Surgeon General, about 60% of Americans with mental illness in the year 2000 received no specialty care at all from a psychiatrist or clinical psychologist . Of course, when troubled individuals do get help, it is unlikely that their treatment will be psychoanalytic or even psychoanalytically informed. Treatment is funded mainly for behavioral or pharmacologic approaches. Yet, apart from the economic factor, it is also the case that in recent years psychoanalysts have not shown much interest in applying their skills to severely ill patients. Since putting aside the grandiose hope of healing schizophrenia and psychotic depression, analysts seem to have succumbed to the DSM IV position that the major illnesses are essentially biological phenomena which psychoanalysis is not designed to treat. Psychoanalysis in the DSM framework seems to be indicated only for a decreasing proportion of patients, as the diagnostic blade separating "biological" from "psychological" disorders slices ever more deeply. In the case of trauma, neurobiological and behavioral models prevail, with the construction of the new medical category of PTSD. How are we to understand this phenomenon?

I will explore the hypothesis that the evacuation of psychoanalysis from the treatment of patients like Mr. R. bears witness to a transformation of the psychiatric subject, one in which a narrow focus upon biological dysfunctions has accompanied the gradual disappearance of the mental patient as a person from the social stage. Rather than representing a limit situation at the margin of self-experience for every human being , madness or mental illness has become the sign of a purely genetic or metabolic deficiency. Its ancient significance as a loss of links to the symbolic order, even, at the extreme, those of language and communication that we recognize as specifically human , has been replaced by a impersonal discourse of abnormal brain function. One effect of this narrowing conception is a diminished interest in the patient as a person. There is then the paradox that psychiatric treatment always and only addresses problems in human experience —i.e., feelings, language, and symbolic activity— which are to be corrected or changed by the medical intervention, while the current approach to psychic facts bypasses experience. The diagnostic interview, for example, which is already the beginning of treatment, becomes a mechanical gathering of facts, not the elicitation of subjective meanings.

Between 1955 and 1994, the population of public mental hospitals in the United States declined by approximately 500,000 people (Torrey, 1996). Many of these patients became homeless or inmates of the criminal justice system. The number of individuals per 100,000 incarcerated in jails and prisons in the United States rose to about 700 per 100,000 (Maguire and Pastore, 1997), giving the United States the world's highest incarceration rate (Human Rights Watch Project, 2003). In Canada the rate is 115 persons, in France about 90. Estimates of the prevalence of mental illness among prisoners range from 6 to 15%, making it likely that more severely ill patients reside in prisons than in all state and federal hospitals combined (Lamb and Weinberger, 1998), the majority of whom receive virtually no services (Ditton, 1999). Similarly,

about one third of the homeless population of the United States, or over 200,000 persons, is estimated to suffer from schizophrenia or manic-depressive disorders.

What this data suggests is an enormous social movement we might call “the great dispersal,” in which the mentally ill, freed from the system of psychiatric surveillance, have been consigned to the streets, to homeless shelters, to foster homes, or to prisons. Many explanations for this almost catastrophic neglect have been proposed, including the fragmentation of existing services and, especially, their for-profit nature, as well as federal and state budget deficits . Beyond these obvious causes, however, I wish to raise more fundamental questions about the biopolitics of neo-liberal societies that underlie the apparent lack of concern for the psychiatric patient and the disinterest in psychoanalytic approaches to suffering.

In his 1979 lectures on “The Birth of Biopolitics," Michel Foucault linked biopolitics to the rise of neo-liberalism, which he saw as an ideology that ultimately subjugates all aspects of the “social sphere” to the economic domain. Through the ideological notion of self-care, he tried to show how behavioral and health norms become intertwined as part of the individual’s responsibility to society. Psychiatric diagnosis, in his analysis, is an instrument for imposing certain standards of performance upon the individual. Medical science has almost unchallenged authority in the contemporary world, continuously enlarging the domain in which “scientifically” validated conditions become disorders requiring treatment-- hence the ever greater number of new conditions like eating disorders, PTSD, and social phobia that previously were considered variations of normal life. Medicalization has two sides: on the one hand it offers help for formerly untreated forms of suffering, but on the other it tends to define human problems in biological terms, a move tantamount to replacing social/structural problems (norms of sociability, body shape, occurrence of traumatic events) with an expanded conception of illness.

The Italian philosopher Giorgio Agemben (1995) has expanded Foucault’s conception by pointing to an erosion of the classic Greek distinction, set forth in Aristotle’s Politics, between zoë— “pure life” belonging to every living being— and bios— a meaningful or good life realized in the polis. The sphere of private life, he argues, the home, has become increasingly incorporated into the political realm, which now regulates basic human needs. Sovereign power, in Agemben’s interpretation, has become ever more linked to the implementation of a bio-politics that regulates private health practices of citizens. At the same time, the neo-liberal state defines effective categories of citizenship, which determine whose needs deserve to benefit from its policies. The elaboration of these distinctions has given new meaning to an ancient category of unprotected human beings that Agemben calls «bare life,» that is, those for whom inhumane treatment can be justified as a legal exception.

By way of example, Agemben cites a German treatise of 1920 on euthanasia by Karl Binding and Alfred Hoche (1996, pp. 136-143) outlined a new political category: «life unworthy of being lived.» The authors wrote:

« In imagining a battlefield littered with healthy young bodies or a mine catastrophe that has killed hundreds of industrious workers and, at the same time, picturing our institutes for the mentally impaired and the treatments they lavish on their patients, one cannot help being

shaken by the sinister contrast between the sacrifice of the dearest human good and, on the other hand, the enormous care for existences that not only are devoid of value but even ought to be valued negatively (p. 138). »

In historical context, of course, this proto-Nazi analysis seems abhorrent, but its disparaging attitude towards expenditure of resources on severely impaired patients in favor of a more highly valued social object has been a persistent thread in political discourse. We might even link it to the political backlash of the past two decades, which have seen declining care provided to the sickest members of the community.

According to the neo-liberal political vision which has increasingly informed American polity, protecting one's health is a personal decision. Within this public posture, techniques for care of the self have been promulgated which reflect biosocial norms for health. The definition of a worthy life becomes a person who assumes these new requirements for bios deriving from the advances of the scientific research establishment in its close relationship with economic interests— really, a fusion of zoë bios. Those who fail to do so fall into categories of non-compliance (Green, 2004), personality disorders, or the "otherness" of problem populations— less worthy lives. Research in psychiatry, of course, is not exclusively determined by problems in treating illness or supporting health but importantly by marketing concerns of pharmaceutical companies. The biomedicalization of madness, in Foucault's terms, represents a confluence of scientific, political, and economic interests. To be alive (zoë) and to have a good life (bios) merge in a normative, medicalized life.

The US policy of supporting the private sector in health care is an obvious reminder of the current biopolitical ideology, privileging economic considerations over public welfare (see Navarro, Lancet, 2002). Still, it is difficult to understand why the presence of 45 million fellow citizens forced to live without health insurance or access to mental health care does not seem to weigh heavily upon the American conscience. What underlying presumptions support this situation? Given the many analyses demonstrating that major reform of our health care system to provide universal coverage would be less expensive than the current patchwork arrangements, it seems inescapable that debates about mental health budgets in particular represent an avoidance of more fundamental issues involving the premises and values of a dominant system of thought in the United States. What we are confronted with in psychiatry is a double movement of exclusion and of medicalization, a movement reducing suffering to a biological diathesis and leading to the exclusion of the category of unworthy persons.

A Short History of the Psychiatric Subject

The phrase « systems of thought » was proposed by Michel Foucault as the focus for his course on psychiatric power at the Collège de France, 1973-74. In his earlier treatise on madness, Foucault had referred to « the great exclusion » of the 17th century when the insane were banished from the public space, to be eventually housed in state institutions under an ever-expanding system of social control. At the beginning of the 19th century, these institutions

adopted a method of moral treatment in which patients were placed in an environment under medical control, a set-up had nothing to do with medicine as it was then evolving, in which a search for causes of illness dictated the treatment. Moral treatment, however, also emphasized the reintegration of the disturbed patient into his community, as if to recapture a fellow soul at risk of being lost to madness (Caplan, 1969). In this respect, psychiatric exclusion in a specialized institution was intended as a step towards a re-inclusion, an acknowledgement that disturbed patients were human beings like ourselves.

We know that in the United States the moral treatment movement gave way to a more prison-like system in the late 19th and 20th centuries in response to the waves of foreign, mainly Southern European immigrants, who were unlike previous citizens (Caplan, 1969). Various eugenic and racist theories were prevalent, marking these new patient groups as exceptions subject to extreme injustices, including forced experimentation, confinement without recourse, sterilization, exploitation, and life-threatening treatments (see Whitaker, 2002). The huge human warehouses were often presented as alternative societies in which patients worked the fields and managed the various everyday institutional functions, but this façade disguised deplorable conditions within. Already by the 1930's, a physician hired by the American Medical Association concluded, in anticipation of Foucault, that the primary purpose of these institutions was not medical but legal, to confine persons unwanted by society (Whitaker, p. 70).

The cultural changes of the 1960's ultimately swept away these large hospitals, perhaps in part because of the newly discovered drugs that controlled behavior; perhaps even more because of new laws providing social security income to disabled psychiatric patients and other incentives to house the newly discharged; and, finally, because of a genuinely reformist spirit. The anti-authoritarian animus of the period saw the state hospitals as psychiatric prisons and resented the near-absolute power of their psychiatrist administrators. The concept of mental illness itself came under attack, while the authority of physicians to hospitalize and treat involuntary patients, relabeled as clients, was greatly restricted by the courts. Community boards began to oversee hospitals, and non-medical clinicians gained influence over their operation. Meanwhile, the passage of legislation authorizing community mental health centers promoted rapid release of patients and provision of services to enable them to function in society. Many psychoanalysts were active in this movement, which appeared to be a humanistic revival of moral psychiatry (Caplan, 1969, ch. 39.

At the same time, the great popular interest in mental disorders, indicated by films such as One Flew Over the Cookoo's Nest, sparked criticism of the socially conservative psychiatric and psychoanalytic establishments. Ivan Illich's book, Medical Nemesis, (1975) spoke of the medicalization of all aspects of life and an inflated illusion of medical effectiveness. The voices of the mentally ill themselves through the poets Robert Lowell, Sylvia Plath, Anne Sexton, and others could now be heard, while the academic success of Foucault's work, the surprising best sellers by Carlos Castaneda about the mystical shaman, Don Juan, and R.D. Laing's influential writings on schizophrenia stimulated interest in alternative treatments. Meanwhile, the omnipresence of psychedelic drug experimentation, which seemed to idealize madness, made the already fuzzy boundary between normality and illness yet more obscure.

The community mental health movement met a tremendous popular need, but it declined for a number of reasons, of which the polarization of approaches exemplified by anti-psychiatry and the growing conservatism of American politics were significant. Perhaps in response to the very real limitations of the psychoanalytic-social model of treatment, psychiatrists turned to research science, which was producing new medications promising to eliminate primitive practices of restraint, dangerous treatments like insulin coma and psychosurgery, and unhealthy hospital conditions. These medications, initially presented by their inventors in France as inhibiting brain function so as to render patients more docile and accessible, soon became incorrectly described as « anti-psychotic » drugs, although research did not suggest anything specific about them related to the underlying disorders. The optimistic metaphor that neuroleptic drugs could correct a chemical imbalance encouraged high hopes for speedy reintegration of patients into society and soon developed a life of its own. The ideologies of both anti-psychiatry and the new biopolitics of mental health converged in the accusation that psychiatrists were overtreating patients, especially with costly psychosocial therapies. Meanwhile, pharmaceutical companies were active in creating a public impression of the specificity of their drugs to correct the so-called imbalances. As late as 1996, newspaper advertisements by drug companies argued that schizophrenia can result when the brain has abnormal dopamine levels. (Whitaker, p. 199).

Unfortunately, studies of neuroleptic drugs not only failed to confirm this erroneous assertion, but suggested a worsening of outcome under the high dosage regimens then utilized in American hospitals. The World Health Organization conducted a number of investigations of outcomes of a standardized diagnosis of schizophrenia in third world and developed countries and found that, without exception, patients in the underdeveloped countries had a better prognosis (Jablensky, 1992; Kulhara, 1994). A plausible explanation was that care in the third world involved more group and family participation and less medication. This strategy, which was found to be successful in studies of model programs in the United States (Mosher, 1995), was not supported by the health care establishment, in part because of the enormous marketing campaign by pharmaceutical companies. Certainly, the publicity that trumpeted the efficacy of drugs towards the end of the 1980's contributed to the unrealistic government planning that has led in the current lack of adequate public mental health care. Meanwhile, in response to economic pressures, private insurers began to contract management of psychiatric services to for-profit corporations, an arrangement which has been cited as an important factor in limiting access to treatment. By now, patients like Mr. R. are fortunate to be able to see a psychiatrist for their medications on a monthly basis, while coverage for "psychosocial" therapies has been reduced to brief supportive help by less trained personnel.

The New Psychiatric Subject

My purpose in presenting this brief history is not to contest the benefits of a rational use of medications nor even the merits of "managed" care, but to underline the transformation of psychiatric treatment in America over the past 50 years from what began as a radical, humanistic concern for afflictions potentially affecting every person to a system of

psychopharmacologic management. The role of the psychiatrist has narrowed, not because we now know the causes of schizophrenia or PTSD, which seem in all likelihood to be the product of multiple factors, but because of a shift in ideology. The current implication that the fundamental issues in mental illness are ones of chemistry in the brain follows a series of developments in biopolitics which tend to consider human persons as essentially somatic entities.

This transformation of the psychiatric subject seems close to placing the mentally ill into the category of defective persons— perhaps persons whose lives are not worth living. It reflects a system of thought in opposition to the traditional view of mental illness as a loss of reason, a process of inflamed emotions and imagination, which represents an existential possibility for every human being. In its modern version, this position regards psychiatric disorders as the outcome of a complex interplay between biological propensity, individual psychology, and social environment, and, conversely, posits « normal health » as a fragile achievement, responding to a number of crucial variables. As an example of this polyfactorial view of illness, I need only mention PTSD, which needs to be addressed on many levels apart from administration of a psychotropic drug.

By contrast, a system which medicalizes the self transforms emotional suffering into an effect of transient chemical imbalances correctable by medications (e.g. the prevalence of articles warning people about depressive and anxiety disorders, often including self-rating scales that suggest a need to medicate). Likewise, psychotic disorders are increasingly seen as stigmata of defects in the brain analogous to neurological illnesses, although traumatic histories are regularly present in a high proportion of patients. Perhaps the epitome of this ideology was enunciated by a prominent psychiatric researcher, who wrote, “When we reach this point, we are able to begin to hope that we can truly prevent illness by utilizing a medication or measures of public health which will arrest or eliminate the lesional process” . While conveying the concern of the author for the ravages of schizophrenia, this statement about unnamed public health measures seems to confirm Agemben’s worst biopolitical fears. It raises the spectre of eugenic practices or other forms of social engineering that reduce illness to a “lesional process” in the brain. What is omitted is recognition that mental disorder, independent of its pathophysiology, has personal and social determinants, reflecting the difficulties inherent in sustaining a bios of meaningful human life, as we heard in the voice of Mr. R..

Man’s fate, Freud said, grows out of his evolutionary heritage, which pulls against the demands of the civilized ego. Unsatisfied hungers and desires, failures of early nurture, and the inevitability of solitude, pain, and loss well up from the basic sources of existence to destabilize or to break the most vulnerable. In this sense, what we call mental illness is a reminder of the brute reality that lies beneath the idealized visions of prevailing systems of thought. Psychoanalysis is founded upon the traumatic split between zoë— pure biological life— and the speaking subject, who must make meaning out of the raw material of the real.

For Agemben, this split between the symbolic and the real can be stated as the tension between language and speech. Agamben elaborates upon Benveniste’s distinction between the semantic and semiotic, in which the semantic refers to how personal meaning can be communicated by

one subject to another, while the semiotic describes a system of signs with fixed reference. Signs are recognized; meaning must be understood. “It is not language in general that marks out the human from other living beings,” he quotes (p. 51), but the split between sign systems and discourse. Psychiatric patients are not simply semiotic creatures who exhibit signs of biological dysfunctions (in their symptoms for example), but also human subjects who attempt to communicate their own particular suffering. Mr. R.’s desire to be heard illustrates this constitutive human desire to symbolize experience, “to write a text that has never before been written,” a text unique to that single person. While accepting that the non-subjective “real”— the semiotics of zoë at the limit— must have quantitative aspects, perhaps readable by medical science as Freud hoped, psychoanalysis in the post-modern era has built upon other strands of his thought, replacing his scientific project with the conception of a subject who cannot be defined by objectifying technologies. Science involves the certitude that signs will persist or vary systematically under different conditions, regardless of the individual case, while speech is by nature unpredictable.

Lacan spoke of the register of the “real” as the ineradicable presence of what is unassimilable to discourse , and this became his definition of trauma. When private experience cannot be symbolized, he hypothesized, it threatens to collapse bios into zoë, the play of impersonal, desubjectifying forces that produce the familiar symptoms of illness. From this perspective, Mr. R.’s problem cannot be totally circumscribed by medical language as a disease entity but represents a traumatic disruption of his subjective experience. If mental illness could be identified wholly as a system of signs, like a flu infection, it could be read and treated by anyone knowing that semiotic language. It would be universal and recognizable in everyone who suffered from it, not specific to the person and requiring semantic understanding. On the other hand, to the extent that the phenomenon of mental illness exceeds its semiotics, it undermines the biopolitical notion of a somatic self.

Current ideology suggests that “problems in living” (psychic suffering not yet defined as illness) can be dealt with by assertions of religious faith, « stress reduction” techniques, or routine use of psychotropic drugs. The religious dimension paradoxically validates the somatization of the subject by reinstating the theological assumption of “natural man,” man as a part of nature without a gap between bios and zoë. In this system of thought, madness is assigned to the excluded category of damaged life, since it can only be managed and controlled, not treated or corrected by medicine. It is a step leading to the gradual disappearance of the mental patient as a person. At a certain point, patients like Mr. R. merely provide clinicians another occasion to discuss the latest advances in psychopharmacology.

Psychoanalysis, through its close historical association with madness, is a painful reminder of the “real” of human desire that decenters the idealized self, points to an irrational unconscious that disrupts adaptation and the economic logic of the marketplace, and refutes the assumption that human needs can be satisfied in a liberal society. Unlike DSM IV, which treats mental illness as an object definable by scientific authority, psychoanalysis sees the ineradicable gap between the person and any possible objectification. In this regard, Benveniste observed that a list of concepts clothed in linguistic form (as signs) can never become a message, can never by

themselves tell one human being what another wants to communicate to him. Psychoanalysis understands that the speaking subject is characterized by an indeterminacy involving a drift of meaning, a polysemous quality, and a plurality of possible punctuations and contexts of interpretation, unassimilable to a formal scientific discourse. Its claim to authority does not rest on replicable (quantifiable) science, but on close attention to the speaking patient. It asserts, moreover, that the truth value of modern psychiatry conceals an ideology that inevitably excludes many aspects of reality holding great personal significance. Agemben restates the principle that, by contrast, important human knowledge is gained through suffering and the laborious work of its translation into speech. The apriori knowledge of psychiatry can only take us so far in understanding Mr. R.. To advance further, we must begin to listen to him.

In the end, we cannot fully know what made Mr. R. ill, why his traumatic accident and sexual failure on top of earlier traumas evolved into a delusional state, any more than we can be certain why any victimized person becomes a clinical case rather than merely a human survivor. He seems to be a casualty of a number of social processes that worked against him, but we know that his personal truth, earned through suffering, can only be approached through dialogue with a receptive other person. Many kinds of intervention might be helpful to Mr. R., but only psychoanalysis tells us to listen to his voice, if only the analysts are there to hear it.