THE STATE OF DEPRESSION:

THE PSYCHOANALYSIS OF HANNAH ARENDT

by

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Abstract

In this thesis I propose that depression is totalitarian in nature. That is, depression appears to utilize the same tactics adopted by the totalitarian to situate itself as supreme ruler of, in this case, the psyche, rather than the nation state. Before beginning the inquiry into totalitarianism there first must be an examination of the clinical side of mental illness with discussion focused on the creation of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM).* This text is considered by many as the ultimate authority on mental disorders, with its contents viewed as a kind of religious scripture in the sense of being the authority on mental illness. The *DSM* will provide a framework for a commonly held understanding of the elements of the depressive state as a jumping off point; however, the project will examine the creation of the *DSM* and, more significantly, the challenges facing the text. This critical discussion reveals the limitations in the manual's ability to offer a holistic, substantial definition of depression. Despite acknowledged limitations, diagnosis of depression as described within the *DSM* still continues to exert a problematic authority. How can one better account for states of being where the psyche is occupied, propagandized, isolated, and rendered helpless to act in its own best interest? The symptomatological definition of depression within the *DSM* is in part what prompted this meditation on melancholia; it was made possible, was indeed inspired, by the work of Hannah Arendt, author of *The Origins of Totalitarianism*, perhaps the most definitive book on totalitarianism. Unlike Plato, Aristotle, Thomas Hobbes, among many others made a connection between a strong state and a strong mind, this thesis I seek to apply Arendt's work on totalitarianism as it applies to mental illness, specifically depression. Both depression and totalitarianism are entities or states based on control and oppression. In order to discuss this further, I will include in addition to the work of Arendt as a primary source, the commentary of Elisabeth Young-Bruehl on Arendt's *The Origins of Totalitarianism.* The conclusive findings are that depression and totalitarianism are alike in their tactics and in their pursuit of complete control such that activities, free movement, the pursuit of interests are not under the direction of the oppressed person and, in fact, where depression is the totalitarian, neither are thoughts.

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Introduction

I came to know of depression through the *Diagnostic and Statistical Manual of Mental Disorders.* I remember before looking it up I took the time to make sure I was alone because I thought I was doing something wrong. At the time, depression had a very strong stigma still surrounding it and I did not want my parents to find out that I had been researching depression. Being young and not fully grasping how the *DSM* was meant to be utilized, I read through the symptoms and determined that all of the symptoms were applicable to me and that I very clearly had a diagnosable mental disorder. Whether or not I actually had depression is of little consequence because after I diagnosed myself with depression there was not a power on earth that could convince me otherwise. Looking back, it's possible the difficulties in my life that followed my self-diagnosis could have been avoided had I read the introduction of the *DSM* which clearly states that its use is only for trained clinicians and researchers. However, since then I have had a fascination with the *DSM* and its power to define healthy and unhealthy minds. This thesis is in part an exploration into the *DSM* as it exists as a centre of power within the mental health profession and the problems and limitations that are associated with such power. The conception of the *DSM* is rooted in good intentions. The American Psychiatric Association (APA) sought to create a text that would help unify American psychiatrists under a single lexicon. However, since its humble origins it has created a dynasty that expands far beyond the capabilities of a single text. The first chapter of this thesis is focused on the *DSM* because of its

presumed authority to define the psyche and its treatment. The section is concerned with the history of the manual and outlines the various problems that occurred throughout its many iterations, problems that were passed down the line to be resolved or neglected by the next generation of editors and contributors. The next section of this chapter centres around the potential demise of the *DSM*, as some psychiatrists and industry insiders believe will occur, if the APA does not substantially change the manual. There is an acknowledgment by these specialists that nothing within the *DSM* makes it the supreme authority on mental illness. There are many mental disorder handbooks and the *DSM* does not offer anything more foundational than any other manual. Following this section which centers around the problems of the *DSM*, there is a brief discussion about the difficulty in diagnosing depression as it is an elusive illness to describe accurately and definitively when it comes to all those who experience it. This chapter ends with a section devoted to the problems of pharmaceutical use in the treatment of depression, a disorder of the psyche that biochemical solutions fall short of addressing, as well as the suspect partnership between the APA and the *DSM*. Without an acknowledgement of the state of oppression in which a sufferer languishes in the diagnosis and treatment of depression, outcomes fall far short of ideal.

In an attempt to recontextualize depression into new terms it is important to first discuss the context from which these terms come. This is why in the second chapter of this thesis there is a departure from what comes before. Instead of offering a discourse into the problems of the

psychiatric industry, the project pivots into the political realm. The *DSM* shortcomings require such a recontextualization and a reconsideration of depression as more than the sum of its biochemical parts. Chapter two is focused on Hannah Arendt's definition of totalitarianism because it provides a provocative and effective framework for understanding the intrinsically oppressive, controlling nature of depression, where 'control' is defined as domination so that a sufferer may not exert their will to move or think as their own agent. The chapter begins with a brief overview of the three main sections of *The Origins of Totalitarianism*: antisemitism, imperialism, and totalitarianism. Following this there is an exploration into the four main elements of Arendt's totalitarianism as discussed by Elisabeth Young-Bruehl. While examining Young-Bruehl's text there is a brief interlude away from *The Origins of Totalitarianism* to discuss another one of Arendt's texts, *Eichmann in Jerusalem.* This text is critical to an understanding of the banality of oppression, not constituted in active, pitchfork and horns evil, but in blank, unblinking bureaucracy. Arendt offers an exploration into evil as it is embodied by Adolf Eichmann, referred to by some as the architect of the holocaust. Despite this title and the countless deaths on his hands, Eichmann is described as an unassuming thoughtless individual who, at least on the surface, did not personify evil. Eichmann was a suit, who went to work every day and filled out forms. As such, he serves as a startling and compelling example of the everydayness of oppression and control, an inescapable cog in an irresistible machine and this fundamental inescapability is how the state of oppression exerts much of its control on the psyche. Following the discussion of Eichmann, the final section of the chapter takes a closer look

into two totalitarian tactics that heavily relate to the recontextualized definition of depression. These are the techniques of propaganda and scapegoating used for totalitarian power.

The third and final chapter synthesizes the two previous. Critical analysis of the clinical definition of depression and its biochemical treatment shows the limits of such approaches. A new framework is needed. My final chapter moves toward a new paradigm for understanding melancholy. I begin with a brief review of the four main elements of totalitarianism, followed by a symptomatography of major depressive disorder according to the *DSM-5*. I follow with four sections on the four elements of totalitarianism as they align with a different aspect of depression. I begin with the ideology of depression, move through the terror tactics of depression, and then follow with an analysis of the destruction of relationships, and finally the bureaucracy of depression. Depression controls the thoughts of an individual; they may even conceive the oppressive force as inescapable. In the depressed person, thoughts are filtered, actions are circumscribed by the negative repetitive internal dialogue, and family and friends are cast as untrustworthy and therefore incapable of encouraging a healthy, alternative counternarrative. The description of depression as totalitarian helps us to understand depression's control over the individual.

I come from a generation of illness. Depression and anxiety are so commonplace especially among the young that it feels as though not suffering with depression or anxiety is irregular. Being atypical is now typical. This thesis is an attempt to grapple with an alarming

trend that is seeing an increase in those suffering with depression without an adequate idea of what is truly occurring within the psyche. I do not suggest that the definition in this thesis is the only correct one, or even that it is applicable to all those who suffer. Rather, this examination of a new framework for understanding the total control and oppression of the illness is proposed in the hope of bringing those hidden power dynamics to light. The ultimate hope is to expose the totalitarian behind the curtain.

Chapter One: Psychiatric Paradigm of Mental Disorders

A new framework is required for understanding depression. Considering depression to be similar to totalitarianism, control and oppression are critical. What follows is a brief overview of the history of *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), its development, and both its usefulness and its limitations as a tool for understanding and treating depression. The purpose of the overview is to provide context and background for a consideration of depression. The *DSM* is a point of departure, from which the focus shifts toward a more nuanced understanding provoked by the lived experience of depression in the context of political philosophy.

I analyze four issues in this consideration of the *DSM* in its various iterations and in its ability to define depression as an illness for which the American Psychiatric Association (APA) recommends biochemical treatments that turn out to be extremely problematic. First, I'll examine the problems inherent in biochemical therapies for a disorder of the psyche, therapies not based on laboratory measures, that reveal a host of inadequacies in the understanding and treatment of depression. Secondly, issues around consensus in defining symptoms of depression, symptoms that read almost like a shopping list and that are agreed upon by, in some cases, a vote and in other cases, a perusal of various texts, present their own host of limitations. Thirdly, the problem of a dodgy partnership between the pharmaceutical industry and the APA provokes a degree of

skepticism that diagnosis and biochemical treatment are not tainted. Finally, the *DSM* has retained much of its authority, despite the loud voices of expert critics who have been sometime supporters and researchers and whose work has in the past reinforced treatment protocols, but who now strongly speak against their own work. This review of the *DSM*, its limitations and its critics, is a first step in attempting to address depression.

We need a new structure for understanding depression if we are to undermine depression's oppression and control instead of only describing shopping list peripheries – irritability, sleeplessness, agitation, etc. – that do not get at the heart of the matter.

DSM contains within its pages symptoms that are meant to assist in the diagnosis of mental disorders. It has been colloquially termed the psychiatrist's bible (Davies 8). The *DSM*, first written in 1952, attempted to unify the psychiatric industry with a common language. Prior to the 1950's psychiatrists did not share a common understanding of mental disorders and treatments, operating rather as atomistic agents (Davies 9). The *DSM* was expected to be the standard for all practicing psychiatrists in the USA who were members of the American Psychiatric Association (APA). As James Davies writes in his book *Cracked: Why Psychiatry is Doing More Harm Than Good*,

> Once the first *DSM* arrived in the 1950s, psychiatrists were expected to use the dictionary in the same standardized way still in operation today. For instance, if you go and visit a psychiatrist tomorrow because you're feeling down, the psychiatrist will ask you to describe your symptoms. The purpose of this is to try to work out from your symptoms what diagnosis from the dictionary you should be assigned. (Davies 9-10)

Since the creation of the first *DSM*, there have been four revisions; currently it is in its fifth iteration, the *DSM-V* (or *DSM*-5). The most significant revisions were evident in the publication of the *DSM-III*. Davies writes,

> Under the leadership of the American Psychiatric Association (APA), the profession in the 1970s plumped for a radical solution. It decided to tear up the existing edition of the *DSM* (then called *DSM-II*) and start again. The bold idea was to write an entirely new manual that would solve all the problems beleaguering *DSM-II*. This new manual would be called *DSM-III*, and its central aim would be to improve the reliability of psychiatric diagnosis and thereby answer the mounting criticisms that were threatening to shatter the profession's legitimacy. (Davies 12)

The supposed problems of the *DSM-II* include the open-ended nature of the manual. Dr. Robert Spitzer of Columbia University reported that the *DSM-II* was much too vague; as an example, the diagnostic criteria for 'depressive neurosis' was only a single sentence long (Davies 15). In order to accomplish this rewrite, the APA hired Spitzer out of Columbia's medical school. He assembled a team of fifteen psychiatrists to assist with the completion of the *DSM-III* (Davies 13). Spitzer's appointment to lead the team responsible for rewriting the *DSM* placed him in a position of great influence within the psychiatric world (Davies 12). This power prompted James Davies to meet with Spitzer long after his retirement to discuss the creation of the *DSM-III*. In this meeting, Davies pressed Spitzer on the methodology of the inclusion of mental disorders, specifically, matters pertaining to the connection between a mental disorder and the biological indicators of that illness. For an illness of the body, there are biological indicators and tests to find these indicators. Urinalysis, blood testing, electrocardiograms, electroencephalography, these are all tools used by physicians to test for irregularities in the body. They are biological

tests that use biological indicators to diagnose illness. One might assume that there are biological indicators for mental illness. However, as Spitzer clarifies, this is not the case. Davies expands,

> 'So presumably', I asked, 'these disorders had been discovered in a biological sense? That's why they were included, right?'
>
> 'No – not at all', Spitzer said matter-of-factly. 'There are only a handful of mental disorders in the *DSM* known to have a clear biological cause. These are known as the organic disorders [things like epilepsy, Alzheimer's and Huntington's disease]. These are few and far between.'
>
> 'So, let me get this clear', I pressed, 'there are no discovered biological causes for many of the remaining mental disorders in the *DSM*?'
>
> 'It's not for many, it's for any! No biological markers have been identified. (Davies 22)

The significance of this admission is breathtaking. There are no biological markers that signify mental disorders, as acknowledged within the pages of the *DSM* itself. This is a critical limitation of the *DSM* and a critical issue in the treatment of depression. The introduction of the *DSM-IV-TR* states,

> Although this volume is titled the *Diagnostic and Statistical Manual of Mental Disorders*, the term mental disorder unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders. The problem raised by the term 'mental' disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of *DSM-IV* because we have not found an appropriate substitute. (*DSM*-IV-TR xxx).

There is an implication that the mind and the body are distinct. The authors acknowledge that this is unfortunate, but beyond that, do not grapple with the issue long before dismissing it. The mind/body problem is a complex one, perhaps so very complex that it goes beyond the capabilities of the APA to address. Nevertheless, the mysteries of interconnection did not limit

the diagnosis of depression or even open a path for consideration of the ways the depressed mind might circumscribe the body it governs.

The questions raised by Davies and Spitzer remain. How is it that mental disorders are treated as though they are biological disorders? This question is one that psychiatrist David Healy tackles in his book *The Antidepressant Era* which explores the history of psychopharmacology. He writes,

> During the 1970s the major psychiatric disorders became defined as disorders of single neurotransmitter systems and their receptors, with depression being a catecholamine disorder, anxiety a SHT disorder, dementia a cholinergic disorder, and schizophrenia a dopamine disorder. The evidence to support any of these proposals was never there, but this language powerfully supported psychiatry's transition from a discipline that understood itself in dimensional terms to one that concerned itself with categorical ones. This legitimized the rise of biological psychiatry, which in turn fostered a neo-Kraepelinian approach to diagnosis and classification, as embodied in *DSM-III*.
>
> (Healy 163)

Healy points out a crucial problem with psychiatry as it is practiced today, regarding the theory that mental disorders are disorders of neurotransmitters, namely, that this theory is not based on evidence but on an assumed legitimacy. This assumed legitimacy opens the way for mental disorders to be addressed with pharmaceuticals. It is interesting that between the first iteration of the *DSM* and the most recent there is not now a more neurological influence on the text despite the fact that the *DSM* is used to diagnose for the purposes of prescribing medication that changes brain chemistry. According to Healy, there is no evidence to prove that mental illness is chemical imbalance in the head. And let us remember, according to the *DSM,* no biological indicators are used to diagnose.

More startling revelations occurred during Spitzer's conversation with Davies, as Spitzer goes on to admit that mental disorders were not included in or removed from the *DSM* based on research, but rather on consensus:

> 'I guess our general principle', answered Spitzer candidly, 'was that if a large enough number of clinicians felt that a diagnostic concept was important in their work, then we were likely to add it as a new category. That was essentially it. It became a question of how much consensus there was to recognize and include a particular disorder.'
>
> 'So it was agreement that determined what went into the *DSM'*?
>
> 'That was essentially how it went – right.' (Davies 24)

The problem underscored by Davies is that regardless of the fact that there may be clinical or scientific bases for the disorders within the *DSM*, Spitzer suggests that the system which led to the inclusion or exclusion of certain mental disorders was not a scientific system, but a democratic editorial one. Thus, we see the head of the taskforce in charge of producing the third revision of the *DSM* admit that agreement, not science, ruled the construction of the text. One might expect that, if the goal for the *DSM-III* was to reinvent the manual and completely start from scratch, it would require more than a pool of experts trained with the *DSM-II* voting on what ought to go into the next edition of the text.

Obviously, in the scientific process, democracy plays a role in the legitimation of theory. However, Davies is critical of the idea of a group of APA certified practitioners and researchers verifying the legitimacy of an APA text. It is worth noting that in the *DSM-IV-TR's* introduction, under the sub-heading "The *DSM-IV* Revision Process", it explains the process for the inclusion and exclusion of mental disorders is a process that includes literature review, data reanalysis, and

field trials to test the legitimacy of the previous iteration *(DSM-IV-TR* xxvi-xxvii). Such a process would provide some reassurance about grounds for consensus. However, during the conversation between Davies and Spitzer, when Davies probes deeper about the research and field testing that went into the creation of the *DSM-III,* he presents a quotation from Theodore Millon, a member of the taskforce. Regarding the *DSM's* construction, Millon states,

> There was very little systematic research, and much of the research that existed was really a hodgepodge – scattered, inconsistent, and ambiguous. I think the majority of us recognized that the amount of good, solid science upon which we were making our decisions was pretty modest.

This prompts a general agreement from Spitzer,

> Well, it's true that for many of the disorders that were added, there wasn't a tremendous amount of research, and certainly there wasn't research on the particular way that we defined these disorders. In the case of Millon's quote, I think he is mainly referring to the personality disorders … But again, it is certainly true that the amount of research validating data on most psychiatric disorders is very limited indeed. (Davies 29)

According to Spitzer, in the case of the third revision of the *DSM,* the research done was at the very least 'limited.'

Admittedly, one could argue that the *DSM-III* was published over forty years ago and has been adequately superseded, given the statement made in the introduction of the *DSM-IV-TR* that the inclusion of mental disorders was based on independent research made by the taskforce in charge of producing *DSM-IV.* However, after interviewing Spitzer, James Davies spoke with Spitzer's replacement on the taskforce. Allen Frances was appointed to the head of the taskforce to produce the fourth *DSM.* In 2012, while the *DSM-IV* was still the most current edition, Davies

interviewed Frances to determine if the fourth iteration of the text verified the research of the previous edition. Frances stated,

> If we were going to either add new diagnoses or eliminate existing ones, there had to be substantial scientific evidence to support that decision. And there simply wasn't. So by following our own conservative rules we couldn't reduce the system any more than we could increase it. Now, you could argue that is a questionable approach, but we felt it was important to stabilise the system and not make arbitrary decisions in either direction. (…) we knew that most decisions that came before were arbitrary. I had been involved in DSM-III. I understood their limitations probably more than most people did. But the most important value at that time was to stabilise the system, not change it arbitrarily. (Davies 51)

Frances and his taskforce limited the amount of research that went into the previous inclusions of the *DSM* in an attempt to avoid bringing about too much radical change. Frances clearly thought it was a better choice to keep things as they were, "to stabilise the system" rather than cause too much change. The problem with this is clear: diagnosis of depression, for example, met the requirements of a status quo that focused only on symptomatography with no insight into the overarching system of control that depression exerts on a sufferer.

The *DSM-IV* did include three new disorders that would reveal in stark terms the problematic relationship between the APA and the pharmaceutical industry, an industry already involved in treatments for depression. Frances responds to Davies' questions about the inclusion what Frances termed the 'three false epidemics in psychiatry' (Davies 48). The *DSM-IV* included Asperger's, Attention Deficit Hyperactive Disorder (ADHD), and Bipolar II (Davies 48). Frances uses the term 'epidemic' to describe the inclusion of these disorders because of the notable increase in their diagnosis:

> we now have a rate of autism that is twenty times what it was fifteen years ago. By adding bipolar II we also doubled the ratio of bipolar versus unipolar depression, and that's resulted in lots more use of antipsychotic and mood stabiliser drugs. We also have rates of ADHD that have tripled, partly because new drug treatments were released that were aggressively marketed. (Davies 48)

In fifteen years, ADHD rates tripled, bipolar rates doubled, and rates of autism increased twenty-fold. One could argue that with the inclusion of these new mental disorders there came a new system for identifying illness, hence the increase in diagnosis. Alternatively, as is suggested, the introduction of these disorders tapped a new market for the pharmaceutical industry. As Frances reveals, it was the marketing of pharmaceuticals that contributed to the increase in diagnosis. When Davies probed Allen further, inquiring whether or not the *DSM* was being used for the purposes of getting people to take pharmaceuticals, Allen confirmed that this was the case (Davies 49).

While the revelation that Davies uncovered regarding the connection between the *DSM* and the pharmaceutical industry seems shocking, it also comes with it a certain level of obviousness. Diagnosis and treatment rely on one another. If an individual is diagnosed with a disorder of any kind, what follows are treatment options. As Frances points out, these new disorders brought about a huge increase in diagnoses and, as one could guess, with an increase in diagnoses comes a larger demand for the treatment. Rather than considering alternative means of undermining the control exerted by depression on the sufferer, it becomes simpler and far more lucrative to prescribe chemical treatments whose effectiveness is at best scattershot, as will be discussed.

Loren Mosher, former head of schizophrenia studies at the National Institute of Mental Health (NIMH) of the U.S.A. took a strong stance regarding this conflict of interest between the psychiatrists and the drug companies and became an advocate for alternatives to psychiatric pharmaceutical treatments and hospitalization (Chamberlin 1). Mosher, the founder of the Soteria project, sought to put into practice a form of treatment that did not revolve around manipulating brain chemistry but instead emphasized the importance of human contact and connection with those living with schizophrenia (Chamberlin 1). In 1998 Mosher wrote an open resignation letter to the APA where he urged them to "Get out of bed with the drug companies," as he considered that the pharmaceutical industry served as the legs that the APA stood on. Mosher writes,

> At this point in history, in my view, psychiatry has been almost completely bought out by the drug companies. The APA could not continue without the pharmaceutical company support of meetings, symposia, workshops, journal advertising, grand rounds luncheons, unrestricted educational grants etc. etc. Psychiatrists have become the minions of drug company promotions. APA, of course, maintains that its independence and autonomy are not compromised in this enmeshed situation. (Mosher)

Mosher outlines in no uncertain terms what he views as a major problem within the psychiatric industry. Recall that Mosher is not an outsider looking towards the psychiatric industry and criticizing it. He is an established member of the APA who took note of a consistent pattern of psychiatrists acting as brand ambassadors for drug companies. This is significant because, as Davies as well points out, the inclusion or exclusion of certain disorders in the *DSM* was the result of decisions made by a group of APA-certified psychiatrists coming to a general consensus. However, as Mosher points out, these psychiatrists have a vested interest in not

changing the *DSM* enough to impact the operation and influence of the psychopharmacological industry. This is in part why the *DSM* is seen by members of the industry as being problematic.

In his book *Between Sanity and Madness: Mental Illness from Ancient Greece to the Neuroscientific Era,* Yale professor Allan Horwitz examines the creation of the *DSM*, stating,

> A former director of the National Institute of Mental Health (NIMH), Steven Hyman, regarded the *DSM* as 'an absolute scientific nightmare,' and 'an unintended epistemic prison that was palpably impeding scientific progress.' In 2013, one of Hyman's successors, Thomas Insel, proclaimed 'there's no reality' to the *DSM* diseases. For Insel, the *DSM's* chief 'weakness is its lack of validity. Unlike our definition of ischemic heart disease, lymphoma or AIDS, the *DSM* diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure'. (Horwitz 2020, 193)

As Horwitz and Davies point out, the *DSM* holds within its very genesis a problematic understanding of the psyche and the complexity, if not impossibility, of taking its measure.

Clearly, the *DSM* is not an infallible text. However, as Donald Black and Jon Grant, two professors of psychiatry who published a guide to the *DSM* under the APA's publishing house write,

> Make no mistake: *DSM*-5 is not inerrant. Those unfamiliar with the diagnostic process—and even some who are—consider the criteria with the same reverence they might apply to passages in such books as the Bible or Talmud. Others may see the diagnostic process as a cookbook in which each ingredient (i.e., criterion) is essential and any deviation invariably leads to fallen soufflé. We remind readers that *DSM*-5—or for that matter any diagnostic manual—cannot be used without applying clinical judgment. This is the critical element missing from any manual and not easily learned in the absence of training and practice. (Black xii)

While Black and Grant write in their *DSM* guide that there are some who believe that this text must be followed without deviation, they are quick to clarify that the manual cannot be used without 'applying clinical judgment.' This is plainly stated in the preface of the *DSM-5*: the use

of the manual is to assist those trained in its use *(DSM-5* xli). It is clearly not meant for someone untrained. It is not meant to be approached as one would approach, for example, a user manual for a car meant for the purposes of customer care. It is rather more in the nature of a service manual, meant for a trained technician with specific experience in order to fully grapple with and understand the text. The *DSM* is a service manual in this context.

However, it is compelling that those most critical of the *DSM* are among the most highly trained experts in the field. Mosher, Davies, Horwitz, Spitzer, in fact, every source cited in this chapter, have been psychiatrists or involved in psychiatry in some way. They have all found a conflict in the legitimacy of the *DSM* or in the problematic relationship between the pharmaceutical industry and the APA where the APA, funded by the pharmaceutical industry and, one could argue, indebted to it, have attempted to codify mental disorders to define them by the drugs available to treat them, as though the drugs they prescribe are a one-to-one cure for any psychiatric issue, despite the lack of evidence to support any diagnostically specifying connections between brain chemistry and mental illness. One may argue that the various mood stabilizers being prescribed are working as people claim their symptoms are not as severe while consistently taking their drugs. As will be discussed in relation to David Healy, the pharmaceutical solution is not as convenient a solution as one might assume. Moreover, it is critical to remember that the pharmaceuticals are not curing the illness, not addressing the causes

of oppression and control, or even recognizing the regime, but rather numbing the symptoms as those are the identifying points of the illness according to the *DSM*.

The problems discussed regarding the *DSM* and the APA could be an indication as to why, as Horwitz points out in another publication, the NIMH is in the process of producing their own manual for mental disorders. Horwitz explains, "the Director of the NIMH, very publicly announced that his agency was going to establish an independent diagnostic system unrelated to the *DSM's* specific entities, stating, 'As long as the research community takes the *DSM* to be a bible,' Insel cautioned, 'we'll never make progress'" (Horwitz 2015, 117). The diagnostic system developed by NIMH is called the *Research Domain Criteria* (RDoC), which, unlike the *DSM* which acknowledges that it does not use biological or neurological indicators for diagnosis, is instead heavily focused on the neurological and physiological aspects of mental illness. As Janine Simmons and Kevin Quinn claim in their article, "The NIMH Research Domain Criteria (RDoC) Project: implications for genetics research,"

> *RDoC* is an attempt to 'carve the nature of mental illness at its joints' by bringing the power of modern research approaches in genetics, neuroscience, and behavioral science to the problem of mental illness while remaining agnostic as to the classification scheme by which patients might best be grouped. (Simmons and Quinn 24)

Given the issues with the *DSM*, such agnosticism, especially accompanied by distance from any vested interest, may prove enlightening.

Despite all the active critiques, the *DSM* is still the main tool used for diagnosing mental disorders, at least in the U.S.A. and Canada. One could argue that the issues with the *DSM* are

exaggerated, since the DSM offers assistance for trained clinicians in identifying symptoms and providing a name to a collection of symptoms, but even such identification comes with its own issues. Giving a single term to a series of symptoms assists with identification and treatment, but it also, in affirming that a mental illness is the same as the collection of symptoms that are used to identify it, creates a problem in that clinicians might seek to fix the symptoms rather than the cause of the illness. Furthermore, as Horwitz explains,

> The capacious MDD (Major Depressive Disorder) criteria could cover a heterogeneous group of people, ranging from irritable adolescents who constantly sleep, eat little, are uninterested in school, and do not concentrate on their schoolwork, as well as morose elderly people, who cannot sleep, overeat, are fatigued, and feel worthless. (Horwitz 2015, 113)

Emphasizing collections of symptoms and equating them with illnesses neglects the causes of illnesses. If illness is manifested as a mode of oppression so naturalized in the sufferer as to be almost intrinsic to their identity, for example, then addressing symptoms only may be perceived as an attack on identity, one met with more resistance. Moreover, as Horwitz points out, especially with depression, the symptoms are broad enough that they could be found in a diverse group of people who may not be suffering from depression. The *DSM* does at best an incomplete job in defining mental illness.

The idea that the *DSM* is perhaps not as exhaustive as one might believe it to be is a conclusion made by the psychiatrist Kenneth Kendler in his article, "The Phenomenology of Major Depression and the Representativeness and Nature of *DSM* Criteria," where he explores the symptomotography of Major Depressive Disorder as it aligns with the lived experience of

depression. He examines "how well *DSM*-5 symptomatic criteria for major depression capture the descriptions of clinical depression in the post-Kraepelin Western psychiatric tradition as described in textbooks published between 1900 and 1960" (Kendler 771). Kendler concludes that the *DSM* is limited in its ability to convey the lived experience of depression but that is because it was not created for that purpose: "The *DSM* symptomatic criteria for major depression do a reasonable but incomplete job of assessing the prominent clinical symptoms and signs of depressive illness as described in the Western post-Kraepelinian psychiatric tradition" (Kendler 779). Kendler openly admits that the criteria used to symptomatize major depression are incomplete regarding their ability to properly identify the signs of depression (Kendler 779).

However, Kendler ultimately acknowledges something that is often forgotten about the *DSM*, which is that it is not meant to be an exhaustive encyclopedic collection of all information that is available about all known mental disorders. This is made clear in the preface of *DSM*-5:

> Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. (*DSM-5* xli)

Kendler alludes to this, beginning as he does with a quote from Robert Burton's *The Anatomy of Melancholy*, which states, *"*The tower of Babel never yielded such confusion of tongues, as the chaos of melancholy doth variety of symptoms" (Burton, qtd in Kendler 771). This suggests that the variety in symptoms of depression is so great that it is incredibly difficult to catalogue all of them. This is why the *DSM* does not attempt to offer a complete collection of symptoms. As the

name might suggest the *DSM* is a manual of mental disorders filled with diagnostic criteria and statistical data regarding mental disorders for the purposes of research guidance. Thus, Kendler believes that the *DSM* does a decent enough job at what it is meant to do. As Kendler states, "the *DSM* criteria for depression, while a good place to start a diagnostic evaluation, do not represent all the relevant symptoms and signs that merit evaluation" (Kendler 779). Kendler confirms that the *DSM* is 'a good place to start' in the diagnostic process. However, he goes on to assert his belief that the *DSM* has generally been misused by the layperson as being a manual offering a total description of the illness it is trying to symptomatize (Kendler 780). Kendler refers to this as confusing the 'index of a thing with the thing itself':

> As in all diagnostic systems, *DSM* criteria were designed to index (i.e., measure or assess) syndromes—to describe signs and symptoms that permit the clinician to classify individuals as being affected or unaffected, with good efficiency, reliability, sensitivity, and specificity. To use major depression as an example, if the criteria work well, then individuals who meet the criteria for major depression have a high likelihood of really having depression and being neither psychiatrically well nor having another syndrome, such as panic disorder. But meeting the *DSM* criteria for major depression is not the same thing as having major depression. (Kendler 777)

Using the example of MDD, Kendler presents a clear example of the conclusion he draws: if an individual meets the criteria for the symptoms of MDD there is a good chance or a higher chance that this individual has MDD. However, it is up to the clinician to determine the diagnosis beyond the collection of symptoms. The inference here is training creates ability to discern beyond the basic symptomatography of the illness and ability to determine the differences between one illness and another. Kendler's conclusions come from examination of nineteen psychiatry textbooks and their definitions of depression or melancholia as they relate to what

Kendler refers to as major depression (Kendler 772). Kendler isolated eighteen signs and symptoms for MDD and cross referenced those indicators with those provided by the *DSM-5.* He found that of the eighteen symptoms identified in the textbooks, eleven were identified by the *DSM,* two were partially mentioned, and five of the symptoms discussed in the other texts were not mentioned at all in the *DSM's* criteria for MDD (Kendler 778). The missing symptoms include motivation, which fifteen of the nineteen identified as being negatively affected by depression. Seventeen texts stated that speech is negatively affected by depression, whether it be quieter, slower, delayed, or a combination. Anxiety was identified by fourteen as being increased with depression. Twelve textbooks saw depersonalization or derealization as being a symptom of depression. Finally, 'Other Physical Symptoms' which covers a myriad of generic physiological issues from headaches to heart palpitations, from bad posture to menstrual issues, has been identified by seventeen of the nineteen textbooks as being a symptom of depression (Kendler 778). Of these five symptoms that are not included in the *DSM,* most of the other textbooks do not consider them to be crucially important in identifying depression. Yet consider these elided effects on their own – motivation, speech, anxiety, depersonalization (or a state of feeling disconnected from one's own body), and 'other' medical symptoms. These are drastic descriptors of a mind, and by extension, a body, not in control of itself, its agency, its ability to communicate, to rest, and to know itself as a whole being. Is this not the total control and oppression of depression? Yet, these symptoms do not make the list of the *DSM's* criteria for MDD. Nevertheless, Kendler affirms that the *DSM* seems like a relatively reasonable, if limited,

manual that offers clinicians and those trained for diagnosis a starting point in order to find a diagnosis for an individual suffering with a mental illness.

As Kendler admits, however, having the symptoms of depression is not the same as having depression. This then reignites the question, if depression is not the same as its symptoms, then why seek to cure the symptoms? Why follow a protocol, prescribe a drug that will perhaps relieve the symptoms without actually attacking the cause?

If the *DSM* was limited to this identity, a collection of symptoms for various mental disorders that was merely a place to start a diagnosis but not sufficient for a total diagnosis, as has been suggested up to this point by Davies, Healy, Horwitz, Kendler, and the *DSM* itself, then I would have less reason to be critical of it. However, as will be discussed the *DSM* is not seen in such a light. As Michelle Lafrance discloses in her article, "The DSM and its lure of legitimacy,"

> Despite the serious critiques launched against it, the *DSM* remains seemingly unshakable in its dominance in North America. Since the release of the significantly revised and medicalized *DSM*-III in 1980, the manual has taken up master status amongst the helping professions, guiding the training and practice of professionals. The *DSM* is the organizing principle for virtually all textbooks in psychiatry, abnormal psychology, and related fields. (Lafrance 123)

Lafrance identifies what most acknowledge, that the *DSM* is a seemingly unshakable titan of mental illness and at the epicenter of psychiatrics. Its legitimacy will only increase as psychiatric professionals trained using the *DSM* are not likely to question the validity of the manual that formed the basis of their training. Professor of psychological medicine Marie Crowe refers to the

DSM as 'The most authoritative text on mental disorder in contemporary western society' (Crowe 69). Crowe writes,

> The reality of mental distress experienced by consumers of mental health services is constructed by psychiatric discourse. The *DSM*-IV is representative of this discourse. *Other explanations of the reality of mental distress are effectively marginalized* in favor of a psychiatric diagnosis. (Crowe 70) (emphasis mine)

Crowe states that the power held by the *DSM* enables control of the conversation about mental illness. As Lafrance affirms, despite the vocal critics of the *DSM* it has not lost its master status. As long as the *DSM* dictates how mental illness is understood, there will be no moving past it and "other explanations of the reality of mental distress" will remain untested.

The authority of the *DSM* has been noted by every source in this thesis thus far but a discussion of where the power came from has not. Allan Horwitz writes about this authority in his essay, "DSM-III and the Revolution in the Classification of Mental Illness." He states that the legitimacy of the *DSM* was established with the publication of the third edition:

> Unlike previous editions, the *DSM-III* rapidly became the authoritative text in mental health and was sanctioned by key institutions, notably the NIMH. By the early 1980s, 'American medical schools and residency programs routinely expected students and physicians to pass examinations based on *DSM-III* criteria,' explains Young. 'Both referees and journal editors expected manuscripts submitted to scholarly journals to be written in its language, and it was simply assumed that psychiatric research proposals would conform to its conventions. Researchers and clinicians who resisted these conventions could assume that they would be excluded from these arenas and their resources'. Government regulators and insurance companies were especially enamored with the *DSM-III*, because it introduced much greater clarity into the reimbursement process. Insurance companies and managed care organizations, which were beginning to gain market share in the 1980s in the form of health maintenance organizations (HMOs), had been demanding accountable diagnoses and threatening to reduce or refuse reimbursement if changes were not made. For them, the *DSM-III* represented a substantial improvement over the previous manuals. (Mayes and Horwitz 264)

With the *DSM-III* came a wave of legitimacy and popularity for the APA. Clinicians in the mental health field would need to adopt the new text and subscribe completely to its discourse or risk falling behind the curve, remaining unheard and unpublished. That the NIMH sanctioned the *DSM* is especially noteworthy considering the fact that the NIMH is a governmental institution. The *DSM-III* was written to make a more declarative, clear-cut, symptoms-based model for understanding mental disorders as biomedical issues. This meant it became more accessible to those involved with mental health but not directly trained in the field, part of the reason the *DSM* became the most influential book in mental health. Because of the pervasiveness and authority of the APA and the *DSM*, they were in a unique position to dictate what would be considered a mental disorder and what would be considered normal. Recall that the *DSM's* legitimacy does not come from a place of exhaustive research but from entities with vested interests, as Kendler and others have shown.

In the case of major depressive disorder, the symptoms need only be present for two weeks consistently before a diagnosis can be given and, in the case of children or teenagers, depression can manifest itself as irritability instead of sadness (*DSM-V* 162). There are obviously many possibilities that might explain the source of a teenager's irritability before determining that it arises from a mental disorder. Additionally, with a diagnosis of this kind come two distinct issues. The first concerns the dependence an individual has on their mental illness once they believe it is an intrinsic part of their essence. The second concerns the treatment of mental issues

as if they were a physiological problem. With the psychopharmacological industry vested interest in the *DSM's* continuing to be used to diagnose issues and calling them problems of the brain, the mind-body problem persists. As Loren Mosher explains,

> Biologically based brain diseases are convenient for families and practitioners alike. It is no-fault insurance against personal responsibility. We are just helplessly caught up in a swirl of brain pathology for which no one, except DNA, is responsible. Now, to begin with, anything that has an anatomically defined specific brain pathology becomes the province of neurology (syphilis is an excellent example). So, to be consistent with this 'brain disease' view all the major psychiatric disorders would become the territory of our neurologic colleagues. (…) there are no external validating criteria for psychiatric diagnoses. There is neither a blood test nor specific anatomic lesions for any major psychiatric disorder. So, where are we? APA as an organization has implicitly (sometimes explicitly as well) bought into a theoretical hoax. (Mosher)

Here, a somewhat facetious Mosher is acknowledging the convenience of brain-based theories of mental disorders as such views takes the responsibility entirely away from the diagnosed individual. If mental disorders are (merely) the result of a defect in the brain, then it is beyond the power of individuals to fix them. Mental disorders from this point forward must be referred to as brain diseases. If this is the case, as Mosher points out, this would render those who study and treat the psyche (psychiatrist, psychologists, etc.) obsolete. However, the fact remains that there is no brain based diagnostic criteria for mental illness, so that, as Mosher states, the APA has bought into their own "theoretical hoax." Mosher delineates the opposition at work here, as he accuses the APA directly for likening themselves to neurologists. In the process they influence the public into believing that there are simple tests and treatments for major psychiatric disorders. Mosher further states that along with this desperation by the APA to be taken seriously as a medical field there is an increased dependency on the pharmaceutical industry: "These

psychopharmacological limitations on our abilities to be complete physicians also limit our intellectual horizons. No longer do we seek to understand whole persons in their social contexts — rather we are there to realign our patients' neurotransmitters" (Mosher). For Mosher, context is critical. Often the context is that of oppression and control of the psyche. Totalitarian control appears to eliminate any access to healthful change. The goal with psychopharmacology is not to substantially change the person or their environment. Rather, it is to change their brain chemistry.

Mosher underscores the fact that a person's brain chemistry has become more important than the person as a whole. Having come to that conclusion, the pursuit of chemical treatments then limits the possibility for creating new forms of treatment even further. By making brain chemistry the singular focus of mental disorders the conclusion is the belief that revolutionizing new treatments for mental disorders actually means just creating a new drug to help cope with the illness.

David Healy, like Mosher, struggled with the overemphasis on pharmaceuticals within the psychiatric discipline. Healy was in the unique position of having been an early researcher of a pharmaceutical that would inhibit the reuptake of serotonin (Healy 1997, 13). This pharmaceutical was meant to help those struggling with depression by assisting the brain in its ability to process serotonin. Serotonin is a naturally occurring chemical in the brain that is traditionally associated with feelings of happiness, contentment, and satisfaction in life. Those

suffering from depression are thought to be individuals who are not producing enough or properly processing serotonin and therefore they feel unhappy and dissatisfied in life. Hence the pharmaceuticals needed to assist in serotonin production/processing. These antidepressants are commonly known as selective serotonin reuptake inhibitors (SSRI); in Healy's case, the SSRI that he was researching would go on to be called Prozac (Healy 1997, 13), one of the most well-known antidepressants ever produced. Healy notes that the purpose of Prozac and all SSRIs is to help provide the brain with more serotonin, based on the assumption, as some studies would show, that there is a link between depression and low serotonin. Healy writes,

> The presence in the brain of serotonin was first reported in 1954. This quickly led to the hypothesis that this monoamine neurotransmitter might play some role in nervous problems. One way to investigate this possibility was to look at the levels of the main metabolite of serotonin in the cerebrospinal fluid that bathes the brain. In 1960, George Ashcroft, working in Edinburgh, found that cerebrospinal 5HIAA levels, the metabolite of serotonin, in depressives appeared to be low, leading to the theory that serotonin might be low in cases of depression.… By 1970, however, Ashcroft had concluded that, whatever was wrong in depression, it was not lowered serotonin. More sensitive studies had shown no lowering of serotonin. Indeed, no abnormality of serotonin in depression has ever been demonstrated. (Healy 32-33)

Despite the fact that there is no apparent connection between low serotonin and depression, SSRIs are still the most common form of antidepressant. Healy came to an understanding similar to that of Mosher, and though he was involved in the research that led to the development of the most popular SSRI on the market, he has written several books on the dangers of antidepressants and the pharmaceutical industry. One of these, entitled *Let Them Eat Prozac,* pursued this specific mission statement:

> This book came about when I was grabbed by a tentacle of the beast and had a five-year chance to study it. The tentacle came tattooed with a Prozac logo. Rooms full of data pointed to the fact that the Prozac drug group could trigger suicide and violence, and that companies producing these drugs knew of the problem. (Healy 2003 15)

Healy explores the many suicides and acts of violence that have occurred by people taking SSRIs, making clear that when a business stands to make a lot of money, the researchers and the patients suffer. Healy writes, "The Prozac story brings interlinked problems to light, among them a creation of depression on so extraordinary and unwarranted a scale as to raise questions about whether pharmaceutical and other health care companies are more wedded to making profits from health than contributing to it" (Healy 2003, 15). Like Mosher, Healy bluntly affirms that the pursuit of financial gain is more important than treating mental illness in the psychiatric or psychopharmacological industry.

In *Let Them Eat Prozac* Healy mentions a *New Yorker* article written in the late 1990's by the writer and psychologist Andrew Solomon who outlines his experiences with depression. Solomon states that he had only begun to experience depression after he was successful and in his early thirties (Solomon 4). During his downward spiral he discusses his pharmaceutical cocktail for dealing with depression:

> 'Depression these days is curable,' people told me. 'You take antidepressants the way you take aspirin for a headache.' Depression these days is treatable; you take antidepressants the way you take chemotherapy for cancer. They sometimes do miraculous things, but the treatment can be painful and difficult, and inconsistent in its results. Trying out different medications makes you feel like a dartboard. 'If many remedies are prescribed for an illness,' Chekhov wrote, 'you may be certain that the illness has no cure'. (Solomon 7)

As Solomon states, he was led to believe that depression is a curable illness. However, it seems more accurate to suggest that it is treatable with the right mixture of drugs in the sense of possibly being manageable, but it is not curable as far as we know.

The purpose of the criticisms above is not to dismantle the modern psychiatric industry but rather to suggest that there is perhaps not as much known about the mind and mental illness as one is led to believe by the psychiatric and pharmaceutical industries. From diagnosis to treatment, there are serious concerns raised by those operating within an industry where there seems to be little oversight and accountability. Healy underscores this issue, writing,

> We are accustomed to the notion that our regulators are looking after us, that they are acting in some sense as consumer watchdogs. But this is not their role. The role of a regulator is to adjudicate on whether, for example, a yellow substance in front of him or her meets minimal criteria for butter; to ensure, for example, that it is not lard injected with color. Regulators are not called upon to determine whether this butter is good butter or not, or whether butter is good for your health. Consumer watchdogs must do that. Within medicine, the physician is supposed to be the consumer's watchdog—which, given that they rarely consume the product, makes for an ambiguous and commercially unique situation. (Healy 2003, 62)

If the only role of the regulators is to determine that something is what it claims to be instead of looking into its efficacy and if the physicians or psychiatrists are not consuming the drugs they prescribe, as Healy suggests, then they are leaving patients with no way of knowing if their medication will work effectively.

Consider the following. An individual is having depressive thoughts. They aren't sleeping well and find that they are thinking about suicide on a regular basis. Because of these symptoms, this individual goes to a psychiatrist who is a member of the APA who has been

trained to use the *DSM* as the authoritative book of their practice. The psychiatrist speaks with the individual and looks for keywords that could be associated with a certain disorder. Suspecting Major Depressive Disorder, the psychiatrist would go through the symptoms perhaps even asking the patient if they are having the other symptoms of MDD. All the while the patient is eager to find a cause to the despair they've been experiencing, which might make them more likely to exaggerate or lie about having some symptoms so that they are more likely to get a diagnosis in hopes of getting medication that they have been told will cure their depression. The psychiatrist identifies the individual as having Major Depressive Disorder and informs them that they should consider taking antidepressants to treat their illness. Under the advice of their psychiatrist the individual seeks out antidepressants developed by a company whose main goal as a company is to make money, bearing in mind the effectiveness of the product is of little consequence if the financial gain is made. Once this individual has been on these antidepressants for a few months they find that not only have they not improved, but they have put on weight, their libido is nonexistent, and they have more suicidal ideation than ever before. The response from the psychiatrist is to change up their medication to see if that helps. There is every possibility that the pattern repeats and that the situation becomes more dire. While I am aware that many people have gone on antidepressants and found them helpful, the above scenario is also not uncommon. Diagnosis and treatment occur in a closed system that is not open to other frameworks for understanding depression. The limitations are clear. Despite the admission in the *DSM* that there is no biological evidence to support their disorders, the pharmaceutical industry

is still using the *DSM* and the APA to sell drugs. The problem is further complicated, as pointed out by Healy and Mosher, by the fact that the pharmaceutical industry has a strong relationship with the APA, which it funds, which means that the APA has a vested interest in continuing to prescribe medication, potentially without focusing on its efficacy. According to the APA, in 2008, pharmaceutical revenue accounted for 28% of the APA's budget (O'Reilly 1).

Kendler seems to offer the fairest appraisal perhaps of the utility of the *DSM*, that for what it is, the *DSM* does exactly what it ought to do. It gives a brief description of mental disorders and some statistical information for the purposes of diagnosis and research only by a trained professional. This is even stated within the pages of the *DSM*-5:

> Clinical training and experience are needed to use *DSM* for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations that require clinical expertise to differentiate from normal life variation and transient responses to stress. To facilitate a thorough examination of the range of symptoms present, *DSM* can serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing a disorder. (*DSM-5* 5-6)

The *DSM* ought to be used by trained clinicians in assisting with a diagnosis but it does not act as an exhaustive manual because it cannot. So long as it neglects to consider the control exerted by depression upon the individual rendering them unable to exert themselves in their own behalf, the *DSM* will falter as a tool both for diagnosis and treatment. It should be thought of as a reference book. However, the problem as it stands is that the *DSM* is not seen as a harmless reference book, but rather a book that is taken by the vast majority of users as being irrefutable. In that way, it exerts its own control on victims of depression, adding a layer of oppression

where one might most look for help. The work of the writers in this chapter (Mosher, Healy, Horwitz, Davies etc.) have conveyed serious flaws within the text, the organization that produces it, as well as the industry that supports that organization. The *DSM* leaves much to be desired in a thorough and reasoned understanding of depression.

These criticisms of the *DSM* and the APA, coming as they do from within the psychiatric/psychological community, suggest an alternative framework for understanding depression that moves the discussion beyond the strictures and limitations of the *DSM* and its medicalization of depression. Such a discussion considers the work of Plato and Thomas Hobbes in their examination of systems of control, specifically concerning the mind as it relates to the body politic. If the government, for example, dictates what constitutes good and evil, then exerting control over anyone challenging that power is paramount. The rational mind is an indulgent, self-interested, and irresistible force. In this case, the oppressor is the depression itself. Exerting control over the sufferer's thoughts and actions. Hannah Arendt's philosophy of totalitarianism and its fundamental elements – ideology, total terror, destruction of human bonds, and bureaucracy – reads almost as a textbook description of the erosion of individual agency and control. Arendt's totalitarianism provides a foundation upon which to develop a new way of understanding and treating depression by recognizing it as the controlling entity it is and by finding ways to undermine its authority.

With the acknowledged inadequacies of the *DSM* to diagnose and treat depression, its conflation of the mind-body problem, its unscientific consensus on symptoms, its suspect partnership with and reliance on the pharmaceutical industry, and its persistence, despite these weaknesses, as the authority on mental illness, I wish to change the narrative proposed by the *DSM* and to explore an alternative point of view on depression in the remaining sections of this thesis, not as one contrary to what is offered in the *DSM*, but one that is re-contextualized and less monolithic. This new point of view, while perhaps not universally applicable, seems to hold some truth and to resonate more profoundly with many who have experienced a depressive episode.

Chapter Two: Arendt's Concept of Totalitarianism

Depression renders one helplessly subservient to its messages, to the fear it inspires – fear to stay the same and fear to change. Depression isolates. Finally, in its utter banality, it exerts control beyond the access of cool reason. It incapacitates instincts a sufferer might have to change habits, to make a call, in short, to take action that would undermine its domination. Reading Hannah Arendt for the first time, I was struck by her insights into totalitarianism. A prominent 20th century political philosopher, Arendt's comprehensive examination of totalitarianism informs the fundamental argument of this study. Arendt's work on totalitarianism and the tactics used by totalitarians illuminates the operation of the mind in the face of total control. As Plato and Thomas Hobbes wrote about the connection between a strong state and a strong psyche, I posit that Arendt's totalitarian state presents a framework for understanding a totalitarian takeover that can occur in the psyche and, as I argue, does occur in those suffering from depression. To my knowledge Arendt never wrote on mental illness. However, her ideas nevertheless present a new and compelling way of understanding mental illness.

Arendt wrote *The Origins of Totalitarianism* in 1951, less than 10 years after the end of World War II, which saw the rise of two totalitarian movements: Nazi Germany and Stalinist Soviet Union. In her discussion of the roles played by Antisemitism and Imperialism (which, at their core, are also systems of control and ideology) in the formation of the totalitarian movements of the twentieth century, she establishes the key elements of totalitarianism that

speak directly to depression as a system of control and oppression. Such systems of ideology and total control are central to the tenets of totalitarianism.

Antisemitism allowed the label of Jew to be used as a catch-all embodiment of villainy for the Nazi movement. Any struggle that fell upon the citizens of Germany, whether it was social, political, or economic, could thus be traced back to the Jewish world conspiracy; antisemitism, already prevalent in Europe, enabled the Nazi party to exacerbate this vilification for political gain. Imperialism allowed a sovereign nation to impose its own political and economic practices upon another nation. Imperialism has often historically been executed with a claim to an explicit humanitarian drive, for example, bringing civility to the uncivilized or bringing God to the godless, a drive that whitewashes more authentic impulses toward the exertion of power either for its own sake and for the benefits it yields. Where depression is concerned, such a superficial impetus might be found in the initial drive to isolation in order to protect the sufferer from hurt or rejection in anticipation of those things.

Two systems fuel imperialism, according to Arendt: racism and bureaucracy. Racism is manifested through a sense of elitism, the believed superiority of one group over another that reveals itself as a so-called duty to rule the inferior race. That relationship will not be based on mutually assured and mutually applicable laws and freedoms, but on a system of control. Coupling racism with bureaucratic imperialism takes a view of a group of people as inferior and forms law and order accordingly, a law and order to which there can be no appeal. Ill-defined

sets of decrees liable to arbitrary change. Imperialist racism requires a group perceived as inferior and needing leadership to be civilized.

The imperialist-racist pretends to help, offering aid. Similarly, the depressed individual may, for example, be isolated from friends and family whose bluntness may be perceived as rejection or deliberate harm. Depression serves as a "protector," against, for example, encouragements to make change that one interprets as criticisms or judgements. Better to stay away from people and messages that on their surface appear to inflict harm by way of critique or challenge. Without notice or even without really understanding, someone whose company might have been salubrious yesterday becomes threatening. Though isolation is the opposite of what a depressed person needs, nevertheless, one falls victim to depression's whim, huddled in self-protection and at the mercy of unreliable sensibilities. At its most effective, an oppressive state's control is established and insulated, as Arendt argues, through a bureaucratic system which dehumanizes the governing body so that it becomes a series of faceless regulations:

> At the basis of bureaucracy as a form of government, and of its inherent replacement of law with temporary and changing decrees, lies this superstition of a possible and magic identification of man with the forces of history. The ideal of such a political body will always be the man behind the scenes who pulls the strings of history. (Arendt 1973, 216)

The ideal totalitarian string puller is not revealed. The oppressed have no one to whom they can appeal and no way to change their circumstances. As Arendt makes clear, totalitarianism does not seek to merely dismantle laws or freedoms but to destroy the possibility of movement and the possibility of challenge.

Arendt establishes the importance of antisemitism and imperialism as key elements of totalitarianism, a form of total or absolute government: “totalitarianism differs essentially from other forms of political oppression known to us such as despotism, tyranny and dictatorship. Wherever it rose to power, it developed entirely new political institutions and destroyed all social, legal and political traditions of the country” (460). Despots, tyrants, and dictators can be seen to operate within and against the systems of established government. Through force, they come to power and through force, they maintain it, but their power is operational within familiar borders and works either with traditions or against them, but without making other traditions invisible. They are arbitrary leaders, more or less effective depending on their armed forces. They are also visible, unlike the leadership within a totalitarian state, which prefers to hide backstage, acting as harbingers of the movement. The totalitarian state takes on an anonymity grounded in what it establishes as an inescapable law. As Arendt writes:

> It is the monstrous, yet seemingly unanswerable claim of totalitarian rule that, far from being "lawless," it goes to the sources of authority from which positive laws received their ultimate legitimation, that far from being arbitrary it is more obedient to these suprahuman forces than any government ever was before, and that far from wielding its power in the interest of one man, it is quite prepared to sacrifice everybody's vital immediate interests to the execution of what it assumes to be the law of History or the law of Nature. (Arendt 1973, 461- 462).

The totalitarian state works behind law and authority, not in front of it, and is therefore concealed, exerting, as depression does, a malign force that cannot be singled out for address or appeal. One may challenge this by pointing out the significance of totalitarian front men like Stalin or Hitler who represent the head of their movement. It is true that they were the arbiters of

totalitarianism. However, as Arendt points out, the demise or overthrow of these figureheads does not mean the end of the totalitarian reign. Stalin and Hitler instigated totalitarian movements. However, once the movement had its own momentum, it does not live or die along with its leader. She explains:

> If it is true that the elements of totalitarianism can be found by retracing the history and analyzing the political implications of what we usually call the crisis of our century, then the conclusion is unavoidable that this crisis is no mere threat from the outside, no mere result of some aggressive foreign policy of either Germany or Russia, and that it will no more disappear with the death of Stalin than it disappeared with the fall of Nazi Germany. (Arendt 1973, 460).

Arendt here discloses the force and durability of those elements of totalitarianism, as well as the disturbing fact that its emergence is not the result of an external threat or policy, nor is it ultimately in the control of any one leader, however prominent. Its power comes from other sources.

A thorough taxonomy of the totalitarian regime as Arendt understands it unfolds in Elisabeth Young-Bruehl's book, *Why Arendt Matters,* where she discusses four elements of Arendt's analysis of totalitarianism that speak to the multi-valent nature of totalitarianism and depression. This distillation of Arendt's definition of totalitarianism into four elements comes from Young-Bruehl's comparison of the *Origins of Totalitarianism* to a field manual for identifying totalitarianism (Young-Bruehl 35). Young-Bruehl is taking Arendt's field manual, taking the four main elements, and writing an abridged version of the manual. These elements

are: ideology, total terror, the destruction of bonds, and government by nobody. Combined, this quartet exert an irresistible and inescapable subjugation on victims.

Ideology's action, Young-Bruehl explains, is to solidify a code which dictates every facet of the member's life:

> The first element of totalitarianism discussed in the field manual [*The Origins of Totalitarianism*] is the existence of an ideology that explains all of history and justifies the regime and its policies: a kind of 'supersense.' This ideology seems perfectly logical to those who subscribe to it and reason from its premises, which are far removed from reality. The ideology designates a superior people and an internal enemy (usually operating as a conspiracy) that must be eliminated. Gradually, the ideology comes to usurp all other foundations for the regime's legal system. (Young-Bruehl 47)

According to Young-Bruehl, this first element of totalitarianism requires full commitment to the ideologies of the movement that encapsulates the past, present, and future. This 'supersense' suggests that the ideology is a foundational perceptive organ through which all information is processed. The 'supersense' is a ubiquitous filter, screening all information for the members of the movement. Where depression takes hold, internal messages occupy the mind, in this case, a system of ideas and beliefs constituted in hopelessness and futility where aspects of one's own personality, one's own family or preferred activity take on the role of enemy within the system. Once ideology is established, as Young-Bruehl notes, terror reinforces the totalitarian's position:

> Ultimately sparing no part of the population, total terror was preceded in these [Nazi and Soviet] regimes by the dissolution of traditional class structures and political allegiances in a fervent political 'movement' that eventually made the uprooting and moving of huge populations in their mass societies seem necessary and justifiable. (Young-Bruehl 52)

They key term is 'total.' The terror is arbitrary and devastating. There is no limit to those who could be sacrificed for the movement and no restriction on removing the potential for freedom

(Young-Bruehl 51). Nazi concentration camps provided the vehicle for enacting total terror: "The camps are meant not only to exterminate people and degrade human beings, but also serve the ghastly experiment of eliminating, under scientifically controlled conditions, spontaneity itself" (Arendt 1973, 438). Arendt describes the use of total terror as a measure to remove all freedom, to remove the possibility of movement:

> By pressing men against each other, total terror destroys the space between them; compared to the condition within its iron band, even the desert of tyranny, insofar as it is still some kind of space, appears like a guarantee of freedom. Totalitarian government does not just curtail liberties or abolish essential freedoms; nor does it, at least to our limited knowledge, succeed in eradicating the love for freedom from the hearts of man. It destroys the one essential prerequisite of all freedom which is simply the capacity of motion which cannot exist without space. (Arendt 1973, 466)

Here, Arendt again contrasts tyranny with totalitarianism. Tyranny is a system that might still allow "some kind of space" in which to move, where totalitarianism seeks to destroy freedom (461). It leaves people unable to even imagine a world not constrained by an iron band, people in this case contained within fences, surrounded by guards and dogs, and forced to observe and participate in a ghastly process of oppression. The concentration camps wielded total control with actual iron. Total terror as a tool is used to abolish the potential for freedom. It leaves a population with no lines of flight and no escape.

The iron band of terror Arendt describes is not a weapon to be used but a tool for the cause (Arendt 1973, 466). The iron band is a function of policy, necessary in order to remove the potential for freedom. It serves, Arendt writes,

> As the obedient servant of natural or historical movement has to eliminate from the process not only freedom in any specific sense, but the very source of freedom which is given with the fact of the birth of man and resides in his capacity to make a new beginning. In the iron band of terror, which destroys the plurality of men and makes out of many the One who unfailingly will act as though he himself were part of the course of history or nature, a device has been found not only to liberate the historical and natural forces, but to accelerate them to a speed they never would reach if left to themselves. (Arendt 1973, 466)

In order for totalitarianism to be successful it must destroy individuality. Plurality must be destroyed (Arendt 1973, 466). Terror is the primary tool in addressing the problem of individual identity for the totalitarian. It eliminates both the potential for freedom and the potential for individual thought that might work against the regime. Individuality is silenced and terror operates as the "device" that accelerates domination.

Terror and fear function to contain; total terror contains totally and sets the stage for the third element of totalitarianism, a continuation of total terror in the form of the abolition of any individual identity, identity found in the intimate bonds of friendship and family life. Young-Bruehl writes,

> Arendt identified as a third element of totalitarianism the destruction of natural human bonds, chiefly of the family, accomplished by laws regulating marriage (and forbidding marriage between peoples designated superior and those designated inferior). Bonds can also be assaulted by police practices that force people to spy on and inform on family members. Along with the destruction of public spaces—the destruction of politics—in a totalitarian regime goes the destruction of private spaces for intimacy and family life. (Young-Bruehl 52)

By destroying the institutions, public spaces, and what was the sacrosanct safety of the privacy of one's home so that people are not able to find community or privacy, totalitarianism destroys that which makes plurality or diversity possible. Plurality and individuality are problems for totalitarianism. Homogeneity is the goal of oppression within the totalitarian state, a

homogeneity where all understand the futility of individual movement because terror has rendered such movement impossible. With the destruction of social bonds, totalitarianism creates a classless society of atomized individuals, with no other paths to follow, with a singular belief. People lose a sense of personal identity when they lose referents as they exist in social bonds. They lose a sense of a private life; they are spied upon and informed upon and they are left in a state where totalitarianism becomes the only truth they know, a truth they all know together. What the regime holds to be true and lawful becomes what its terrorized, disconnected citizens find true and lawful.

The totalitarian also secures power through a fourth and final element, identified by Young-Bruehl as 'Government by bureaucracy,' or what she also refers to as 'government by nobody' (Young-Bruehl 54). A bureaucracy allows for a government to act and oppress while remaining essentially in the shadows, or in other words, the violence of the government and the terror it enacts is hidden. There seem to be no individuals making laws but only a rather vague government-shaped entity acting upon the citizenry:

> At the basis of bureaucracy as a form of government, and of its inherent replacement of law with temporary and changing decrees, lies this superstition of a possible and magic identification of man with the forces of history. The ideal of such a political body will always be the man behind the scenes who pulls the strings of history. (Arendt 1973, 216)

The 'man behind the scenes' is the essential depiction of a bureaucratic government which relies on all movement being constricted from behind the surface, enacting total terror by a government

with seemingly no one to blame. Michelle Caswell enlarges upon Arendt's 'man behind the scenes' in her essay, "Hannah Arendt's World: Bureaucracy, Documentation, and Banal Evil:"

> Arendt constructs the banal, bureaucratic murderer, as epitomized by Eichmann, as a uniquely modern form of criminal, alienated from the impact of his murderous efforts in the same way modern men and women are alienated both from the fruits of their labour and from the rigid goals of the bureaucratic system by which they are imprisoned. (Caswell 6)

Caswell refers to Adolf Eichmann and alludes to Arendt's *Eichmann in Jerusalem,* where Arendt analyzes the necessity of bureaucracy and its connection to the banality of evil. Arendt's discussion of Eichmann bares scrutiny. After serving as an S.S. officer in Nazi Germany throughout World War II, Adolf Eichmann escaped to Argentina and remained there until his capture by a group of Nazi hunters working on behalf of the Israeli government in 1960 (Arendt 1964, 14) to stand trial for the crimes he committed as a Nazi officer. He has been called the architect of the holocaust but at the very least he was accused of "'aiding and abetting' the annihilation of the Jews" (Arendt 1964, 15). During the trial, Eichmann was likened to a monster; he was assumed to have been a horrible brute with a sadistic soul, and because of his bestial nature, thought to be somehow distinct from everyone else, unique. Arendt argues that this is not the case. Eichmann was not a monster, Arendt states:

> The trouble with Eichmann was precisely that so many were like him, and that the many were neither perverted nor sadistic, that they were and still are, terribly and terrifyingly normal. From the viewpoint of our legal institutions and of our moral standards of judgment this normality was much more terrifying than all the atrocities put together. (Arendt 1964, 129)

He was more of "a clown" (Arendt 1964, 29).

Consider the idea of normal. For psychiatry, normalcy is the goal. Mental illness, according to the *DSM,* is based on an idea of behaviours and thoughts that are typical and atypical and a distress that is associated with this abnormality. If an individual acts in a completely ordinary way there would be no reason to diagnose them. It is only when behaviours and thoughts no longer align with what is normal and are deemed abnormal, impacted as they are by feelings of distress, failure, and hopelessness, that someone seeks a diagnosis. Eichmann would not have been a candidate for such a diagnosis. As reported by Arendt, he was alarmingly normal. He had no distress about his actions or mindset. History would have forgotten the name Eichmann had it not been for the role he played in the holocaust; a mass murderer whose weapon of choice was not a firearm or a blade, but a rubber stamp at a desk. On the surface there seemed to be nothing diagnosable or atypical about Eichmann.

Arendt considers that Eichmann was not a one in a billion kind of criminal but rather an ordinary individual who did as he was told. This is what Arendt means by the 'banality of evil.' We think of evil as something grotesque, monstrous, full of hate and engendering hate, and certainly obvious. According to Arendt, Eichmann was not hateful; in fact, he lacked agency altogether: "The longer one listened to him, the more obvious it became that his inability to speak was closely connected with an inability to think" (Arendt 1964, 27). The wholly self-interested and somewhat clueless Eichmann, renders for Arendt a perfect example of the banality of evil:

> For when I speak of the banality of evil, I do so only on the strictly factual level, pointing to a phenomenon which stared one in the face at the trial. Eichmann was not Iago and not Macbeth, and nothing would have been farther from his mind than to determine with Richard III 'to prove a villain.' Except for an extraordinary diligence in looking out for his personal advancement, he had no motives at all. And this diligence in itself was in no way criminal; he certainly would never have murdered his superior in order to inherit his post. He merely, to put the matter colloquially, never realized what he was doing. (Arendt 1964, 134)

Millions were killed at the hands of an individual who seemingly never fully grasped the nature of the situation (Arendt 1964, 134). It was not his cruelty that made Eichmann such an evil man. His inability to think and his self-interested nature made him a perfect personification of a banal evil and of the invisible bureaucracy enacting terror with no one apparently to blame. Eichmann was a man focused on himself more than anything else. Arendt claims that his self-interest enabled him to survive as long as he did. His natural instinct was self-preservation and self-enrichment. When Arendt refers to him as being thoughtless it may be because his instinctual selfishness allowed him to be thoughtless. Eichmann, when faced with any decision, would think on what he would personally stand to gain:

> He was not stupid. It was sheer thoughtlessness - something by no means identical with stupidity - that predisposed him to become one of the greatest criminals of that period. And if this is 'banal' and even funny, if with the best will in the world one cannot extract any diabolical or demonic profundity from Eichmann. (Arendt 1964, 134)

For Arendt, Eichmann represents an ordinary and potentially common evil. Such an evil could rest within any individual.

The four elements - ideology, total terror, the destruction of bonds, and government by nobody - empower totalitarianism so that it can destroy 'the one essential prerequisite of all freedom' which Arendt identifies as the possibility of movement (Arendt 1973, 466). In addition

to these four elements, there is another element of Arendt's totalitarianism that I believe must be discussed in further detail. It is not necessarily distinct from the other elements, but it is a tool used in the execution of each: scapegoating within the context of state propaganda.

The potential totalitarian's gift of insight lies in their ability to understand the mob. They can see that there is public unrest and a desire for change. However, instead of offering legitimate solutions, the potential totalitarian utilizes hate mongering and fear tactics in order to appeal to the emotions of their base (Arendt 1973, 353). Arendt explores these tactics, discussing the emergence of the totalitarian movement and its popularity in the twentieth century, often using the example of Jewry in Nazi Germany:

> The most efficient fiction of Nazi propaganda was the story of a Jewish world conspiracy. Concentration on antisemitic propaganda had been a common device of demagogues ever since the end of the nineteenth century and was widespread in the Germany and Austria of the 1920's. The more consistently a discussion of the Jewish question was avoided by all parties and organs of public opinion, the more convinced the mob became that Jews were the true representatives of the powers that be, and that the Jewish issue was the symbol for the hypocrisy and dishonesty of the whole system. (Arendt 1973, 354)

The Jewish population became the cause for all bad things in Germany. Hitler took a real problem, offered a manufactured explanation for the problem, and stated that only he could solve the problem. He created a system with responsibility for malaise in the country passed from the leader, Hitler himself, onto the Jewish people. Hitler did not say anything that was not already discussed. His propaganda worked because he was echoing back to the populace the words of the mob. As Arendt explains,

> It is no accident that the two totalitarian movements of our time, so frightfully 'new' in methods of rule and ingenious in forms of organization, have never preached a new doctrine, have never invented an ideology which was not already popular. Not the passing successes of demagogy win the masses, but the visible reality and power of a 'living organization'. (Arendt 1973, 361)

By adopting a narrative, a totalitarian can promote their own agenda and name their own enemies, developing a familiar narrative for the mob that will satiate their desire for scapegoats. Arendt concludes that, "From these sore spots the lies of totalitarian propaganda derive the element of truthfulness and real experience they need to bridge the gulf between reality and fiction" (353). The totalitarian legitimizes the voice of the mob and the mob legitimizes the power of the totalitarian. The designated scapegoat serves as the source of every problem and must be removed so that the totalitarian accomplishes two goals: they can assign blame, regardless of the situation, and they can vilify a community that would speak out against them. The totalitarian needs the mob to reject anything not fed to them; the totalitarian provides the mob's gospel for all truth.

In *1984* George Orwell writes, "The Party told you to reject the evidence of your eyes and ears. It was their final, most essential command" (46). This is strikingly similar to Arendt's claim:

> They do not believe in anything visible, in the reality of their own experience; they do not trust their eyes and ears but only their imaginations, which may be caught by anything that is at once universal and consistent in itself. What convinces masses are not facts, and not even invented facts, but only the consistency of the system of which they are presumably part. (Arendt 1973, 351)

The goal of the totalitarian is to create a watertight narrative through mechanisms such as the concept of the mythic past – a past where times were better and there was more prosperity,

safety, and respect for laws – as well as multi-pronged propaganda campaigns – a Jewish world conspiracy, for example – in order to leave the masses in a state where they do not need to fact check or think critically. The criteria for truth for the mob then shifts from empirical data to elaborate hidden conspiracies:

> Like the earlier mob leaders, the spokesmen for totalitarian movements possessed an unerring instinct for anything that ordinary party propaganda or public opinion did not care or dare to touch. Everything hidden, everything passed over in silence, became of major significance, regardless of its own intrinsic importance. The mob really believed that truth was whatever respectable society had hypocritically passed over, or covered up with corruption. (Arendt 1973, 351)

This creates a situation where the harder it is to prove something the more the mob will believe it. As Arendt articulates, the totalitarian finds power in secrets, in the elisions where, as the mob suspects, deals are made behind closed doors that serve an elite and invisible group. So, plain statements of fact, which should have traction, do not. The problem presents a sort of reverse Ockham's Razor where instead of the simplest explanation being the correct one, the explanation most difficult to prove is given credence. Challenging the conspiracy makes you part of it. The leader, with appeals to a better past and a scapegoat everyone concurs is to blame, becomes the lone source of reliable information in the eyes of the mob. The citizenry submits to the narrative and relinquishes control before control is forcibly or terrifyingly removed. The totalitarian creates truth and, in the process, defines good and evil.

Thomas Hobbes discusses the power of the sovereign to dictate the definitions of good and evil in *Leviathan,* writing that good and evil are subjective concepts. However, he claims, it is within the power of the commonwealth to codify good and evil:

> But whatsoever is the object of any man's appetite or desire, that is it which he for his part calleth good; and the object of his hate and aversion, evil; and of his contempt, vile and inconsiderable. For these words of good, evil, and contemptible are ever used with relation to the person that useth them: there being nothing simply and absolutely so; nor any common rule of good and evil to be taken from the nature of the objects themselves; but from the person of the man, where there is no Commonwealth; or, in a Commonwealth, from the person that representeth it; or from an arbitrator or judge, whom men disagreeing shall by consent set up and make his sentence the rule thereof". (Hobbes 33; see also 213)

Hobbes maintains that objects in themselves are neither good, evil, nor contemptible. Such perceptions come from the person so that: the object of one's desire might be called good; of hate "and aversion," evil, and of contempt, "vile and inconsiderable." Good and evil are not absolute in themselves, but are judged to be so, either by a man or by the Commonwealth's representative whose authority, having been established "by consent" enables the capacity to "make his sentence the rule thereof." Disagreement with the rule of what is good or evil is not possible in the totalitarian situation; as Arendt writes,

> The fundamental reason for the superiority of totalitarian propaganda over the propaganda of other parties and movements is that its content, for the members of the movement at any rate, is no longer an objective issue about which people may have opinions, but has become as real and untouchable an element in their lives as the rules of arithmetic. (Arendt 1973, 636)

The totalitarian narrative is meant to be so intrinsic and natural that to challenge its ideals would be to challenge foundational truths. Two plus two will always equal four. The totalitarian's propaganda is just as inevitable and inescapable.

Arendt constructs an image of a leader whose control exceeds that of a traditional despot or tyrant. Their power extends to every facet of existence within the regime, and particularly to thought. This is a system that indoctrinates a populace with an ideology, and limits, almost eliminates their ability to move and to express themselves or think for themselves, through fear and terror tactics. As Arendt discloses, the twin evils of Antisemitism and racist imperialism provided fertile ground for the rise of Nazism in Germany. In the use of propaganda spread by a bureaucracy that appealed to the fear and anxiety of an economically struggling population, in the scapegoating of the Jewish people and in the terrifying banality of evil as embodied in Eichmann, Arendt revisits the perfect storm that was Germany in the 1930s and 1940s that gave rise to an all-encompassing totalitarian regime. In its execution of total terror, the regime bound its citizens in a ring of iron that, whether metaphorically in the streets or actually in the camps, prevented movement and dissent.

Without movement, without trust, and living in fear, no one can make or sustain intimate, meaningful bonds. These limitations are realized through a system that, while enacted by the totalitarian, is seemingly run by no one, a bureaucracy of forms and stamps that protects the totalitarian from appeal or challenge. In a reconsideration of depression as an entity, like totalitarianism, based on total control, these four or five elements similarly present themselves. Sufferers can experience depression as an entity of control that deploys these same tactics in order to repress and contain anything that may challenge the hold of the illness, such that any

change, any push toward healthful movement or familial bonds, can come to feel like an undermining of fundament identity and fundamental truth. The next chapter explores this at length. What is the connection between totalitarianism as it pertains to the psyche, specifically, as totalitarianism is manifested through depression?

Chapter Three: The State of Depression

The first chapter's review of the *DSM's* role in defining, diagnosing, and treating depression exposes the inadequacies of the psychiatric paradigm of depression, which, in its understanding and treatment, is limited at best and damaging at worst. Throughout its iterations, the *DSM* has maintained a reliance on research that has been characterized by critics as "scattered" and "hodgepodge" (Davies 29). Laudable in its intent to unify and codify diagnostic language for depression, the *DSM* has been consistently hampered by a lack of transparency and rigor. These are evident in the means by which, as Robert Spitzer has said, symptoms were included as part of the actual textbook definition of depression or Major Depressive Disorder (MDD). Those inclusions or exclusions turned out to be nothing more rigorous than consensus with little to no research data, a vote on the most likely and most prevalent indices of an illness of the mind. Having delineated the terms of that illness, and having acknowledged that depression is an affliction of the psyche, psychiatrists turned to biochemical treatments for an illness that cannot be physically tested for, *and* psychiatrists persist in recommending medications despite evidence, as presented by David Healy, the very researcher who developed Prozac, that those medications are, for the most part, ineffective and often come with serious, detrimental side effects, including suicidal ideation and suicide. Added to this is the tainted partnership between the APA and the companies who manufacture those drugs. Clearly, the

DSM, even in its current iteration, demonstrates its inability to provide a satisfactory understanding of depression and its treatment.

I argue for the need for an alternate framework for approaching depression and for treating it. Depression is a system of control and oppression. Most, in my experience, who experience depression speak of incapacity, weakness, hopelessness and fear. With a mind that governs all internal messaging, the depressed person exists in what has become for them a naturalized state. They cannot conceive of an alternate mode of being. In this way, the function of depression on the mind mirrors the function of the totalitarian on the body politic. My second chapter, in its unpacking of Hannah Arendt's concept of totalitarianism, offers a unique philosophical paradigm against which to consider the state of depression.

In the four elements of Arendt's totalitarianism as presented by Young-Bruehl – ideology (specifically propaganda and scapegoating), total terror, destruction of human bonds, and government by bureaucracy (47) – there is a clear potential application to the analysis of the lived experiences of depression.

Young-Bruehl's use of the term 'supersense' (47) in her description of totalitarian ideology means that the beliefs of the movement are so foundational that, for the indoctrinated, there can be no challenge or dispute. The ideology is beyond disagreement. Part of its work, according to Young-Bruehl, is to name a superior people as well as an enemy to the movement (46). Total terror, or total oppression, follow ideology, enabling the totalitarian to oppress the

whole population, or to justify the murder of large portions of it (Young-Bruehl 51). As Arendt described in detail, total terror was fully realized in the form of concentration camps and Soviet labour camps where one might undergo years of a sort of living death: underfed, overworked, freezing, tortured, oppressed, and chronically frightened with no hope of respite, contained within an "iron ring" (Young-Bruehl 50). Adding to total terror and compounding it is the destruction of human bonds, which involves creating an atomized society with disposable people. In destroying the foundational human bonds of community, intimacy, family, and marriage, a totalitarian creates a homogenous society of individuals with no real allegiance to anything other than the movement.

Functioning as the final element of totalitarianism, bureaucracy, or 'government by nobody' (Young-Bruehl 54), eliminates the possibility of appeal. The operations of the government function through a series of orders that seemingly originate from nowhere. Arendt presents Adolf Eichmann as an example of a bureaucratic functionary whose job, as far as he was concerned, was to fill out forms and stamp them. He did not make decisions. He served the totalitarian state. Determining where the decisions are occurring is impossible as is the goal of the shadow-government. Young-Bruehl examines the work of the secret police as an example of bureaucracy. The government, she argues, asserts its authority through the secret police, who then act without any apparent leadership (54). The very nature of secrecy necessitates that it appears leaderless and opaque, so that its actions are unappealable and its operations inspire

terror. This is the final critical element of totalitarianism, according to Young-Bruehl. A constricting, all-encompassing ideology, a sense of total terror, the destruction of loyalty to any human connection, and a blind, inescapable bureaucracy compose the four elements of a system of complete control and oppression.

Arendt augments Young-Bruehl's definition of totalitarian ideology as a kind of 'supersense' or foundation, claiming that ideology must be so ingrained that to question it would be like questioning the laws of mathematics:

> The fundamental reason for the superiority of totalitarian propaganda over the propaganda of other parties and movements is that its content, for the members of the movement at any rate, is no longer an objective issue about which people may have opinions, but has become as real and untouchable an element in their lives as the rules of arithmetic. (Arendt 1973, 363)

Here, and most significantly, Arendt delineates the lived experience of depression, which, to the sufferer, becomes intrinsic to identity, so entrenched in the psyche that it is not possible for the individual to imagine a day without it. This insight provides a critical framework for understanding depression as the exertion of a totalitarian regime upon the mind.

If depression is totalitarian in nature, then what is the ideology of this particular totalitarianism? The basic signifiers of depression, delineated by the *DSM* (as Kendler states, despite its limitations, the *DSM* is a good place to start when looking into mental disorders), are in the symptomatography. Here, the *DSM* provides a kind of outline of the ideology of depression. The *DSM*'s constellation of symptoms of Major Depressive Disorder (MDD):

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) 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).
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 gain.)
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.

(*DSM*-5 160-161)

The *DSM* delineates what someone would expect from the symptoms of depression: melancholy, fluctuations in weight, fatigue, thoughts of death and suicide. Many symptoms are intertwined. An individual who is not eating properly or sleeping well is probably feeling sluggish, absent minded, and fatigued. Four symptoms alone give a stark idea of what depression can be like. Suicidal ideation, feelings of worthlessness, diminished pleasure, and depressed mood function together as a quartet of symptoms that creates a system of oppression. One symptom, "diminished interest or pleasure in all, or almost all, activities most of the day" (*DSM-5* 161) suggests that there is nothing that a depressed person desires, which reads as perhaps an oversimplification. It seems obvious that a depressed individual no longer gets much pleasure out of what they formerly would have. However, a depressed person is still overcome with desires,

or what might be more accurately called pursuits of indulgence. Such a pursuit functions equally as well to exert a toxic hegemony on the mind and establish depression's total dominance.

Mark Fisher discusses this pursuit in his book, *Capitalist Realism*. In his exploration of the current state of capitalism in the 21st century, Fisher describes an inherent connection between indulgence and capitalism, as capitalism is an economic system which requires constant growth. Further, he discusses the connection between indulgence and mental illness, probing the rise in cases of mental illness for the generation colloquially referred to as millennials, a generation that has been tacitly or explicitly encouraged to pursue pleasure above all else:

> Many of the teenage students I encountered seemed to be in a state of what I would call depressive hedonia. Depression is usually characterized as a state of anhedonia, but the condition I'm referring to is constituted not by an inability to get pleasure so much as it by an inability to do anything else except pursue pleasure. There is a sense that 'something is missing' but no appreciation that this mysterious, missing enjoyment can only be accessed beyond the pleasure principle. (Fisher 21-22)

Centuries before Fisher, this idea that 'something is missing' was posited by Hobbes, who wrote in *Leviathan,* "For appetite with an opinion of attaining is called hope. The same, without such opinion, despair" (Hobbes 34). Hobbes reinforces the notion that while the pursuit with the intent of growing or progressing is hope, pursuit of appetite without progress leads to despair. Such despair is the cornerstone of depression. Both Fisher and Hobbes draw a similar connection between indulgence and depression or the pursuit of pleasure and depression so that, rather than a 'markedly diminished interest or pleasure in all, or almost all, activities,' depression is characterized by a markedly diminished interest in anything that does not offer immediate

pleasure or apparent relief. Whatever will offer the quickest sedation from a depressive state, including indulgences like alcohol, junk food, and pornography, are what individuals often cling to more than ever before, thus becoming what David Foster Wallace calls the 'bad thing' (29), embodying a totalitarian oppression that has burrowed as deeply as it can into the psyche.

A conceivable revision to the second symptom of MDD, which could be called the pleasure principle, would then be a part of the ideology of depression, functioning, along with all other symptoms, as the law-enforcing ideology of totalitarianism, that 'supersense' which becomes second nature to citizens, as Young-Bruehl claims, Depression acts in the same way, becoming so ubiquitous that the individual cannot perceive anything except for the depression. As psychiatrist R. D. Laing discusses in his book, *The Divided Self,* in a section entitled "A 'Borderline' Case – David," a former patient, an eighteen-year-old named David, suffers from an undisclosed mental illness. Laing writes that David is an

> individual in one sense is trying to be omnipotent by enclosing within his own being, without recourse to a creative relationship with others, modes of relationship that require the effective presence to him of other people and of the outer world. He would appear to be, in an unreal, impossible way, all persons and things to himself. The imagined advantages are safety for the true self, isolation and hence freedom from others, self-sufficiency, and control. The actual disadvantages that can be mentioned at this point are that this project is impossible and, being a false hope, leads on to persistent despair; secondly, a persistent, haunting sense of futility is the equally inevitable outcome. (Laing 75)

The state of being here, where David acts as "all persons and things to himself" provides for him an imagined "safety for the true self, isolation and hence freedom from others" that lead only to "persistent despair… haunting sense of futility." David is immersed in a reality he cannot escape

all the while thinking that his actions, his isolation, serve his best interest even as they undermine it. Thus, a person with depression may reject the evidence presented to them by external forces, as David does, and instead choose to give legitimacy only to the authority of their own mind. The interactions that these individuals have with the outer world are filtered and interpreted for them by their illness. The individual enters a state where they do not engage with the exterior world; rather their depression operates as an intermediary for all things coming in and all things going out. Laing states that an individual in this situation is perpetually in despair and in a haunting state of futility (75).

Totalitarian ideology operates as a supersense in that it must be believed to be as foundationally true as mathematics (Arendt 636). Similarly, depression acts on the mind as a foundational truth for those who suffer under it. On any sunny day, in full health and strength, housed and flush with cash, a depressed person will dodge objective truths of their actual life with the construct of hopelessness, suspicion, and ultimately, a longing for death. It is not useful to tell a depressed person that they have family or friends who care about them when they would perceive such care as a threat, as a desire to control. For someone who wants to be dead, bodily health does not offer comfort. It has no traction. Andrew Solomon underscores this state of being:

> When you are depressed, the past and the future are absorbed entirely by the present, as in the world of a three-year-old. You can neither remember feeling better nor imagine that you will feel better. Being upset, even profoundly upset, is a temporal experience, whereas depression is atemporal. Depression means that you have no point of view. (Solomon 6)

The notion that "you" as a depressed person cannot properly process information is a difficult one to face. Indeed, sufferers may reject the notion that they are depressed altogether or they will claim that the depression is integral to their personality, but not in charge of every sensory or intellectual experience. This depressive film has formed around their vision so gradually that they have not noticed a difference in the way they think and once it has formed it is too late. A depressed person becomes like a schizoid, rejecting any information that does not adhere to their sense of reality. They believe so strongly in the sanctity of their own mind that they will convince themselves that the rest of the world is mistaken or insane in anything it claims to be right or wholesome, before they will acknowledge the fallibility of their own mind. Depression becomes a supersense. As a result, a depressed person will subscribe fully to the ideology of a totalitarian enforcer.

The ideological supersense is reinforced in depression by total terror which effects continued domination. Total terror is the physical embodiment of totalitarian ideology. If the totalitarian ideology is intended to convey the total power of the movement, then it is through total terror that those ideas are enacted. Arendt states, "Total terror, the essence of totalitarian government, exists neither for nor against men. It is supposed to provide the forces of nature or history with an incomparable instrument to accelerate their movement" (Arendt 1973, 466). In the case of depression, the total terror used for the "acceleration of the movement" operates through the feelings of depression itself, particularly through that inescapable despair that is

more present and more reliable than any other relationship. Wallace explores this total terror in his short story, *"*The Planet Trillaphon as it Stands in Relation to the Bad Thing." He describes the state viscerally and precisely: "There's nothing in this world you know but horrible rotten smells, sad and grotesque and lurid pastel sights, raucous or deadly sad sounds. Intolerable open-ended situations lined on a continuum with just no end at all" (29). This is depression's enactment of total terror. A sufferer shares every meal with their depression, they go to bed and wake up with their depression, everywhere they go, they are accompanied by depression. There comes a point where a person with depression cannot conceive of a time where depression was not a part of them. As Arendt writes, "Total domination, which strives to organize the infinite plurality and differentiation of human beings as if all of humanity were just one individual, is possible only if each and every person can be reduced to a never changing identity of reactions" (Arendt 1973, 438). Depression seeks the same goal; it seeks to make the individual a personification of depression itself, "a never changing identity of reactions". This keeps an individual docile and predictable and contained. The depressed individual can ponder if they were ever anything other than how they currently exist but depression limits their ability to recall accurately. The individual is no longer a multiplicity of feelings and ideas, hopes and dreams, they are singular, monotone, and levelled in their identity. To secure its hold depression executes the third element of totalitarianism, the destruction of human bonds.

To reiterate, according to Young-Bruehl, totalitarianism requires the death of intimacy and family (52). As Arendt claims (1973, 466), there must be an end to plurality under totalitarianism. The totalitarian seeks homogeneity across the population. In creating a populace of atomized individuals what's left is the totalitarian movement as the only foundation. The movement becomes all there is to cling to in a totalitarian regime. In the context of the psyche and depression, the aim is much the same. Depression atomizes the host individual so they will not seek the bonds of family, friendship, community, intimacy, because all these relationships give rise to alternatives other than depression. As Solomon states, as his depression became more severe, he found himself becoming increasingly more apathetic to his friends and family (Solomon 10). If these relationships are allowed to flourish then the individual will no longer cling to their depression. Isolation becomes an essential quality. Laing discusses the nature of this isolation:

> The abundance there is longed for, in contrast to the emptiness here; yet participation without loss of being is felt to be impossible, and also is not enough, and so the individual must cling to his isolation - his separateness without spontaneous, direct relatedness - because in doing so he is clinging to his identity. His longing is for complete union. But of this very longing he is terrified. Because it will be the end of his self. He does not wish for a relationship of mutual enrichment and exchange of give-and-take between two beings 'congenial' to each other. He does not conceive of a dialectical relationship. (Laing 91-92)

Here Laing reflects on the case of a former patient named James who suffered a delusion that his subjectivity was only possible through the subjectivity of those around him (Laing 47). James both longed to have meaningful relationships and feared that becoming too close to others would

make him lose his identity (Laing 93). James' dilemma left him with a desire for relationships but an inability to create those bonds in fear of losing himself.

An individual with depression may operate in much the same way as the patient named James. Depression forces away the bonds of intimacy, and, just as totalitarianism does, forces a stronger belief and commitment to the regime. When Laing writes that James would cling to his isolation, the insight is clearly applicable to those suffering from depression: depression becomes their identity, and maybe not just part of that identity. Perhaps to some this is a semantic issue and not one that warrants further discussion. However, when considering the construction of identity, there is a fluidity to that identity. Interests, thoughts, feelings, social groups, jobs change. Many of the elements which make up an individual's identity will change. But there are core signifiers to which people cling. For some it might be their nationality or religion, for others it could be an astrological sign, or all of the above. These signifiers form a foundation for the individual. Nothing shy of an identity crisis will shake them. When I say that depression becomes the identity of the depressed individual, I mean to say that depression becomes a foundational identifier. It forms their essence. If one considers the different aspects of their own identity, one could pose the question of which of those aspects could be stripped away while still maintaining that personal sense of identity. Depression becomes a part of that essential identity, which if stripped away would mean that the individual would no longer be themselves. As Wallace writes,

> And then all of a sudden it sort of dawns on you ... that the Bad Thing is able to do this to you because you're the Bad Thing yourself! The Bad Thing is you. Nothing else: no bacteriological infection (…) or any other excuse; you are the sickness yourself. It is what 'defines' you. Especially after a little while has gone by. You realize all this. here. And that, I guess, is when if you're all glib you realize that there is no surface to the water. (Wallace 29)

Wallace declares here that his depression became him, not a part of him or a reflection of him. He and his depression were one thing.

It is a common occurrence for people with depression to compare the sickness to rainclouds hanging overhead, or a suit they wear, or a shadowing figure or demon that constantly hovers over them. It is more unusual for people to discuss their depression as if there is no difference between the individual and the illness. However, depression like totalitarianism, functions as this kind of singular identity. As Arendt states, the destruction of human bonds puts the atomized individuals into a situation where there is nothing left except for the totalitarian movement (1973, 466). Depression can become inseparable from the individual once it has seeded itself. It becomes the only thing with which the individual can engage.

It might be argued that the depression only gets to this point if it goes unchecked. Left unchecked, depression can grow in the mind and become pervasive so that the individual with depression cannot separate themselves from their depression. There is some difficulty in suggesting this as it engages with certain issues to do with subjective mental sanctity or authority. Depression is so embodied, and the sufferer so immersed in their depression as they are in the air they breathe, they can resist the notion the illness is a foreign adversary, not

intrinsic to their being and as necessary as air. As Wallace says, “you’re the Bad Thing yourself! The Bad Thing is you. Nothing else: no bacteriological [external, in my terms] infection” (29). The knowledge of the self as the bad thing, the thing in its entirety, functions on two levels: it eliminates the possibility of challenge and it provokes that sense of terror – the fear of badness, fear of living, and fear of dying without which the totalitarian regime cannot be secured. Arendt reinforces this notion, stating that this is the execution of total terror, a terror that accelerates the control of the movement beyond what would normally be possible (1973, 466). Even once a person acknowledges their depression, there is often still a struggle to accept that there is a force compromising one's abilities. The depressed individual may thus become dependent on their depression as intrinsic (and self-justifying) to their mental processes just as Laing and Wallace suggest. Maintaining the status quo, however full of despair, can seem preferable to the exertion required to consider a different way of being. It can feel safer in the short term to keep external appeals out and to stick with the devil you know.

That longing for safety, for the known, however full of despair, facilitates totalitarian control. The final element of bureaucracy, government by nobody, ensures that an individual in despair feels unable to change the course of their own life. As Arendt discloses in *Eichmann in Jerusalem*, it is through a bureaucracy that the banality of evil is perfected. To Eichmann, the acts of evil he committed were nothing more than signing papers or giving orders to generals (1964, 16). He was responsible for the loss of countless lives, yet Arendt paints him as ‘self-

interested' and ‘thoughtless’ (Arendt 1964, 134). The notion of a bureaucratic shadow government parallels a noteworthy but relatively unexplored aspect of depression. It seems to set up within an individual as a type of alternate decision-maker. Bureaucracy, for Arendt, in fact functions as a substitute for government. A bureaucracy governs people not through a constitution enacted by representatives but through an “administrator who ruled by reports and decrees in more hostile secrecy than any oriental despot grew out of a tradition of military discipline in the midst of ruthless and lawless men” (Arendt 1973, 186). A bureaucracy rules over the masses without considering their needs; it is typified by “the man behind the scenes who pulls the strings of history” (Arendt 1973, 216). In the context of depression, the depressed individual feels unable to be autonomous, as though there is a shadow government, a puppeteer behind the scenes. A depressed individual is not usually thought to be under duress. Yet their mind is so completely affected by depression that their ability to process information and therefore make decisions is impacted. As Solomon writes, “When you are depressed, the past and the future are absorbed entirely by the present, as in the world of a three-year-old. (…) Depression means that you have no point of view” (6). Solomon refers to the backslide into another episode as living ‘without my mind’ (27). This is ultimate control and oppression. This is Solomon’s acknowledgement of his state while depression has a hold on him, fully realizing that when his depression has lifted his mind will return.

Depression's impact on cognition was studied early on by Dr. Aaron T. Beck, considered by some to be the father of cognitive behavioural therapy. In his book *Depression: Causes and Treatment*, he identifies five forms of bias that affect those suffering with depression: arbitrary inference, selective abstraction, overgeneralizing, magnification and minimization, and inexact labelling (Beck 204-205). Depression deploys each of these techniques to filter understanding, cognition, perception so that all information skews into the negative. Positive, hopeful data, for example whether the sun is shining or puppies are delightful, find no purchase. Arbitrary inference allows a depressed individual to consider that pleasant or hopeful experiences are in fact shaded with nefarious intent, an intent that is disconnected from actual material events. Minimizing positive statements or experiences and magnifying petty slights work equally well to confirm what the depressed person already knows – that their depression, reflexive as it is, gives them insight, sets them apart, and confirms that despair and hopelessness are appropriate, necessary responses to everyday life. Beck recognizes that these biases are automatic:

> One of the striking features of the typical depressive cognitions is that they were generally experienced by the patients as arising as though they were *automatic responses*, that is, without any apparent antecedent reflection or reasoning. For example, a patient observed that when he was in a situation in which somebody else was receiving praise, he would automatically have the thought, ''I'm nobody. . . I'm not good enough.'' Later, when he reflected on his response, he would then regard it as inappropriate. Nonetheless, his immediate response to such situations continued to be self-devaluation…
>
> …The depressive thoughts not only appeared to be automatic, in the sense just described, but they seemed, also, to have an involuntary quality. The patients frequently reported that these thoughts would occur even when they had resolved ''not to have them'' or were actively trying to avoid them. This involuntary characteristic was clearly exemplified by repetitive thoughts of suicide, but was found in a less dramatic way in other types of depressive cognitions. (Beck 205-206) (emphasis mine)

An individual is so oppressed by their depression as to be unable to interpret objective sensory data and is able only to take that data and respond to its worst possible interpretation – thus the "I'm not good enough" response to observing someone else being praised. No slight is intended, nor is any insult, but both slight and insult are taken on board without thought. To fight their depression is to fight an automatic response. This response has been secured by a government of nobody pulling strings that a depressed individual is unaware exist. Beck understands the depressed person to have misconstrued reality, to have impaired cognition (207). In this understanding of depression's impact on cognition, Beck underscores the power of the totalitarian bureaucracy as it is embodied in depression. Depression imposes executive power with no executive, only layer upon layer of bureaucracy without treaty or constitution, enacted in a series of decrees (Arendt 1973, 216) and operating through a shadowy and untouchable ideology. Depression is the quintessential shadow government because it can and does operate entirely under the radar while the depressed individual goes on believing that every decision they make is their own. Thus, depression gains control of the individual just as a totalitarian does the state.

Depression is an illness that seeks to align an individual with a strict paradigm of thought, creating an ideology foundational for that individual. Depression expedites its power through a seemingly never-ending barrage of negativity and misery, by imposing automatic biases -- arbitrary inference, selective abstraction, etc. – as Beck asserts, to deflect anything hopeful and

positive (205). The individual will begin to isolate themselves and turn away from those things that may challenge the sovereign power of the depression. Family and friends, any members of the community, will be forced out. All activities and ambitions will be neglected as they offer a glimpse of an alternative ideology. The person must become homogenous in their way of thought. Depression will not allow them to serve two masters. The individual has very little agency despite their assumption that they are in complete control of their minds.

This manifestation of MDD can be broken down into the same core elements used by Young-Bruehl in her description of Arendt's totalitarianism. The four elements are: ideology, total terror, destruction of human bonds, and government by bureaucracy. In the case of totalitarianism, the ideology is that which the mob must cling to. There must be a system of beliefs and that system must be foundationally true. This is true for depression as well. Depression must make the individual believe in its ideology so strongly it seems impossible to question it. In order to accelerate indoctrination, the totalitarian creates a system of total terror in which the population fears any movement outside of the strict paradigm established through the ideology. As Arendt points out, total terror is perfected in the form of the concentration camp, a physical representation of the iron ring. This is similar for depression which deepens indoctrination through self-loathing and manipulating all phenomena so that life appears macabre and bleak. In extremes, depressive total terror can take the form of self-harm. With fear and mistrust, the destruction of human bonds is relatively straightforward. The destruction is

thorough. Relationships and communities only create competition for the regime. Thus, the totalitarian must remove any and all things that might offer a challenge. Without community, without movement, the individual with their own ideas and motivations disappears into homogeneity, absorbed into a herd with no discernable differences among its members. Similarly, depression eliminates competitors. Like the totalitarian, depression changes an individual from being a multiplicity of passions and intensities into a homogenous singularity of misery. The final element of totalitarianism, the shadow government of bureaucracy, is typified by a lack of transparency. There are no representatives and no foundational laws to guarantee rights. As Arendt's example of Eichmann demonstrates, this shadow government enables horrific events to be ordered and authorized by office workers signing papers. Depression too acts as a bureaucratic agent. It is pervasive, governing perceptions so that they align with the overarching constitution of hopelessness, isolating the individual from any source of fulfilment or hope, controlling parameters of daily life with a frightening totality and offering slender possibility than any alternate message of love or inspiration will be heard. MDD functions as a terrifying supersense. As banal as oxygen, the bland bureaucracy of depression feels just as inescapable.

Conclusion

In this thesis I consider the power dynamic of depression. I claim that depression oppresses the psyche in the same way totalitarianism oppresses. This project is in part an exploration of the *DSM* as this text forms the centre of the power dynamic within which mental illness is understood. I began this study originally in order to deepen my understanding of depression. Throughout the process I have found myself in a seemingly never-ending series of rabbit holes around issues relating to the *DSM* and the APA. The first chapter of this thesis is the result of my study of the thorny interrelations of the *DSM* and the APA that demanded consideration in the inquiry into a definition of depression as a diagnosable and treatable illness. Both in its conception and in each revision, the *DSM* is problematic in its lack of rigor and in its fraught partnership with the pharmaceutical industry. Despite the obvious and acknowledged issues, there nevertheless persists an assumed legitimacy when the *DSM* is referenced, even though those who work or worked within the industry and who in some cases have contributed to the creation of the manual have openly acknowledged how problematic it is. Nowhere does the *DSM* claim that it uses biological or neurological indicators in diagnosis. There is a colossal industry making billions by selling pharmaceuticals to those who have been diagnosed with the *DSM*. After these considerations, I arrive at the enigma of depression itself, the intended focal point of the chapter. As noted, the diagnostic criteria for depression are certainly limited. As well, they are so vague as to make it possible to apply them to a multiplicity of individuals, many of whom

may not have any form a mental illness at all. As Kenneth Kendler concludes, many of the symptoms of depression described in other texts are not present in the *DSM's* definition and according to the *DSM*, symptoms need only persist for two weeks to receive a depression diagnosis. How is it possible to understand depression at all if the diagnostic criteria for depression are so incomplete? If the best we can do is to claim that the *DSM* does a basic yet incomplete job of defining depression, how then do we define it? These questions were central to my consideration. In order to tackle them, it became obvious that the next step would be a fundamental recontextualization of depression within a framework that might provide a more multi-dimensional and nuanced understanding of the illness and its power.

In order to define depression properly in a new context there must first be an understanding of the world it creates. In the earliest days of studying depression, I noted its strong similarity to a political system. By this I mean, depression operates as a system of governing and being governed. Depression is a system of control. The key to understanding it, I came to understand, is to identify how one is being controlled by depression. My initial belief about depression's governing structure was similar to Plato's view of the tyrant. For Plato, the power of the tyrant may be total but it is also unpredictable. The tyrant need not have a strict regime. People can operate in the world in peace so long as they do not negatively impact the tyrant. However, this does not adequately address the power of depression. Depression's power is total and seeks total control. It is not unpredictable or arbitrary; its goal, as is obvious by every

outward manifestation in the sufferer, is to limit the potentiality of flight or existence beyond anything that does not involve depression. It was during my reading of Hannah Arendt, particularly of the language she uses to define totalitarianism that I noted a marked similarity in the two power systems. In reading Arendt and her political philosophy, I came to understand depression more completely than I had previously. Arendt's definition of the totalitarian provides a haunting checklist for a constellation of operations of depression on the mind and the material effects of depressive behaviours on the sufferer, as I had not seen before. It is crucial to my thesis that Arendt's totalitarianism is understood in order to understand depression as I'm presenting it.

In order to draw out the discussion of totalitarianism as defined by Arendt, I have used the work of Elisabeth Young-Bruehl, who breaks down Arendt's totalitarianism into four major elements: ideology, total terror, destruction of human bonds, and bureaucracy. These four qualities, as discussed by Young-Bruehl, are foundational facets of Arendt's definition of totalitarianism. In order to exert the total control that this kind of system manifests the population must first be indoctrinated into the ideology. Total terror follows as the second element to put a population in a position where they fear any movement. From total terror there comes the destruction of human bonds. This is done in order to solidify totalitarianism as the only consistent, reliable, and defining feature of the population. Family, friends, community, even privacy are no longer an option because they encourage the possibility for an alternative ideology

to creep in and supplant the totalitarian. This creates an atomized population that is simultaneously separate from one another while being completely homogenized. The final element of totalitarianism is revealed as the bureaucratic shadow government which rules over this homogenous atomized populace. Those working within the bureaucracy are nameless faceless cogs who function as desk clerks who rubber stamp orders and file their paperwork. There are no elected representatives; there is no bill of rights. It is a government that operates within the shadows to prevent any change. There is no one to whom one can appeal. These are the core elements of totalitarianism presented in this thesis, but as the final chapter explains, they are also the core elements of depression as it has been reframed for the purposes of this thesis.

The third and final chapter of this thesis provides a synthesis of the previous two chapters. Of first importance was a discussion of depression and its current paradigm within the APA and the *DSM*. It was equally important to provide context to the political system that gives my definition its framework. This is why the final chapter begins with a reiteration of the four elements of totalitarianism presented by Young-Bruehl as well as a clinical definition of MDD according to the *DSM-5,* in which there is a general agreement regarding the symptoms of the illness and what most people would expect. However, I follow this up with an analysis of the claim made by the *DSM-5* that individuals living with MDD have diminished interest in almost all things in their lives. I claim instead that they still have interests, but that these interests are not in anything that will fulfil them in the long-term. This is referred to as the pleasure principle,

where an individual is so wholly motivated by their own need for indulgence that they find it difficult to do much else other than pursue and try to fulfil indulgent desire. The pleasure principle itself operates as the first salvo of depressive/totalitarian control. Ideologically, depression indoctrinates the individual into a strict creed that revolves around the specious present, driving the sufferer to fulfill the craving of that moment, keeping them focused inwardly. After ideology is total terror. In depression, total terror looks different than in a totalitarian state. There are no fences or guards; there is no visible, external force exerting violence to induce terror. Rather, the sufferer endures bouts of serious and deep self-loathing, in some cases emphasized by self-harm. Following total terror, we observe the destruction of human bonds, or, as it is experienced by the sufferer, isolation. The depressed person withdraws from their community and the life that once brought them joy. Depression controls the regime of thoughts; if there is anything within this system that attempts to challenge the sovereignty of depression, it must be removed. The destruction of human bonds leaves a bureaucratic government which controls individuals with automatic responses. Even if someone's situation or environment changes, the blind persistence of embodied depression, best described as a bureaucratic government installed by that very depression - filtering out personal will, moments of insight and self-realization - will control how the individual perceives and reacts.

This is depression recontextualized. Depression is not merely a deficiency or alteration of brain chemicals; it manifests in the sufferer as a malicious, almost sentient agent that seeks to

limit one's ability to think, feel, and experience. The goal of this thesis was to present the clinical world in which this illness exists and then offer a new lens from which to view it.

Totalitarianism and depression are both systems of control and oppression. Whether the constraint is exerted by the populace or the body politic, there is an attempt to gain control and implement a system whereby all things beyond the movement are disposed of and displaced. Depression separates the individual from things, activities, and people that will challenge its sanctity. The totalitarian nature of depression can be seen even in the name itself. Consider what it means as a verb: to depress. To depress something in a physical sense is to put and keep something down or to deflate and limit. Totalitarianism is a system of oppression and control, in other words, a system to put and keep down a population. Considering depression as a totalitarian regime provides new insight into its force and power and, it is hoped, as well provides a means by which to kick at the seams, undermine the power, and let light in.

Afterword

In writing this thesis I fully acknowledge the intensity and personal passion and investment I bring to this issue. Millions of people suffer with depression and it does not appear to be an epic battle between good and evil as described in these pages. It is typically thought of as feelings of neutral blandness with a few bad days a week and perhaps some daily medication to help with moods and urges. However, the reason I write about depression as though it was a life-or-death issue is because it is not uncommon for it to become a life-or-death issue even with antidepressants. Andrew Solomon writes of suicide, "Suicide is a seductress, and those who have sailed near it stay alive only when they stop up their ears and flee from its Siren song. Even with chemical assistance, it's a fight against the wind and the tide to stay off the rocks" (10). The purpose of the thesis is to present the real issue that depression poses not as an illness for an idle indulgent generation, but its potent capacity to be a terminal illness. Even if it is not fatal, depression can still take years off your life; one day you may shake off the depressive shackles that bind you and realize that you have wasted years, you have burned bridges, and allowed the decay of your body, mind, and spirit, for no other reason than that a hostile force took over your mind and took it for a joy ride. If you are lucky enough to move past your depression you will realize that there is nothing to be gained. You may have more perspective now and an ability to see signs quicker than others but it is not a good trade. And it does not mean that you will be depression-free for the rest of your days. In fact, as with cancer, depression is something you will

have to keep an eye on for the foreseeable future as it will constantly attempt to coil itself around your mind any chance it gets. It is not sexy or trending; it is deadly and ugly and should not be sensationalized. It makes sloths out of the ambitious, cowards out of the brave, it makes the learned ignorant, and the selfless completely selfish. Depression, though it may not have agency as an entity on its own, seems to operate as a thinking learning demon that is hellbent on obscuring vision, limiting speech, hindering brain power, and fatiguing the soul. What has affected me most profoundly has been to see so much potential wasted in people who suffer with depression, who acknowledge they suffer with depression, but who are still incapable of doing anything about it. I am speaking here of an advanced stage of depression where a person grows to depend on depression for their identity. Either they see it as a compelling affect or they feel their depression makes them unique. They seem to wear depression like a badge of honour, this mental illness trying to control them. Whatever the reason why people succumb, the point is still the same. People become frightened to live without the familiarity and known borders of their illness. They need it like an addict needs their fix. A depressed individual must remain addicted.

I was not planning to devote a chapter of this thesis to discuss my issues with the *DSM* and the APA. As an individual who lived with depression for more than half my life, I was disappointed to learn that with all the research into mental illness and depression there was not a pill I could take that would cure it. I did take antidepressants. They did not help me. Thinking back now, I realize there was much I could do to try to fight my depression. The problem is that

this is where depression gets its strength. Depression acts on an individual so as to make one feel thoroughly infected and hopeless so that they consider that any resistance is futile. Even with the use of antidepressants and any other form of depression fighting tactic you can think of, the fact remains that if the sufferer does not actually want to get rid of the depression, it will not go. This is a part of this illness's great strength. It functions to make itself seem indispensable to the individual it has infected. Even when I knew I had depression, even when it was all I could think about, I didn't want to lose it. I feared who I was without it and because of that fear, I would much rather suffer than abandon my identity. Depression became my identity. I needed it. Even now when I feel its cold presence attempting to clutch my heart, I have to wrestle with myself. Like a recovering drug addict, depression is something I'm aware I could slide back into very easily. This is why I have to remember to fight it. I don't give it an inch because it will take everything it can from me. Writing this thesis has been fascinating because it has brought me face to face with my depression every day. Like Clarice and Hannibal Lecter, I study the depression while it remains behind glass but while I'm studying the depression, it is studying me. Depression looks for a weakness to exploit. I am relying on context, philosophical frameworks, and hope to keep it behind glass. My hope is that perhaps I can help others put their depression behind glass as well.

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