Life is a double-edged duet – should it be lived with or without anti-depressants?

A genealogy of the Danish health care system’s treatment of depression

Kandidatafhandling - 25.09.2014 - Cand.merc.(kom.)

Rosa Ellise Abigaile Nørgård

Vejleder: Lynn Roseberry
Antal anslag: 176.665 svarende til 77,65 antal normalsider
Executive Summary

Hypotesen for denne afhandling er, at det danske sundhedsvæsen diagnosticerer for mange patienter med depression og at anti-depressiv medicin er den mest benyttede behandling, uden at det overvejes, hvilke konsekvenser det har for den enkelte. Denne afhandling søger derfor at svare på, hvordan det er gået til at 450.000 danskere lige nu bruger medicin og hvordan det er gået til at antidepressiv medicin er blevet en flittigt anvendt behandlingsløsning i det danske sundhedsvæsen.

Afhandlingen benytter Foucaults genealogiske analysemetode til at vise ved hjælp af historiske begivenheder at vores forståelse og behandling af depression, har været anderledes i forinden og dermed også kan være anderledes i dag. Ved hjælp af genealogien bruges dernæst Foucaults begreb governmentality til at vise, hvordan statens og sundhedsvæsnets magt teknologier bruges til at fremme patientens selvstyring, hvilket medfører at patienten i langt højere grad accepterer anti-depressiv medicin som behandlingsløsning. Gennem analysen vises det, hvordan det patologiske diagnose system øger muligheden for at naturlige følelser bliver diagnosticeret som depression. Ligeledes pointeres det, hvordan normalisering som magt teknologi, forårsager at flere danskere bliver stemplet som deprimeret. Det vises også at autoriteternes kommunikation af viden har en stor indvirkning på den enkelte patient, og at det derved er med til at patienten vælger anti-depressiv medicin. Afsluttende for analysen vises der, hvordan disse magt teknologier i konsultationen og samtalen med lægen ikke kun begrænser behandlingsmulighederne i det diskursive regime, men også har stor indflydelse på patientens selvforståelse og selvstyring og dermed også valget om at benytte anti-depressiver.

Denne afhandling belyser derfor at den eksisterende “sandhed” omkring nutidens forståelse og behandling af depression er opstået på baggrund af historiske begivenheder, kontinuiteter og diskontinuiteter, og at denne sandhed derfor ikke er sand, men blot opfattes sådan. Derfor benyttes epilogen til sidst i afhandlingen til at diskutere, om vi er på vej mod en æra af mental sundhed eller psykisk sammenbrud og den vil skitsere farerne ved den historie om depression, som bliver fortalt af det danske sundhedsvæsen.
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Prologue: The Story

More and more people claim to be depressed and/or are declared depressive, general practitioners (GPs) prescribe anti-depressive medicine like ever before and the pharmaceutical industry has glory days. The World Health Organization (WHO) predicts that depression will be the second leading cause of disability throughout the world by the year 2020. But what is the difference between mental health and mental illness? Sometimes the answer is clear, but often the answer is less clear and the fact that there is no precise definition of depression makes it even harder to determine. If you cannot give a speech, does it mean that you have a disorder (social phobia), or is it just "nerves"? Or if you are tired and discouraged, does it mean that you are just a little off? Or do you have a depression that needs to be treated? One thing that makes it so difficult to distinguish normal mental health from abnormal mental illness is that our perception of depression changes frequently. For instance, according to Foucault, madness is as variable as any other concept:

“As a history, the thesis of this book is that whether madness is described as a religious or philosophical phenomenon (an experience of inspiration, a loss of mind, etc.), or as an objective medical essence (as in all classifications of types of madness that have been developed by psychiatry), these conceptions are not discoveries but historical constructions of meaning.” (Foucault, History of Madness, s. xiv).

Likewise, that is the case for depression. At one point in history depression was an accepted condition due to idleness. Today we perceive it as a disease that needs to be treated with anti-depressive medicine. However, the focal point of this thesis is not that things should be different than they are. They can never be. There is a purpose for everything and perhaps we needed to know what we know now before things can be different. Therefore, the focus is that the understanding and treatment of depression have been different in the past and thereby that it could be different today. The question is; are we on our way towards the era of mental health or mental breakdown?

This thesis will therefore tell the story of the treatment of depression, however, not as a traditional, continuously or evolutionary historiography, but as a genealogy.

Enjoy your reading!

Rosa Ellise Abigaile Nørgård
”Depression indtager pladsen som en fuldgyldig sygdom i det moderne liv.”

Alain Ehrenberg
Chapter 1: Problem Area and Research question

Problem Area
Currently, more than 450,000 Danes are using anti-depressive medicine. The use more than quadrupled from 1996 to 2012 and doubled between 1999 and 2012. It is especially women who are prescribed with antidepressants, in fact 80 percent more women than men (Danmarks Apotekerforening, 2013). But as the nation of the world’s happiest people, how can it be that so many of us use anti-depressant medication? Do we need drugs to feel normal - or maybe even happy? It seems like a disturbing high number of Danes are using anti-depressive medicine in order to cope with everyday life.

In Denmark the health care system is responsible for the treatment of depression. As a result of the Health Insurance Act in 1973, all citizens are insured equally and have free access to primary medical care. Other services within the health care system needs the GPs approval, which means that society, has made the GP into a "gatekeeper" (Denstoredanske.dk, 2014). Therefore, it is the GP’s assessment, in collaboration with the psychiatric field, to determine whether the patient is suffering from depression, and also whether the GP will be responsible for the treatment or refer the patient to a psychiatrist, psychologist or recommend admission to a psychiatric hospital (Møgeltoft, 2006). However, unlike physical illnesses there are no tools like MRI or blood testing in order to determine depression, and the diagnosis and treatment are therefore solely based on the GP’s initial judgment.

My hypothesis is that the Danish health care system diagnoses too many patients with depression and the way they treat the patients with anti-depressants has become the way to treat depression without considering the consequences of each individual. The question is how this has happened, but also why so many Danes accept this treatment? It seems to me, that there exists a strange and blind faith in authorities and most of us are not questioning the authoritative advice and statements, even if they are contrary to common sense. Looking back in history there is reason to believe that we should not always believe in authorities. In the 1400s, the earth was flat according to the authorities. In the 1500s, the authorities said that the sun circled around the earth. In the 1600s, the authorities believed that illness was caused by sin. In the 1700s, the Danish military doctor Meyer was ridiculed by the authorities because he wanted to isolate the infected cities during an epidemic of cholera. In the 1800s, the Austrian obstetrician Semmelweiss proved that mortality from puerperal fever could be reduced if the obstetrician washed hands prior to the birth. The authorities laughed at him. In the 1900s, penicillin was ridiculed for 20 years by the authorities before they even took it into use. In the 2000s, according to the authorities, nutritional supplements were potentially fatal. Today, the same authorities assure us that anti-depressive medicine is safe, despite the fact that there are a lot of studies claiming the opposite, that it is shown ineffective and
addicting and not investigated properly yet. According to Peter la Cour, associate professor specialized in health psychology at the University of Southern Denmark; the authorities need to wake up:

“Sundhedsstyrelsen laver ikke deres arbejde. Hvis de skal forestille at styre sundheden og oplyse om den, så burde de gøre opmærksom på, at vi har et folkesundhedsproblem i forhold til det stigende forbrug af lykkepiller, hovedpinepiller, statiner m.m., der ikke bare skal tages som en ny slags vitaminpiller.” (Information.dk, 2011).

How is our confidence in these authorities, which for half a millennium have been wrong in so many occasions? One of the biggest threats and dangers we face are the ones we do not see. Not because they are secret or invisible, but because we are willfully blind (Heffernan, 2011). However, the difficulties in a criticism of the present are to analyze the contemporary history due to the lack of temporal distance. A lot of social practices can appear so normal and natural that it is hard to imagine alternatives. But when we do not question the authorities, we can easily be ignoring the obvious.

How did it happen?
The leading question of this thesis will therefore be: How did it happen? How did it happen that 450,000 Danes currently are using anti-depressive medicine? How did it happen that the concepts of diagnosis and normality within the Danish health care system have become a necessary part of treating depression? How did it happen that the GP became the one to ensure fair treatment and simultaneously act as a ‘gatekeeper’? And how did it happen that in a society that tribute the individual’s free choice, the GP provides knowledge to the patient in order to make this free choice, and based on this knowledge, the patient chooses anti-depressive medicine?

My point is that the Danes who are feeling depressed do not necessarily want or need the anti-depressive medicine as a treatment solution for depression and that the patient simply wants knowledge about all the treatment options and therefore, seeks advice from the GP in order to be improved, supported or 'normalized'.

Based on the problem area the thesis will focus on the different rationales, which arise from the Danish health care system’s treatment of depression today. This leads to the following research question:
**Research question:**

*How did it happen that 450,000 Danes currently are using anti-depressive medicine and that the use of anti-depressive medicine has become an extensively used treatment solution in the Danish health care system?*

It will be analyzed how this has occurred and what events that have shaped this way of thinking and acting. This particular way of asking into the problem area requires a special analytical approach that is presented in the following chapter.

The problem area and the research question is based on present wonderings. The following questions are designed to structure the analysis, which is closely linked to the research question:

- How did it happen that we use pathological diagnostics to determine depression and does it increase the possibility of labeling natural emotions as depression?
- How did it happen that the concept of normalization is used in the assessment of depression and does it cause more Danes to be labeled as depressed?
- How did it happen that the contemporary communication of knowledge became a way to govern the patient and does it have an impact on the increased use of anti-depressants?
- How did it happen that the conversation with the GP became a way to govern the patient and does it limit the treatment options?

The following chapter outlines the choice of the analytical strategy, the empirical data, and provides a reading guide for the thesis.
Chapter 2: The Analytical Strategy

The analytical strategy aims at explaining the consequences connected with the selected choices and provide transparency regarding the empirical data (Andersen, N. Å., 1999, p. 14). Thereby the perspective of this thesis is made visible for the reader, due to the fact that the choices that are made have consequences for and provides a framework for the conclusions of the analysis (Esmark, 2007 p. 7). The analytical strategy provides the scientific framework, which is used to examine the research question.

In the following sections the theory and the used concepts in the analysis will be explored, as it is formative for my observations and thereby have an impact on my predication and the way in which the world appears to me (Mik-Meyer & Villadsen, 2007, p. 13).

Foucault

Michel Foucault has served as a theoretical inspiration across a multitude of disciplines, so much that the term “Foucauldian” is often applied to analyses that utilize his theoretical approach. Foucault eventually became one of France’s most notable intellectuals due to his contribution on especially the exercise of power in the modern, liberal society. His thesis on the history of the concept of madness was immediately well received, and Foucault continued to write influential books on some of the West’s most powerful social institutions. Most of his works deal with the history of something; *Madness and Civilization* deals with the history of exclusion and the creation of normality in opposed to definitions of mental illnesses. *The Birth of the Clinic* discusses ideology and hegemony as functions of the history of medicine. *Discipline and Punish* is his text on the history of prisons, and *The History of Sexuality* is about the structures and controls society has placed on the individual during different epochs of human history. While the objects of Foucault’s studies seem to range widely, they all tend to focus on how knowledge of human beings is connected to power over them. For Foucault, the many modern concepts and practices that attempt to uncover the “truth” about human beings (psychologically, sexually, or spiritually) actually create the very types of people they purport to discover.

Even though Foucault's work, lectures and interviews contains a number of methodological reflections and rationalizations, there are no specific standards for how a genealogical analysis must be conducted. The vast majority of existing genealogical analysis (by Foucault and others) does not base their analysis on a permanent approach. Therefore, this thesis’ analytical strategy is shaped in the light of Foucault’s own genealogies by using Kaspar Villadsen (2006) attempt to create a general method to commit genealogical analysis.
Part one: Genealogy as a method
The starting point for the analysis is a contemporary wondering about how something happened. One method to try to answer the questions emphasized in chapter one is the genealogical analysis – an analytical strategy which deals with the investigation of how people throughout history have been made objects of certain forms of knowledge and specific governance strategies. In order to answer the research question in the best possible way this thesis uses Foucault's genealogy, as the genealogy favors how-questions at the expense of what- and why- questions (Andersen, N. Å., 1999, p. 14).

Foucault's writings are often divided into two phases; An early archaeological phase where the analysis aimed at visualizing the rules of formation that controls the appearance of the discourses, and a genealogical phase where the focus were on the power relations that within a given context controls the emergence of the discourse and the organization of reality (Jørgensen, 2011, p. 21). Thus, Foucault have expanded the concept of genealogy. Through his genealogies Foucault has shown how the distinctions we have set in modern society between, for instance, madness and sanity, sexuality and perversion, what is considered legal and illegal, and more generally how our distinction between normality and deviance are related to specific practices, battles and coincidences as far back in history. This means that through the genealogical analysis it is possible to show how the current way of treating depression, both break with the past and also continues or reactivates certain historical elements (Villadsen, 2004, p. 13). This is one of the reasons why this approach has been chosen.

Another reason is that by acknowledging that the truth is created discursively it is possible to see how medicine in today’s treatment of depression has become a discourse that we understand and that we accept as meaningful. According to Jørgensen (2011), Foucault tends to only identify one regime of knowledge in every historical era. However, most of the different discursive analytic approaches acknowledge that there exist different types of discourses that are struggling for the right to determine the truth (Jørgensen, 2011, p. 22). In this thesis several discourses will also be presented as there exists a battle in determining the truth about treatment of depression.

A history of the present
The first part of the analysis, chapter 3, will be the genealogical analysis. According to Foucault the history is a necessary tool to illustrate the present (Villadsen, Magtens former, s. 31). A genealogical analysis is not a traditional, logical or evolutionary historiography searching for origins. This means that it is not a causal description of our history that confirm us in our understanding of the present nor seeing the present as a logical end product of the past (Villadsen, 2006, p. 88). Instead it attempts to reveal a predominant
understanding rather than support it and studies how our contemporary forms of knowledge and institutions are historical creations. Foucault describes a genealogy as a particular investigation into, for instance, depression and other elements of everyday life that we tend to view as without history (ibid.). It seeks to show the sometimes contradictory past that reveals traces of the influence power has had on what is perceived as the truth. This means that the empirical evidence and the analysis focus on the historical acceptability in which something observable is accepted and becomes acceptable through the knowledge-power interplay.

The focal point is that the genealogy is to deconstruct the “truth” of the present, as truth is viewed as questionable (Villadsen, 2004, p. 19). These truisms that exist in our society are neither necessary, natural, desirable, enlightened nor civilized. Genealogy is thereby, unlike the traditional historiography, a form that by focusing at the present it attempts to identify and shake fixed truisms rather than legitimize existing ways of thinking and acting (Villadsen, K., 2006, p. 87). Through the genealogy it is possible to point out the struggles and ruptures that today’s predominant forms of knowledge in regards to the treatment of depression are a result of. Our modern distinctions and practices regarding people who are depressed (from now on depressed) are therefore viewed as contingent: possible but not necessary (ibid.).

Based on the method of genealogy, this thesis will display a history of the present using the past’s (often significantly) different forms of thoughts and actions in relation to the treatment options of depression. In other words, the genealogical analysis of the treatment of depression is an attempt to get the reader to think differently and provide the reader with a different relation to the way we reflect upon today’s treatment (Foucault, 1987, p. 9). The thesis will retrospectively examine how the understanding of depression and the need for medical treatment has gradually been intercepted, modified and expanded over the years to become integrated into more general approaches to regulation through, for instance, the GP.

Eventialization, Continuity and Discontinuity
Throughout the analysis various historical events are seen as objects of observation (Villadsen, K., 2004.). Foucault uses the concept of *eventialization* to emphasize that it is the analysts’ strategic choices that are applied as incidents in the analysis. This means that I, as the observer, construct the object of the analysis as I “create” a historical event (Foucault, 1972, p. 8, 1991a, p. 76) (Villadsen, K., 2004, p. 19). Thus, the eventialization in this thesis is considered as a product of numerous consequences where an incident is constituted of a multitude of elements that are a product of my empirical work. Eventialization is, therefore, about rediscovering points of support, blockages, struggles for power and strategies within the
treatment of depression in the Danish health care system, which has established certain incidents that are
seen as obvious, universal and necessary (Villadsen, K., 2004, p. 20). In order to do so it is, according to
Villadsen (2006), important to emphasize both continuities and discontinuities (Villadsen K., 2006, p. 93)
due to the focus on the strategic lines of the historical incidents linking both statements, actions, rules,
rationales, plans and truisms (Triantafillou, 2005, p. 8). In the analysis the term continuity is used as an
observation tool in order to highlight how a particular understanding has evolved and transformed into a
perception of the present (Villadsen, 2006, p. 93). For instance how the biologically approach used in
today’s treatment was established in the ancient Greece.

One of the reasons of choosing this method and one of the functions of the genealogy is to show that the
treatment of depression has been different in the past and thereby that it could be different today
(Villadsen, 2004, p. 17). In other words, that is why it is not enough to search for the incidents that are
obvious seen from the present, it is necessary also to look at the strategies, structures and practices, that
for one reason or another have not been renewed, have been dissolved or transformed into something else
(Foucault, 1970, p. 155). This is why the analysis also deals with the time before the 18th century in order to
show that despite similarities melancholia was understood and treated differently than depression.

Thereby, the term discontinuity is used when I as a genealogist designate a specific rupture and make an
analytical, strategic intervention in the narration that is being shaped. When for instance, the history is
described by using discontinuities which claims to put the past’s barbaric, inhumane and irrational ideas
behind, the genealogy searches to show continuities between our ‘enlightened humanism’ and the
primitive past. This analysis will pursue a similar strategy by demonstrating how the present treatment of
depression with anti-depressive medicine can be viewed as inhumane as lobotomy turned out to be
(Villadsen, 2004, p. 21). Part of the genealogy’s critical effect consists off showing the struggles through
which certain forms of knowledge have been outdated and others re-articulated. This means that the
objects that the genealogy seeks to show the construction is never stable due to the fact that the
genealogical analysis are not using permanent objects (ibid., p. 102). As the analysis will show, the
observation of ‘normalization’ is, for instance, never stable in the Danish health care system.

When I observe the empirical data by using the terms discontinuity and continuity, I will be shaping a
certain segment of reality at the expense of another. This means that by using genealogy as a method some
aspects will become visible while others will be blind to me as an observer.
A problematizing analysis
Since this thesis’ genealogical analysis selects certain points in history where there seems to be discontinuities where knowledge and power are connected, the genealogy is therefore described as a problematizing analysis (Villadsen, 2004, p. 19). Problems are characterized as something that creates an occasion for reflection, discussion and enables debates, and the essential is to observe the process of this problematization. Foucault explains:

“What I tried to do from the beginning was to analyze the process of ‘problematization’ - which means: how and why certain things (behaviour, phenomena, processes) became a problem. Why, for example, certain forms of behaviour were characterized and classified as ‘madness’ while other similar forms were completely neglected at a given historical moment; the same thing for crime and delinquency.” (Foucault, 2001, p. 171).

According to Foucault I must ask how different techniques or ideas about the Danish health care system’s treatment of depression and the challenges in relation to that has been mobilized and categorized as important problems that must be solved and overcome (Foucault, 2001, p. 171). For instance, throughout history there are examples of different approaches to solving the problem that the psychiatric field and the treatment of depression was the less scientific field of all medical fields. In addition, questions arise about how the depressed improve in the best possible way, how the framework for their improvement should be and who should be held responsible for this improvement. Therefore, problems are not seen as either good or bad, but as something that need to be reconsidered or changed (Lopdrup-Hjorth, 2013).

Discourse
One of the consequences with the connection between power and knowledge is that it becomes closely related to discourse. According to Foucault the discourses that surround us help to produce us as the subjects we are and also the objects that we know something about. This is interesting because it is the opposite of the western perception of the subject as being an autonomous and sovereign entity (Villadsen, Magtens former, p. 22). According to Foucault a discourse is a limited group of statements from the same discursive formation that makes is possible to define the available options. The truth becomes a discursive construction and it is the different kinds of regimes of knowledge which determines what is true or false (ibid.). Even though there are several possibilities to create statements, the statements that are made are within a certain domain. As the analysis will show, there are statements about the understanding and treatment of depression, which are either accepted as meaningful and other statements that due to the dominant discourses are considered false. What is interesting is that the truth is being created within the
discourses (Jørgensen, 2011, p. 22-24). Throughout the genealogy the different forms of discourses will be presented and we will see which discourses that have been dominating and which discourses that have tried to break. This way it is possible to see which discourses that have had an impact on how it happened that 450.000 Danes are using anti-depressive medicine.

Part two: Governmentality
Chapter 4, the second part of the analysis, will enable the genealogy in relation to the present and the questions, which appear in the problem area, will be unfolded, through the use of the term governmentality. In the famous lecture regarding governmentality Foucault defined it in an ambiguous way (Villadsen, 2007). The concept represents at once the mentality, that is, the forms of knowledge which the governance of the modern state is based on, along with its instruments, institutions and technologies. There is, however, another way to characterize governmentality. A definition, which is simpler and in regards to this research question even more relevant for producing a critical analysis. The alternative formulation found in the lecture Technologies of the Self, defines governmentality as the particular modern, liberal governance mentality, where governance take place by the control of the individuals' self-governance (Villadsen, 2007). Explained in another way, the use of power technologies is linked to individuals' self-technologies, which is an absolute core issue in today's welfare state. In relation to the treatment of depression it is therefore important to examine the technologies of power and the technologies of the self and the relationship between the two. These two concepts will be used to show how the number of Danes using anti-depressive medicine has increased over the years. Villadsen (2007) argues that the governmental technologies and self-technologies and their inter-relation have become a central analytical framework for contemporary critic analysis:

“(…) that the classic dilemma of government versus freedom, of collectivity versus individuality, has been intensified in ‘advanced’ liberal welfare states. We are witnessing a relentless creativity aimed at inventing new governmental technologies that can influence and direct the individual’s self-government without governing ‘too much’ or taking over responsibility.” (Villadsen, 2007)

Therefore, the second part will, based on the genealogy, focus on the concepts of the power technologies and self-technologies to study the link between the two in the Danish health care system’s treatment of depression. A short introduction will here be made of each technology.
Technologies of power and self-technologies

Foucault defines the power technologies as technologies that seek to determine the behavior of individuals and subjecting them to forms of domination. These technologies objectify the subject and the power technologies are both instruments in order to govern and instruments for observing. Technologies of power are those:

“technologies imbued with aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired ones” (Rose, 1999, p. 52).

This implies the network established between several elements: Discourses, institutions, architectural structures, regulatory decisions, laws, administrative precautions, scientific statements and moral and philanthropic learning. Therefore, the important elements in the analysis are just as much the unsaid as well as what is being said (Foucault in Agamben, 2010, p. 9). In regards to depression power technologies are for instance used to hospitalize, divide and examine people with depression which has been a key element in the formation of the treatment of depression. As an example, the analysis will highlight diagnosis as it has been used as a solution to recognize symptoms and thus ensure the proper treatment.

At the end of Foucault’s writings he became more interested in the technologies of the self. Self-technologies refer to the practices and strategies by which individuals represent to themselves their own ethical self-understanding and how they makes themselves into objects of their own control. This self-governance is often initiated and assisted of various experts, such as GPs and psychiatrists. Thus, the self-technologies are closely linked to both discourses and power technologies (Villadsen, Magtens former, p. 23). Foucault defined it as techniques that allow individuals to shape themselves:

“(…) permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault 1987, p. 18).

There are different ways in our culture that humans develop knowledge about themselves for instance through psychiatry and medicine. The main point of this thesis is, not to accept the knowledge of for example medicine as the truth, but to analyze this science as a specific truism related to specific techniques that human beings use to understand themselves.
Governmentality as a control mechanism

The second part of the analysis will be based on the questions that support the overall research questions. It will be analyzed how the power technologies of diagnostics, normalization, knowledge and conversation is used in order to promote the patients’ self-governance. This section of the analysis, therefore, uses the genealogical analysis in order to show how the historical events have shaped our understanding and treatment of depression. By using the concept of governmentality it is shown how the state and the Danish health care system uses power technologies in order to promote the patients’ self-governance. This means that the patient much more likely accept the anti-depressive medication as a treatment option. Through the analysis it is shown how the pathological diagnostic system increases the possibility of that natural feelings are diagnosed as depression. Also, it is pointed out how the normalization as a power technology causes more Danes to be labeled as depressed. It also appears to the reader that the authorities’ communication of knowledge has a major impact on the individual patient, and thereby helps the patient to choose anti-depressant medication. Finally, the analysis show how these technologies of power in the consultation and conversation with the GP not only limits the treatment options in the discursive regime, but also has great influence on the patient's self-understanding and self-governance and thereby the choice of using anti-depressants.

Is it a descriptive analysis?

Some critics point out that the genealogy analyzes the claims which it is based upon. However, in order to refute this criticism it is important to make it clear that the thesis does not intend to confirm anything, and the analysis does not attempt to prove concrete explanations for the historical development of the treatment of depression. The aim is to problematize current understandings and explanations of the historical development of the Danish health care’s treatment of depression and its relation to the present (Triantafillou, 2005). However, it is obviously impossible to follow all the threads that can be claimed to be interesting. Therefore, I have necessarily had to make some crucial choices about which elements I want to problematize. These choices depend on what I want to problematize in regards to the present based on the problem area and research question (Villadsen, K., 2006). This means that the genealogical analysis cannot be described, without being bound to a certain perspective and problem. Foucault points out in his writing that this:

“(...) ikke fører til relativisme, men til perspektivisme (...) Historier vil altid være kontingente og konstruerede, men ved at have et bestemt perspektiv og problem bliver genealogien følsom for sit materiale på en særlig måde” (Andersen, N. Å., 1999, s. 62).
According to Triantafillou (2005):

“Med udgangspunkt i genealogien ses kilderne ikke som repræsentationer for en bagvedliggende virkelighed, men i stedet som konstituerende for denne” (Triantafillou, 2005, s. 9).

Some might point out that this conflict with scientific criteria of validity, criticism of sources, etc. However, the genealogy is not aiming at being measured by such criteria (ibid.). Instead it is measured by ‘efficiency’ as criticism. That is why this thesis provides a critical view of the Danish health care system. The quality of the analysis must therefore depend on whether the material is deemed to be treated in a sensitive manner and that the selections are valid, although it is of course also possible to question the relevance or appropriateness of the selected perspective (Foucault, 1970). However, the thesis’ analysis must enroll in a scientific field; by determine continuities and discontinuities, documenting references and events, etc. - just like any other science (Triantafillou, 2005).

Epilogue
Inspired by Kasper Villadsen (2006) I have chosen to use an epilogue at the end of this thesis as the final chapter in order to bring closure to the work. In the 1700s, the epilogue was frequently used in particularly dramatic genres, providing an assessment of the play as a "lesson", which also will be the case in this context. This means, that it is used to allow me as the author a chance to "speak freely" to the reader. Due to the fact that the genealogy only seeks to explain how something has occurred as part of different practices, it will be used to wrap up the overall points of this thesis. Thereby, history will be seen in relation to the present and the problematizations and wonderings, which appeared in the problem area and throughout the analysis. The existing truism that will be outlined in analysis emphasize that there is a single story being told by the authorities and the epilogue is used to discuss if we are on our way towards the era of mental health or mental breakdown and will outline the dangers of the single story. It is therefore, an essential part of this thesis, and the reader should have in mind that this chapter draws connection to today's treatment options, and relates to the techniques and ways of thinking about the treatment of depression and provide the reader with an alternative view.
**Empirical considerations**
The genealogy uses texts as a monument that can help uncover an event in a critical way, and does not study text as proof of a specific intent or meaning, which lies outside the text.

Based on the selection of the source material I have tried to make it as transparent as possible in order to shape the analysis in a way so that it could be checked by others. The selection is based on a search for texts that illustrates key continuities and discontinuities. Therefore the choice and weighting of the various sources will be highly contingent and must be assessed for the reliability within the application.

According to Foucault no text can stand alone. The text will always be conditioning and conditional in relation to other texts (Villadsen K., 2006, p. 101). Therefore, I have through my exploration of the empirical data been aware to register the mutual referrals of the texts. Thus, I as a genealogist have had to read 'all that is' rather than read in depth and look for underlying intentions or meanings (ibid.). Villadsen (2006) points out that text that can seem insignificant may play a more significant role than large canonized works (ibid. p. 100).

As shown in the analysis, the sources consist of everything from legislative texts and reports to personal notes from patients. It has therefore required a much larger exploration of the empirical data than what appears throughout the analysis.
“Depression is melancholy minus its charms.”

Susan Sontag
Chapter 3: A Genealogy of the Treatment of Depression

The basis for this thesis is a wonder about the high number of Danes using anti-depressant medication and also a wonder about the truism regarding the treatment of depression with anti-depressive medicine that seems to have been dominant in the Danish society especially since the 1990s.

The following chapter will form the genealogy based on how the understanding of depression throughout history defines and problematize the treatment of depression. As the analysis will show, the history of the treatment of depression is not only attached to the history of the medical profession, but that it cuts across many different fields. The genealogy is based on how the Danish health care system, doctors, scientist, politicians, patients etc. throughout history assess and problematize the definition and the treatment of depression.

The genealogy is written in order to make a point about our present and to show that contemporary ways of observing, talking and acting is governed by certain historical events. The goal is to show that the understanding and treatment of depression have been different in the past and thereby show that it could be different today. The genealogy will show how the understanding and treatment has changed over time – and continue to change - with crucial impact on the depressed and society in general (Kaspar Villadsen, 2004, p. 7, 17). Thereby the analysis aims at encouraging a critical reflection on the new discursive regime that seems to have been accepted (Villadsen, Magtens former, p. 35).

From Melancholia to Depression
Depression is mostly seen as a contemporary disorder. However, what is known today as clinical depression, major depression, or simply depression was previously known as melancholia. Looking back in history depression has existed as long as mankind, and yet we are still trying to understand it. The following section will focus on the discourses struggling to be established before the term depression came into general use from the mid-nineteenth century, in order to show the impact it have had on our present perception.

The Father of Medicine
The Greek physician Hippocrates (460–370 BC) is considered to be the father of medicine and he is also acknowledged to be the first to consider melancholia. In Internal Affections he described it as a depressed or anxious disorder that mostly emerges in the autumn caused by one of the humors black bile "Melaina Chole":

...
“If anxiety (phobos) and moodiness (dysthymia) are present for a longer period, that is melancholia”. (Radden, 2002)

What is interesting about Hippocrates and his findings is that he described the clinically melancholia as a distinct disease in the body, and especially in the brain (ibid.). In Diseases II (paragraph 6) it is described as a terminal disorder where the black bile has attacked the brain, and in Internal Affections (paragraph 16) it is a less serious disorder arising from black bile in the kidneys (Ancienthistory.about.com, 2014). The concept of balancing the health was at that time a key feature in the treatment. Hippocrates focused on treating his patients with a regimen of diet, activity and exercise, designed to balance the imbalanced body:

"Let thy Food be thy Medicine and thy Medicine be thy Food" (Radden, 2002)

Hippocrates and his descendants were physicians who studied and understood physics and nature, which became the dominating discourse within the medical literature and profession. However, throughout history there were many different considerations and discourses attempting to break with this understanding of melancholia.

The Father of Psychology
In ancient times the Greek philosopher Aristotle (384–322 BCE) challenged the medical view in Hippocrates writings by introducing nonmedical views on melancholia. He thought that the excess of melancholia suggested that a person was in possession of a specific and highly regarded artistic temperament. He believed that people who have, or have had, depression also had an increased empathy and became more attuned to other people’s suffering (Radden, 2002). Aristotle, thereby, contributed with a more positive view due to the insights the condition could bring. The authorship of Problems is famous for its influential discussion of melancholia and begins with the question:

“Why is it that all men who have become outstanding in philosophy, statesmanship, poetry or the arts are melancholic, or are infected by the diseases arising from black bile” (Aristotle, Problems)

Aristotle not only acknowledged melancholia as a condition, but also valued it for the inspiration for poetic or philosophical genius and religious prophecy. This view is well in line with the fact that Aristotle was concerned with the connection between the psychological processes and the underlying physiological phenomenon and he is, therefore, often regarded as the father of psychology due to his work and especially the book, De Anima (On the Soul) (Radden, 2002).
A Disease or a Privilege?
In the Renaissance melancholia was romanticized. The melancholic was provided with a voice through the works of great artist and writers such as Albrecht Dürer, Desiderius Erasmus, Miguel de Cervantes, and William Shakespeare.

Especially Shakespeare (1603) contributed with insight about melancholia by the figure of Hamlet. Some of the most famous words "To be or not to be, that is the question" (Shakespeare, Hamlet, Act Three scene one, ll. 56-68 ff.) is said by Hamlet when he is questioning whether life is worth living with all of its pain and suffering. In another play by Shakespeare the endless variety of melancholies I showed:

"I have neither the scholar's melancholy, which is emulation; nor the musician's, which is fantastical; nor the courtier's, which is proud; nor the soldier's, which is ambitious; nor the lawyer's, which is politic; nor the lady's, which is nice; nor the lover's, which is all these: but it is a melancholy of mine own, compounded of many simples, extracted from many objects, and indeed the sundry contemplation of my travels, which, by often rumination, wraps me in a most humorous sadness." (Shakespeare, As You Like It: Act 4, Scene 1)

Before Shakespeare, melancholia had mostly been separated from the person of the condition due to the belief of the biological emergence, but afterwards it was hard to separate the condition from the personality. At the same time melancholia was now not only viewed as a disease, but also as a privilege. Due to the curious cultural and literary awareness of melancholia it became one of the major historical conditions worth suffering from, if one wanted to be literate. As melancholia also was connected with terms like depth, soulfulness, complexity and even genius, people started mastering the depressives’ behavior. Even though real melancholia was painful, melancholic behavior could be pleasant; lying on the couch, staring at the moon and asking existential questions. All this led to melancholia becoming even more unclear and ambiguous (Solomon, 2006).

The diversity in symptoms, that the quote from Shakespeare’s play also emphasizes, caused the frustration of the English scholar Robert Burton. One of the most quoted books from the 17th century was his book The Anatomy of Melancholy from 1621, where he throughout his work struggled to find coherence in the numerous symptoms melancholia displayed (Radden, 2002). According to Burton the issue was to distinguish between normal and everyday subjective and behavioral symptoms of melancholia and more serious conditions:

"Melancholy, the subject of our present discourse, is either in disposition or habit. In disposition, is that transitory Melancholy, which goes and comes upon every small occasion
of sorrow, need, sickness, trouble, fear, grief, passion, or perturbation of the mind, or any
manner of care, discontent, or thought, which causeth anguish dullness, heaviness and
vexation of spirit, any ways opposite to pleasure, mirth, joy, delight, or causing frowardness
in us, or a dislike” (Radden, 2002)

Furthermore, Burton pointed out that different people handle common everyday life events in vastly
different ways and has a different ability to endure pain, which is why it is both the amount of burdens and
the threshold of pain that determine whether one becomes ill. Burton described melancholia as caused by
the mind which then in turn affected the brain, heart and other organs. He noted that it is the manner,
personality, and temperament of the mind that transmits the disease and not the physical body. Like
Hippocrates Burton suggested, melancholia could be combated with a healthy diet, sufficient sleep, music,
meaningful work, along with talking about the problem with a friend:

“There is no greater cause of melancholy than idleness, no better cure than business.”

“But to leave all declamatory speeches in praise of divine music, I will confine myself to my
proper subject: besides that excellent power it hath to expel many other diseases, it is a
sovereign remedy against despair and melancholy, and will drive away the devil himself.”
(Radden, 2002).

Burton’s familiarity with the vast medical literature made him careful to maintain a difficult balance
between melancholia as a diagnosis and as a metaphor for life; the biomedical model of madness as a
physical illness and the opposite tradition, in which melancholia could be the source of genius, prophecy,
and poetry. Burton thereby contributed to the understanding of melancholia by expressing the complexity
of the cause and that there were typically many factors causing melancholia. In his writings melancholia
suggested from everything from a disease resulting from the imbalance of black bile which named a wide
number of medical disorders including epilepsy, apoplexy etc., to a gloomy, pensive temper or habitual
disposition. Melancholia was also considered a kind of madness, characterized by delusional thinking,
which became the dominating definition throughout the 18th century (ibid.)
“The tears of the world are a constant quantity.”

Samuel Beckett
The Arise of Psychiatry

Since the understanding and treatment of depression are highly linked to the development of the psychiatric field and also that depression in most of the literature is not always separated from other mental diseases, the following section will analyze the emergence of the psychiatric field in order to understand the view and treatment of mental diseases and thereby depression. The following will show a change in the medical treatment, as the approach towards the body and mind became increasingly evidence-based. At that time the idea about how the framework for the treatment had huge impact on the improvement of the depressed aroused and different rationales occurred.

A Shift in Paradigm

In the 1800s hospitals and other forms of public care facilities flourished and the society began to take care of those who were ill, unemployed, prisoners, poor, mad etc. According to Foucault the modern medicine is not an understanding of the true nature of the body or disease. From the beginning it was closely linked to political and economic power structures of society and was simply a shift in the structure of knowledge (Foucault, 2003). The shift is shown by the concept of the medical gaze that indicates the dehumanizing medical separation of the patient's body from the patient's identity:

“Generally speaking, it might be said that up to the end of the eighteenth century medicine related much more to health than normality; it did not begin by analyzing a ‘regular’ functioning of the organism and go on to seek where it had deviated, what it was disturbed by, and how it could be brought back to normal working order; it referred rather, to qualities of vigour, suppleness, and fluidity, which were lost in illness and which it was the task of medicine to restore. To this extent, medical practice could accord an important place to regimen and diet, in short, to a whole rule of life and nutrition that the subject imposed on himself. This privileged relation between medicine and health involved the possibility of being one’s own physician. Nineteenth-century medicine, on the other hand, was regulated more in accordance with normality than with health; it formed its concepts and prescribed its interventions in relation to a standard of functioning and organic structure, and physiological knowledge – once marginal and purely theoretical knowledge for the doctor – was to become established (...) at the very centre of all medical reflexion.” (Foucault, 2003, s. 41).

The new and more positivistic medical profession viewed the individual as both subject and object of its own knowledge. As the quote indicates individuality is put into perspective and highlights the tension between oneself and the general and normal. The medical profession turned into institutions with the
purpose of identifying the various diseases and teaches how to recognize them and throughout Europe the mad were being excreted and isolated in asylums (Foucault, 2003). This reorganization of knowledge and the emergence of medical institutions also had a great influence on the understanding and treatment of depression.

**Mental Illness is a Disease of the Brain**

In Denmark the liberal bourgeoisie increased in the 1830s and 1840s and achieved a growing political influence and power, criticizing the institutions and the authorities of the monarchy. The changing “Stænderforsamlinger” in the 1840s discussed and also enabled “Daarevæsenet” and the care for the mental disordered, leading to a “Helbredelsesanstalt” for deviants exclusively designed and built for the treatment of mental disorders (Kragh, 2008). The idea of treatment of mental diseases as physical continued and was in particular represented by Chief physician Knud Pontoppidan, who through his work tried to establish the biological discourse that helped to initiate the paradigm shift in the perception of the character of mental disorders:

“Det, vi have at gøre med i vor Egenskab af Læger, er legemet; dersom der gives noget saadant som Sygdomme af Sjælen, saa kunne vi ikke gøre Noget derved. Negative og positive sjælelige Symptomer ere for os kun Tegn til, hvad der ikke gaar for sig eller hvad der gaar forkert for sig i de højeste Nervecentrer.” (Kragh, 2008, s. 90).

Also Chief physician Selmer explained:

“At de Afsindige hverken ere mere eller mindre end Syge” (Kragh, 2008, s. 90).

This view characterized the discourse from the 1830s. The leading psychiatrists at the newly constructed institutions were, thereby, trying to consolidate psychiatry as a somatic and pure medical scientific domain. Chief physician at the asylum in Viborg, Christian Geill, stated:

“Sindssygdom er altid en Sygdom i Hjernen, paa samme Maade som Lungebetændelse er Sygdom i Lungen” (Kragh, 2008, s. 90).

Thereby, the efforts during the latter half of the 1800s were marked by a quest to get psychiatry as a medical specialty in line with other fields of the somatic medical science. However, despite the psychiatrists’ attempts, for instance, to identify a hereditary cause of the mental suffering based on a lot of autopsies, they never succeeded to identify and detect visible changes in the brain or a reasonably common, unambiguous and consistent description of depression or any other form of mental disease (ibid).
The Moral Treatment

Even though psychiatrists from the 1840s used chloral hydrate, opium, barbiturates and lithium in order to treat their patients, they were well aware that these medications were not curing the patients and that they were associated with side effects, even some of them directly toxic in overdose. Also, they were aware that the medical treatment was a way for them to control the patients – a form of coercion. Some even distanced from it and called it a chemical restraint (ibid. p. 102). In other words, it was the hospitalization, which was the center of care. According to Selmer, the institution should also constitute the framework of "moral treatment" of the patients:

“(...) ved den indflydelse, som den pludseligt forandrede Livsorden i Forbindelse med en fast og konsequent Leveplan, der udgjør et organisk Led i en fornuftig Tingenes orden, ikke vil udlade at udføre: dels mere umiddelbart (direkte), ved at bearbejde de Sjæleevner, som endnu er modtagelige for en speciellere Paavirkning. Den moralske Behandling bestaar væsentlig i en af Humanitet og fornuftig Kjærlighed gennemtrængt, med Alvor og Fasthed overholdt, og paa den Enkeltes Individualitet næje beregnet Opdragelsessystem, som først og fremmest berover Patienten den tøjlesløse Raadighed over sine Handlinger, og nøder ham til at finde sig i de Indskrænkninger, hans nye Opholdssteds love udkræve, og til i Et og Alt at rette sig efter en højere fornufts uindskrænkende Bydende....” (Kragh, 2008, s. 102).

This indicates that the institution was more a therapeutic community or a social psychiatric measure which offered order and care, regularity and occupation, located in quiet and beautiful surroundings. However, it was not being themed as such by the psychiatrists, which indicates the contradictions within the somatic view and a coexistence of two rationales. On one hand the moral treatment was valued by some; chief psysician, Valdemar Steenberg stated in 1866:

“(…) en rigtignok paradoxagtig, men dog træffende Yttring af en af Tydsklands første og største Psykiater, at han havde helbredet flere patienter ved Hjælp af Hjulbøren end ved sit Medicinskab” (Kragh, 2008).

On the other hand other psychiatrist found that unfortunate. Pontoppidan noted in 1901:

“(…) de to ældste Statsanstalter var blevne aldeles overvejende Plejestiftelser.” (Kragh, 2008).

Based on that, it was difficult for the psychiatrists to establish the field of psychiatry and the treatment of depression and other mental diseases as to be treated under the same conditions as the physical diseases. A doctor assistant at the municipal hospital in Copenhagen noted in 1918 that:
“(...) det er Hjernen, der er syg; men til syvende og sidst ved vi bedre end alle andre, at det kun er saa som saa med Beviserne. Det psykiske Symptombillede er tydeligt, men dets somatiske Ækvivalent kender vi ikke.” (Kragh, 2008).

At this time it is seen how the treatment of the psychiatric patients were dominated by different rationales and the psychiatrists were not able to explain neither the cause nor the proper treatment.

**Depression, Women and Anti-psychiatry**

Another radical change was that depression became more and more associated with women through the 19th century (Radden, 2002). According to Inger Hartby (2006) women were marginalized due to the dominant social norms in the 1800s and 1900s. Assigned housework was, for instance, harmful for women when it was not their own decision; they missed the freedom to control their own lives. Hartby suggests that the women’s mental health problems were a symptom of an intolerable situation, shown in a self-destructive manner. Body language or symptom language were, therefore, to be seen as when the individual wanted to express something without taking full responsibility for it and expressed “ondt i livet” (Rønn & Hartby, 2006, s. 256). Marie Kirstine (1862-1926) who was hospitalized for most of her life mentioned in one of her letters that she has become who she was due to the lack of love. Her history had been fertile ground for discussions about whether it was a congenital disease or due to social and cultural circumstances (ibid.). Likewise, the writer Amalie Skram who had been hospitalized wrote in 1894 a fierce criticism of her meeting with psychiatry in her key novels *Professor Hieronimus* (Knud Pontoppidan) and *Paa Sct. Jørgen*. Amalie Skram described the humiliation and the institutionalized power by psychiatry as a field and especially its psychiatrists. It was one of the most dramatic incidents in the history of Danish psychiatry, and he books provoked a strong public debate on contemporary mental health care, and in the mid-1890s there was a genuine anti-psychiatric protest movement, where several respectable citizens explained that they have been detained against their will. It raised debate in the largest newspapers in Denmark, and the matter was brought up in Parliament (Kragh, 2008). Thus, soon after the emergence of the psychiatric field it was met with massive criticism. This form of criticism continued to battle with the existing way of treating the psychiatric patients, however, it never succeeded to break with the dominant discourses.
“Vi har ingen fakta, som i dag sætter os i stand til at lokalisere de psykiske processer i hjernen bedre, end det var tilfældet for 50 år siden.”

Shephard Ivory Franz, 1916
The Ongoing Discursive Struggles of Power

In the beginning of the 1900 century there were still no effective treatments in psychiatry, but only endless disease descriptions and philosophical-speculative discussions about mental illnesses. After approximately 100 years, psychiatry had not come closer to understanding or curing depression or any other mental health problems. As shown, there has always been a battle between those who viewed mental disorders as a physical defect in the brain and those who viewed it as a mental flaw (Kragh, 2008). This continued in the 20th century where two important movements regarding both the treatment and the understanding of depression emerged; the biological, which led to more absolute categorizations and the psychoanalytic, which led to many social science theories of the mind. This section will look into how the two different beliefs contributed to the treatment of depression as we know it today.

The Father of Modern Psychiatry

Emil Kraepelin (1856-1926) was one of the leading psychiatrists of his time and is particularly known for his clinical description and classification of mental disorders. Like Hippocrates, Kraepelin worked from an assumption of underlying brain pathology postulated that a specific brain or other biological causes was at the root of each of the major psychiatric disorders (Davison, 2006). The term depression came into general use in the 1850s (Solomon, 2006), and Kraepelin was one of the first to use it as the overarching term, referring to different kinds of melancholia as depressive states (Davison, 2006).

His book *Manic Depressive Insanity and Paranoia* (1921) included comprehensive descriptions of myriad forms of depression and mania and the risk of suicide. Even though it had been well known, for instance in the figure of Hamlet, Kraepelin was one of the first to describe it in a more clinically way in one of his writings *Manic-depressive Insanity*:

“Nevertheless the danger of suicide is in all circumstances extremely serious, at the volitional inhibition may disappear abruptly or be interrupted by violent emotion. Sometimes the impulse to suicide emerges very suddenly without the patients being able to explain the motives to themselves.” (Radden, 2002, s. 260).

Kraepelin’s system, developed through his famous Textbook of Psychiatry, stands out as one of the most systematic and clinically based. His classification and diagnostic system of mental disorders remains the basis used by both the World Health Organization and the American Psychiatric Association, which also provided him with the name; “Father of modern psychiatry” (Radden, 2002, s. 260). Contemporary scientific psychiatry is therefore directly based on Kraepelin’s findings and theories (ibid. p. 21). Not only
did it become the primary source for the 20th century classifications, it also dominated the discourses and contributed to the continuation of the biological approach. However, the biological concept of depression was by others considered to be too narrow, which led to alternative approaches.

The Establishment of the Psychoanalysis
At the same time as Kraepelin, Sigmund Freud (1856-1939) broke new ground with the entry of the psychoanalysis. This was considered as an alternative approach to the treatment of depression and most of the psychiatrists were (and still are) skeptical. As opposed to Kraepelin and the biological approach, Freud implicated childhood trauma and unresolved developmental conflicts. He theorized that objective loss, such as the loss of a valued relationship through death or a romantic break-up, resulted in subjective loss as well, which could result in severe depressive symptoms more profound than mourning. In this respect Freud relied on some of the psychological believes by Aristotle at the same time as he also introduced a new kind of theory due to the intrinsic focus directed towards the self (ibid. p. 44). Likewise several aspects of the Renaissance tradition appear to have found its way into the writing of Freud, by for instance admitting that; “the definition of melancholia is uncertain; it takes on various clinical forms (...) that do not seem definitely to warrant reduction of unity.” (ibid. p. 282-283). Also, by choosing Hamlet as an example suggesting that the melancholic; “has a keener eye for the truth than others who are not melancholic”. This gave in the eyes of Freud the melancholic a glamorous aspect, which is also quit similar to the view of Aristotle (ibid.).

In 1917 Freud wrote his groundbreaking essay *Mourning and Melancholia*, which have had a great influence on our contemporary understanding of depression (Solomon, 2006, s. 450). As the title revealed Freud pointed out the similarity between mourning and melancholia although the treatment of the two were very different (Freud, 1917, s. 223-224). Ever since Burton, the conviction of the danger of idleness and that the man was made to be active was expressed by different medical writers of the 20th century including Freud (ibid.). In contrast, Kraepelin recommended the rest cure treatment of melancholia prescribed especially for middle- and upper-class women whereas he saw work as valuable primarily for men (Radden, 2002).

From the mid-1930s, it was in medical journals as *Hospitalstidende, Ugeskrift for Læger* and *Yngre Læger* discussed, which justification psychoanalytic insights and processes had in relation to both depression and other mental disorders. Amongst other things, it was argued that:
This shows how the psychoanalytical inspired realizations began to spread to both doctors and psychiatrists, which also led to the first Danish children's psychiatric ward in 1944 (Brinkmann, 2008). Furthermore, it was argued for greater involvement of Freud in the medical school (Liebman 1948, p. 1203).

These events should not be understood as an expression of that the biological approach towards depression was replaced by psychological forms of knowledge and treatment techniques. It only suggested the beginning of involving the individual's self-relation and the relation to its surroundings, in the psychiatric practice. Unlike the past when people were viewed as born either ill and deviant or healthy and normal regardless of socialization and the individual's will, by that time the individual was now seen as born healthy and normal, but could be ill if it later in life did not have the opportunities to develop the right relationship with its self and the surroundings. Thereby, the subjective techniques to work with the individual's own relationship to develop a healthier mind were founded. During this period there were established national consulting clinics which emphasized the importance of the character of advice should be; “hjælp til selvhjælp” rather than “gode råd” (Christiansen, 1955, p. 64) (Larsen, 1954, p. 57). The interesting about these clinics is that it was pointed out that it was only those who regulated themselves who could expect to get something out of the treatment. Meaning that those who thought that the counselor or medication should solve their problems were not curable (Larsen, 1954, p. 58).

The psychological and psychoanalytical discourses that Freud and others tried to establish did not succeed to break with the dominating biological discourse. It was important for the psychiatrists that psychiatry was similar to the other medical specialties with the same type of object in the form of diseases which could be explained, classified and treated like any other physical disease; exactness and science were the focal point (Kragh, 2008). Therefore, there was a lack of interest among most of the Danish psychiatrist in relation to the Freudian psychoanalysis and the development of the biologically oriented psychiatry continued. However, as shown, some of the ideas from the psychoanalytical approach managed to influence the psychiatric practice and a new focus on the psychiatric patient started to emerge. Nevertheless, it was difficult for the psychiatry field to emerge as an authoritative form of knowledge and it was still, ever since the beginning, the weakest field of the entire medical fields (ibid.). Therefore, a lot of experimentation took place, as the following will show.
“Ufrugtbargørelse af vise sindssyge og psykopater (...) – det er en tanke der i høj grad fortjener fordomsfri diskussion. Forslaget om ved sterilisation at forhindre fødsel af sådanne defekte individer er da logisk og humant nok”.

Wimmer, 1929
From Miracle Treatments to Huge Mistakes
Since there was no clear explanation of depression or any other mental disease or any proper treatment, the psychiatric field continued to experiment with different types of treatment solutions. Many of them were in an attempt to approach the treatment methods used for physical illnesses. However, a lot of them opened up to even more criticism as will be shown in the following.

The time of experimentation
From the 1920s the psychiatric field introduced a lot of experimental treatment. There was a trend towards physical ‘treatments’ such as shock treatments with insulin etc. Ph.d. Elliot S. Valenstein noted that:

"Fysiske behandlinger også hjalp psykiaterne med at opnå respektabilitet inden for det lægelige område og gjorde dem i stand til mere succesfuldt at konkurrere med neurologerne, som ofte behandlede patienter med såkaldte 'nervøse forstyrrelser'" (Valenstein, 1998, p. 19)

One treatment that was used to treat thousands of patients included injecting malaria infected blood into the patients and Professor Julius Wagner-Jauregg at the psychiatric university in Vienna, received the Nobel Prize in Medicine for his discovery. The Danish psychiatrist August Wimmer noted in 1936 that many had been experimenting with the different treatments with fever, but "the results are questionable" (Kragh, 2008). In the early 1940s electroshock and lobotomy were introduced, once again accompanied by a significant belief in better times for psychiatry. Chief physician P.J. Reiter states in regards to electroshock:

“(...) de fleste steder i verden, også herhjemme, er taget systematisk op som et fast led i hospitalsbehandlingen (...) og behandlingsresultaterne har allerede givet anledning til en betydelig optimismе”. (Kragh, 2008).

During the 1940s Denmark achieved supposedly "world record" in electroshock therapy, especially targeting deep depressive states. However, later studies showed that only in a very modest scale there was a durable treatment effect. Lobotomy was developed by the Portuguese neurologist, Egas Moniz, who also received the Nobel Prize for his discoveries. It was practiced on a large scale throughout the 1940s due to the belief that mental illness 'was' in the brain, it provided a basis for the belief that creating physical changes in the brain could cause behavioral changes. A massive governmental support and financing also contributed to its widespread as well as the opportunity to get some of the many psychiatric patients out of the overcrowded mental hospitals (Kragh, 2008). This led to more than 4,000 Danes, especially women with depression, being conducted to lobotomy in the period between 1939 and 1983 (Videnskab.dk, 2010). Years later lobotomy was discovered as extremely damaging and that the suffering consisted of mutilation
and primitivisation of personality. The treatment was soon after convicted as an unfortunate mistake – just like the other experimentations. One of the doctors at Medical City Hospital, J. Welner, indicated that lobotomy was “verdenspsykiatriens skandale” (Kelstrup, 1983).

The Anti-Psychiatry Continued
The experimentation and the many mistakes and scandals led to the anti-psychiatry intensifying the attempt to break with the dominant discourses. In 1960 psychoanalyst Thomas Szasz published the book *The Myth of Mental Illness* and described the concept of mental illness as directly harmful (Szasz 1970). He also considered the diagnosed patient as a scapegoat and a victim of the institutionalized psychiatry’s ideological practices; those diagnosed are just people with great moral and interpersonal conflicts. Like the witches were persecuted by a society in crisis, he believed that our current society also needs scapegoats and an institution that appoints, stamps, ‘treats’ and neutralize scapegoats (ibid.)

At the same time the British psychiatrist Laing published his criticism of psychiatry in *The Divided Self* and became the head of the anti-psychiatry movement in England. Inspired by American psychotherapists, Laing (1970) believed that the diagnostic psychiatry does violence on people by considering them as objects and diagnose them. He believed that the encounter between patient and therapist should be a meeting between two people where the therapist’s role is to empathize with and understand the patient’s experience the world, feelings and divided mind (Laing, 1970).

The criticism pointed together in the direction that the psychiatric practice with its institutions, diagnoses, understandings of the individual and biological causal explanations of diseases exercised inhumane and repressive forms of power that excluded and stigmatized patients. However, once again it did not influence the medical practice.

As mentioned, there were already several political and economic incentives in play at this time which will be examined in the following.
“Vi sindsygelæger har aldrig været forkælet af Heldet eller forvænt med straalende sejre, og nu da jeg bliver spurgt lige ud, saa maa jeg erkende, at der intet Gennembrud er sket i Sindssygebehandlingen i min tid...Derfor er det i Dag lige saa ulykkeligt for et Menneske at blive sindssygt, som det var for 30 Aar siden.”

Hjalmar Helweg
The Economic Policy Discourse as Part of the Medical Development

In *Madness and Civilization* Foucault explains how the houses of confinement in the seventeenth century, was one of the answers to the economic crisis at a time when European states were expanding and exercising greater control over their citizens. It was an age that tried to define "normality" in terms of economic productivity attempting to isolate and exclude those who could not or would not produce.

According to Jesper Vaczy Kragh the political will to delimit mental disorders from the public sphere had already been there for decades:

"Linjen lå der allerede. Fra 1929 og senere havde man vedtaget love om sterilisation og kastration og ægteskabsslove, som forbød psykisk syge at gifte sig. Vi sendte åndssvage ud på øde øer og gav psykopater tidsubestemte straffe" (Information.dk, 2010).

Likewise the Danish political and economic context was also central in regards to the treatment and use of anti-depressive medication as the following will show.

The Revolution in Treatment

As Edward Shorter (1997) describes, a revolution occurred between 1950s and 1990s and the biological discourse within the medical field led to a new discovery. In 1953 the antipsychotic drug chlorpromazine came on the market and was immediately used in psychiatric treatment. Two years later it was estimated that 5 million people worldwide was treated with it. Already in 1956, there were published more than 3000 articles about the drug and its clinical application. Chlorpromazine inaugurated the psychopharmacological era in psychiatry. Psychiatrists were again talking about a treatment miracle, which also contributed further to the legitimization of the biomedical disease concept in terms of mental disorders. Once again, a Nobel Prize was handed out, this time for the dopamine theory developed by the Swede Arvid Carlsson.

Psychiatry and the treatment of depression seemed to have developed into pure science and a biological-chemical matter (Vaczy Kragh, 2009, p. 262). Earlier rationales regarding the use of medicine as only symptom relieving and not curative, which had existed right from the beginning of the psychiatric field until the consulting clinics, were now being replaced by an optimism of the new breakthrough.

The biological psychiatrists that had been challenged by the psychoanalysts and psychotherapists attempted to change the discourse, not only became the most dominated by the development of the psychoactive drug, it was also considered a success that the treatment focused on the dysfunction in brain chemistry. At the same time the Danish national economy was under a lot of pressure and there was a need to conserve the resources of society. Due to higher wages and regulated working hours, the Danish health care system had become expensive. The decentralization policy was part of the economic policy.
pursued from end-1960 and along with the Danish Local Government Reform from 1970 was a political pressure to save cost by increasingly treating the psychiatric patients ambulatory instead of by hospitalizations (ibid.). On April 1, 1976 the law on state hospital transfer to the counties came into force.

Decentralization and a single hospital system were politically desirable. In Betænkning om psykiatriens udvikling i Danmark i den nærmeste fremtid (Sundhedsstyrelsen, 1970) three arguments were referred to as central; first, the transfer of state hospitals to the counties was part of the decentralization process and general changes in the distribution of tasks between the state, counties and municipalities. Secondly, it was viewed that the medical science had blurred the distinction between mental and physical diseases, therefore, it was no longer necessary to have state hospitals with a special status but should be administered in the same way as in other diseases. Thirdly, the mentally disordered were now able to enter the hospital the same way as with any other physical disorder. An equality that was believed to have a non-stigmatizing effect. The rationales behind the decision to establish the district psychiatry were, therefore, not based on the new knowledge and therapies that had emerge by Freud and others. Rather, it was emphasized that the reorganization was due to the development within the medical science that did not require the need for special hospitals for mental diseases (Ibid.).

Also, the arguments were based on economy rather than treatment purposes. Soon after the Food and Drug Administration approved the use of chlorpromazine, classified as a typical antipsychotic, the number of psychiatric patients in public hospitals in New York began to decrease. Within 30 years the reduction of patients was 80 percent. A similar decline occurred in Denmark. This means that not only did the revolution of the treatment options regarding both anti-psychotic and anti-depressive medicine help to legitimize the biomedical disease perception, there were also economic incentives that triggered the process as it helped with the cost savings in the Danish health care system. The process surrounding the introduction of the anti-psychotic drugs in the 1950s also became known as de-institutionalization because it resulted in massive discharge of psychiatric patients (Shorter, 1997, p. 331):


Fast-cost reductions were needed in the health care sector, and in the magazine Medicinal Debat it was emphasized that; increased use of medications can lead to fewer sick days and hospital admissions. A 10% increase in drug consumption - equivalent to approximately 150 million DKK - could be matched by 5-10% savings on the total cost - equal to 1-2 billion DKK (Kelstrup, 1983, s. 241-242). This view was followed up in another issue of the magazine with a special view on psychoactive drugs. H. Dybroe from the Medicine
Importers Association was asked during an interview if we were using too little medicine. The answer was a clear yes and he introduced the following calculation:

“In 1950/52 - before the introduction of psychoactive drugs - the number of mental patients were 27,000. In 1972 - after the introduction of psychoactive drugs – there were 54,000 patients, but the treatment time decreased at the same time from an average of 142 to just 80 days. This meant that twice as many patients almost could be treated in the same number of beds. The total savings went up in millions.” (Kelstrup, 1983).

It was, therefore, recommended to treat the patients with the psychoactive drugs. The money spent on the development of the medicine and the increased use of symptom-relieving chemicals was, therefore, in order to offer a cheap solution to people’s mental health problems (Scheff, 1966). The question is whether the treatment with medicine as a cost saving solution will cost society more money on the long term than if the focus was on finding long-term solutions?

However, the success regarding the anti-depressant medication was not only due to the development of the medicine and the political and economic incentives. It was also greatly connected to the huge media coverage and awareness of both the condition and the medicine as the following will show.
“Selv for tidstypiske lidelser som angst og lettere depression, som er menneskehedens lod, kan symptomerne lettes med medikamentel behandling, der sparer timevis af formålsøs snak. (...) Freuds ideer, som dominerede psykiatriens historie i det foregående halve århundrede, er glemt, som den sne, der faldt i fjor.”

Edward Shorter
The Entry of the Happy Pills

Even though most of the history of psychiatry is marked by the institutions not using medical care as the primary treatment, which changed radically. First, with chlorpromazine and then with the entry of the anti-depressive medicine. The development of the medicine and the accurate diagnostics suited the biological psychiatry and was, therefore, a sign of progress and contributed to legitimize the biochemical perception of the mental diseases (Kragh, 2008). The following will show that patients' attitude towards the medical treatment can be influenced by the awareness of the anti-depressants in the public sphere.

The Public Awareness

The Pharmaceutical giant Eli Lilly introduced Prozac in January 1988 as a new generation of antidepressants. Soon after it became a heavy debated topic in the media. In March 1990 Newsweek had a picture of a huge a green-and-white Prozac capsule floating against a blue sky on the cover with a headline saying: “A Breakthrough Drug For Depression” (Appendix 2). Newsweek covered a story anticipating that "these breakthrough drugs may change the lives of millions." Along with the story was a photo of a smiling woman saying "I'm nowhere near perfect, but it's a big, big improvement." Newsweek reported how the patient had declared to her doctor, "I call myself Ms. Prozac." (Newsweek, 1990). This became the starting point of a huge media coverage and heavy advertising. Also, a lot of books became published. Psychiatrist Peter Kramer’s Listening to Prozac became a bestseller describing how anti-depressants could transform lives – curing not only depression but also shyness, low self-esteem, and compulsiveness. However, the portrayal in the media was not only positive. Time Magazine released an article with the headline: Warnings About a Miracle Drug due to the raising doubts related to reports of suicide attempts by Prozac users:

“A swift and sweeping popularity is often followed by a stinging backlash. That is as true for medical therapies as it is for hit TV series and fashionable restaurants. The latest example: Prozac, a drug taken to combat depression. Introduced in January 1988 and hailed as safer than competing medications, Prozac quickly surged to star status, thanks to skillful promotion by manufacturer Eli Lilly, glowing word of mouth among doctors and patients, and heavy media attention, including cover stories in Newsweek and New York. Sales are expected to top $700 million this year, making Prozac the leading antidepressant.” Time, July 30, 1990 (Time.com, 1990)

Also The New York Times, December 1993, declared the concern: “With Millions Taking Prozac, A Legal Drug Culture Arises” (nytimes.com, 1993). The media coverage led to an enormous awareness of the drug,
not only within the medical field, but in the general public. By 1993, Prozac had been taken by some 10 million people around the globe and annual sales neared $800 million (fortune.com, 2005). This media coverage continued with all kinds of discourses trying to establish themselves as objective and thereby influence views, which also led to an evolving of our language.

The Awareness Changed the Language which Changed our Perception

Our language is constantly evolving in line with the evolving of society, and we keep getting new things to name in order for us to talk about them. From the early 1990s, due to the huge media coverage a number of discursive movements happened and medical concepts, explanations and solutions began to flow confusingly and contradictory together. From being exclusively a discourse associated to the medical field to now being a part of everyday language in a way not seen in any other medical specialty. One can talk about being mad, schizophrenic or a little paranoid and the term depressed is used as a general slang for sadness, confusion or dissatisfaction; "it makes me feel depressed". Terms that were previously unknown became part of the everyday language. Depression, serotonin level etc. Also anti-depressive medicine has been called a lot of things over the years. One term has stuck to it; happy pills, which is rather misleading since it only aims at ‘normalizing’ the mood. The word happy pills has since early 1990s been used more than 10,000 times in the Danish media stories, and it has been in the Danish dictionary since 2001. Happy pills has been an applied term in everything from business news in Børsen; “Lundbecks markedsføring af den nye lykkepille, Cipralex” to headlines in Ekstra Bladet like; “Lægeformand slår alarm: 460.000 danskere på lykkepiller”. Our use of the clinical language to describe non-pathological disorders has, according to philosopher Rasmus Johnsen, Copenhagen Business School, provided new challenges:

“Når det ikke længere er skamfuldt at have en depression for eksempel, så begynder mennesker at bruge diagnosen på nye måder. Det giver os nogle nye udfordringer. Vi satser måske politisk på hjælp til de forkerte, fordi den virkeligt syge bliver usynlig. Eller vi kommer til at sige til den virkeligt syge: ‘Vi ved godt, at du er deprimeret, men det er der jo så mange, der er. Du er nødt til at tage dig sammen.’ Det sniger sig ind via sproget”. (Information.dk, 2013)

The use of the new terms led to a form of non-stigmatizing of depression, which means that it became much less shameful to have a depression than previously, and the language contributed to make both the condition of depression and anti-depressive medicine harmless and commonly. Signe Kierkegaard Cain, author of Det handler ikke om lykke stated:
If it was difficult before to distinguish whether a person had a clinical depression or not, by the medical terms being a part of the everyday language, depression became more common and thereby it became even harder to determine:

"Amerikaneren Elizabeth Wurtzel, der skrev Prozac Nation, sagde allerede i 90’erne, at det var blevet trendy at have en depression. Man kan ikke bevise, om vi har fået flere diagnoser, fordi den antidepressive medicin udskrives så bredt, som man har gjort. Men medicinen har været med til at gøre det mere almindeligt at være deprimert." (Information.dk, 2013a)

According to Montagne (2001) an individual’s knowledge about medicine from either reading information, listening to the media and promotional campaigns, receiving descriptions of others' experiences, and recalling their own previous experiences, will affect the actual use of the medication. In every society there is also a social knowledge that has a symbolic component (psychiatrictimes.com, 2002). The nature and meaning of the use of medicine is often described, remembered and transmitted through society in symbolic forms, as images, representations or metaphors. The imagery and symbolism in advertising and mass media in regards to the anti-depressive medicine sometimes showed how it promised to solve health and life problems in magical ways. This means that those who are labeled as depressed and were offered anti-depressants could become "trapped" within the discourse and within the structures designed to confine them when it was not the case.

The question is whether the increased number is caused by people actually needing it or if it is due to the awareness in the mass media? Like Shakespeare’s contribution to the understanding of melancholia showed, along with the increased awareness came an increased number of people feeling melancholic. The same could be the case in regards to anti-depressants and that the awareness led to more people feeling depressed. And perhaps also diagnosed with depression as will be analyzed in the following.
Awareness Makes the GP Diagnose More Often

Even though the psychiatric field was responsible for most of the mental diseases, the report from the conference in 1999 "Depression – en folkesygdom der skal behandles" declared:

"Det bør også fremover være en lægelig opgave at stille diagnosen depression, og det anbefales at denne diagnosticerings fortsat varetages af den alment praktiserende læge. Der skønnes behov for efteruddannelse af alment praktiserende læger i diagnostik og behandling af depression." (laeger.dk, 1999).

The pharmaceutical industry conducted a comprehensive propaganda towards the GPs and psychiatrists in order to promote the sale and use of the drugs (Kelstrup, 1983). Also, the psychiatrists launched in 1998 an even stronger coordinated effort to gain support from the GPs - primarily through the Collegium Internationale Neuropsychopharmacologicum (CINP), the American National Institutes of Mental Health (NIMH) and the World Psychiatric Association (WPA). WHO even produced an information package on "Sindslidelser i praktiserende lægepraksis", which was released internationally, and made it easier for the GPs to diagnose mental disorders (Glenmullen, 2001, p. 12.). The psychiatrist Joseph Glenmullen from Harvard stated:

"I starten bliver psykofarmakaen aggressivt markedsført med påstande om, at de er revolutionerende gennembrud, bemærkelsesværdige videnskabelige forbedringer i forhold til deres forgængere. Efterhånden som de oplever medvind, breder brugen af midlerne sig ud over psykiatriens rammer, og de bliver ordineret af praktiserende læger for hverdagens sygdomme." (Glenmullen, 2001, p. 12.).

This contributed to that the psychiatric thinking and practice ever since it emerged, no longer have to deal with to imitate and gain acceptance from the medical field. Through marketing of its diagnostic system and psychoactive drugs, psychiatry has become an integral part of the GPs medical practice.

By the awareness in the public the GPs experienced more patients demanding to have the new drugs (ibid. 14), and both the awareness, demanding and the campaigns also made the GPs diagnose their patients with depression more often (Shorter, 1997, 344). As Shorter notes; GPs’ prefer to diagnose conditions they can treat rather than those they cannot process (ibid., p. 344):

"Anecdotally, pharmacists have reported that the day or two after a news story or new DTCA (direct-to-consumer advertising) for a medication comes out, they will see a massive increase in the number of prescriptions for that specific medication" (psychiatrictimes.com, 2002).
Both the awareness and availability of the medicine thereby contributed to the increased use of medicine, and as a consequence depression had become one of the most common diseases in the western world.

The Huge Awareness Led to Prescriptions for Everything
The promises about a problem free life provided by the anti-depressive medicine had a faster breakthrough than any other psychiatric medication. Scientists were publishing a huge number of articles about the effect not only on depressions but also all sorts of affective spectrum disorders (Edward, 1997, p. 382). *The New England Journal of Medicine* published an article in 2000 saying:

“Since normal bereavement can lead to major depression, grieving patients who have symptoms of depression lasting longer than two months should be offered antidepressant therapy.” (Whooley, 2000, p. 1943).

In regards to Freud, the behavior of someone mourning was at his time explainable and was not considered pathological. However, as the quote indicates this view seems to have changed. The medicine was also seen as a solution to women, who throughout history had been viewed as more likely to have depression. Likewise, in the book *Lykkepillen – lys for enden af tunnelen*, Helge Holst Kjærsgaard explains how treatment with anti-depressive medicine also can have a dampening effect on the mood swings associated with pre-menstrual syndrome (PMS) and suggest either SSRI’s or ECT if one experiences being sad during and after pregnancy, abortion, aging and in relation to menopause - in short, virtually all forms of sadness that are an inevitable part of life:


Also a lot of other conditions were added to the list of what anti-depressives could prevent; anxiety, obsessions, compulsion, eating disorders, headaches, back pain, impulsivity, drug and alcohol abuse, hair pulling, nail biting, upset stomach, irritability, sexual addictions, premature ejaculation, attention deficit
disorder, and premenstrual syndrome (Glenmullen, 2001, p. 14). Joseph Glenmullen (2001) also described how it was given to people with homesickness and even pets scratching too much (ibid., p. 15). Likewise, Solomon (2006) describes how the families who were waiting for news about their loved ones after a TWA plane had crashed were offered anti-depressive medicine, like they were being offered a pillow or a blanket (Solomon, 2006). When social phobia became an official diagnosis, it was questioned whether ordinary shyness in social situations could be described as a disease. Because social phobia is often associated with reduced quality of life and that some anti-depressants were found useful, some believed that there was evidence to call it a disease and offer medicine as treatment (ibid.). These examples are showing that normality increased radically with so many natural human reactions on the list of symptoms that the medication can alleviate. This is also one of the reasons to the increased use of anti-depressants.

The Impact of the Huge Awareness
The same pattern as with the discursive struggle between the biological and psychological approach as we have seen throughout history, occurred in the public debate and have continued ever since until the present time. All kinds of discourses tried to break, but the discourse about the positive effect on anti-depressives remained the dominating. However, the enormous awareness and public debate have not yet led to a clear answer as to what “reasonable” treatment is. The picture of how the treatment of depression is adequately conducted is, thus, still blurred. However, the awareness of depression and other mental disorders has led to, like in the renaissance, a cultural flourishing in theaters, music, writings and movies. Saga Norén from the TV series Broen suffers from Asperger’s, super hacker Lisbeth Salander from Stieg Larssons Millennium trilogy is anti-social, CIA agent Carrie Mathison in the American series Homeland have bipolar disorder (formerly manic depression) where her ingenuity is inextricably linked to her suffering. In these cases their mental disorders are also the secret of their success and it is, therefore, hard to say whether they are mad or brilliant. This dilemma also has a long cultural history, especially in terms of melancholia where particularly Aristotle articulated the question to why great thinkers, poets and politicians often are at risk of melancholia. Due to the fact that it is difficult to know a person’s limitations, to determine whether a person for instance is depressed, mad or brilliant is in fact what depression seems to be all about. In that sense the individual feels obligated to listen and seek advice from others, doctors, psychiatrist etc. and is, thereby, guided by the experts within the medical field and the individual’s self-perception becomes affected by the statements. In this sense, depression is a matter between the individual, its self-governance and self-development and the cooperation with the GP, as opposed to that it is just something the GP solves for the individual as the next section will elaborate on.
"We are only at the dawn of pharmacological exuberance. (...) New medications that are being developed may likely make it quick, easy, cheap, and safe to block many unwanted emotions. We should be there within the next generation. And I predict we’ll go for it, because if people can make themselves feel better they usually do. I could imagine the world in a few decades being a pharmacological utopia, controlling viciousness, fear, and pain. I can equally imagine people so mellowed out that they neglected all their social and personal responsibilities."

Randolph Nesse
The Emergence of the Self-Development

After psychiatry had established as a medical field, it was since 1930 supplemented by psychological forms of knowledge and techniques which extended the psychiatric field of action and objectification of the mentally disordered as the analysis showed. It was a series of contingent and contradictory rationales and events that made and demanded that individuals increasingly were seen as being able to take care of themselves and the disease.

Although the reorganization of psychiatry in the 1970s was based on medical rationales and a general political administrative decentralization, also the neoliberal rationales for the modernization of the public sector from the 1980s gained a foothold. What is interesting is that both rationales have, in fact, the self as the focal point. The modernization of the welfare state from the 1980s was based on a neo-liberal critique of the state’s role as possessive and passivating. Citizens should be involved in the solution of common problems and their own initiative and accountability was to be strengthened:

“(...) vi kan få vendt den udvikling der truer med at reducere danske borgere til klienter i et mere og mere omfattende og indgribende system” (Finansministeriet, 1989, p. 2)

The rationale behind was, through diverse and personalized services, to develop citizens' opportunities and abilities to choose and manage their own lives (ibid.) and thus; “(...) gøre det bedre uden det koster mere” (Finansministeriet, 1987, p. 14). The main argument is that the contingent events had enabled the new control techniques in psychiatry. The control technique does not oppose individual freedom but instead act through it. The new forms of power occur in the context of apparently “neutral” scientific knowledge, societal changes and the need for political governance:

“Recovery eller at komme sig (fra en sindslidelse) er (...) stærkt knyttet til det enkeltes meneskes egen, active indsats – man kan ikke blive recovered af andre, lige som man kommer ‘sig’. Personen er subjekt i sin egen recovery-proces.” (Jensen 2002, s. 7)

In Selvudviklingens opkomst i psykiatrien, Thomas Hansen demonstrates the shaping of the “kompetente sindslidende” and how the mentally disordered in the period from 1950-1970 is being articulated as an individual with the willingness and ability to take care of themselves. Autonomy and self-governance seen as self-subjectification strategies become key elements of the neo-liberal critique and modernization of the welfare state in the 1980s and 1990s (Brinkmann, 2008).

Part of the current psychiatric practice is, thereby, seeking to enhance the responsibility of the individual to manage his own life and his mental disorder. The practice is based on knowledge of the individual as having intrinsic needs and resources to develop themselves through self-governance in order to achieve a
healthier mind. The individuals are responsible for their own situation. Thus, it has become possible to try to manage the individual through the exercise of freedom and it is, thereby, problematized, if it is in fact a liberating humanization within psychiatry.

When scientific norms for an independent and self-evolving individual merge with the political rationales, it becomes impossible to distinguish knowledge from power and freedom from control. The political control is, thereby, effective since it is based on the individual's needs and potentials (Brinkmann, 2008).

The subjectification strategy that characterizes the modern welfare state’s treatment of depression can be described as a radicalized subjectification. The possibility of the individual to overcome life's problems by themselves guided by its own self-perception is discovered. Therefore, the patient's self-relation is drawn into the effort and the state's role is, thus, to assist the patient to eliminate depression. That means that the patient must recognize oneself as a resourceful subject with the help of anti-depressive medication in order to get rid of the depression. The forms of power used in the Danish health care system’s treatment of depression have in common that they seem to want to free the subject in the form of personal clarification and objectification of the patient's symptoms.

With this new view on the individual within the medical field the following will show how the power mechanisms are influencing the treatment of depression and the increased number of Danes using anti-depressive medicine.
“I will take Zoloft every day for the rest of my life. And I’m quite content to do it.”

Mike Wallace
Chapter 4: Governmentality as a Control Mechanism

This section will enable the genealogy in relation to the present and the questionings, which appear in the problem area. The following will show the logic and technologies of power that appear in the treatment of depression in the Danish health care system. On one hand it is about empowering the suppressed patient by the increasing use of dialogue-based technologies, which can be observed in the encounters between the state and the citizen, in this case in the medical room. On the other hand, the state still have an improvement, educational and moralizing role (Rose, 1999). In a Foucauldian perspective, governmentality as the modern, liberal governance mentality, where governance is pointed towards by controlling the individuals' self-governance. Governmentality; a rationality with which power is made visible as a way to process the individuals' self-relation and get the individual to be autonomous in relation to certain ideals (Raffnsøe, S. and M. Gudmand-Hoyer, p. 19).

The key challenge within the exercise of power in the treatment of depression is the existing dilemma between respecting the self-governed individual and the intervention of the GP in order to relieve the patient's symptoms. The treatment of depression is characterized by a number of methods and techniques to maintain the fragile balance between help and self-help, autonomy and influencing opinions, responsibility and the construction of a client. The preferred solution strategy is to prescribe anti-depressive medicine in order for the individual to become “normal” again. The question is how the power, that promotes the patient self-governance, is exercised in the relation between the GP and the depressed?

Based on the analysis, examples of how power, exercised in the Danish health care system are provided in the following. A distinction is made between these different forms of power that due to the events throughout history have become the most considerable in the treatment of depression:

1) Diagnostics as a power mechanism
2) The power of normalization
3) Governance through knowledge
4) Conversation as a control mechanism

It is important to state that one form of power does not exclude the other and they can, as it will be shown, easily be present at the same time.
Diagnostics as a Power Mechanism:

- How did it happen that we use pathological diagnostics to determine depression and does it increase the possibility of labeling natural emotions as depression?

According to Järvinen & Mik-Meyer (2003) a welfare institution is not a neutral "service institution" which only offers clients (patients) assistance from the needs and desires they may have. In the relation between the patient and the welfare institution certain processes cause a person to become a “case”. This is also the case with the medical profession; it always reflects a particular way of viewing the world (Järvinen & Mik-Meyer, 2003). Therefore, the diagnosis provides information not only about the patient but also about the medical profession - without which the cases would not have been created (Järvinen & Mik-Meyer, 2003). The diagnostics in regards to depression are viewed as critical for treatment decisions, prognostic assessment and communication between the healthcare providers (Jørgensen, Bredkjær, & Nordentoft, 2012).

Through the continuities in history, from Hippocrates until today, the biological perception of depression has been the most dominant. Since Kraepelin, who made a clinically description of depression and other mental diseases, the authorities including the Danish health care system have been using the pathological diagnostics in order to determine depression. This means that the patient’s symptoms are translated into a specific system and language in which the individual situation is being resolved in institutionally defined understandings and diagnoses where the patient is tried adapted into categories that correspond to the actions and models within the medical field. This means that it is in meeting with the GP or psychiatrist that the patient’s options and assessment of the future are defined; a form of construction of identity. However, it has never been examined whether the GPs diagnoses are valid and meaningful, and it is not examined whether this type of registration of the GPs work leads to more health and less illness. In this context we do not know how many diagnoses are misleading or even wrong. As an example one of the interviewees, Sofie, was within three days in the psychiatric unit diagnosed as having a chronic depression:

“I starten var det en lettelse. Det var rart at finde ud af at der var noget galt med mig”
(Appendix 1)

After 7 years, she has recently been informed that it is in fact not a chronic disease. Not only has it changed her whole view on herself as a person it also means that she now believes that she can and are willing to fight her way out of the daily use of medicine. As she explained the diagnosis have had a huge impact on her life:
“Jeg har ikke haft et normalt liv. At det ikke er kronisk, betyder at jeg har fået mit tilbage og at jeg nu kan vælge selv. Uden diagnosen så havde mit liv været bedre.” (Appendix 1)

According to Sofie the diagnosis and medicine help to maintain patients in the process (Appendix). As Järvinen & Mik-Meyer (2003) explain, people see themselves through the eyes of others; they assess, perceive and experience themselves through social mirrors. This means that the individual’s self-image to a large extent harmonize with other people’s image (Järvinen & Mik-Meyer, 2003). The example shows the effect a diagnosis can have on a person. Even though Sofie did not have a chronic disease her self-perception did not change until the medical field confirmed it. It also shows that the diagnosis is not a neutral practice and the criteria for when the symptoms is perceived as natural to the circumstances or as a problem that needs medical attention are ambiguous and changing. As the analysis has shown, the perception of depression has changed throughout history and there is also great differ from one medical professional to another. They may perceive their work as a neutral mapping of the patient’s problems, resources and goals, but that is rather simplistic as the patient’s problems also are created in this mapping process (Järvinen & Mik-Meyer, 2003). In another setting, in a different institution with different categories it might be a different diagnosis and thus a different outcome.

When depression is only defined due to the biological and pathological causes and since the diagnosis of depression is used for the ability to offer the right treatment, do the current diagnostic system and way of viewing depression block for the determination of the cause and thereby the right treatment? The question is what consequence the pathological approach has if depression is due to emotional reactions? According to psychologists Jørgen Rønsholdt and Else Marie Bech:

“En del af årsagen skal findes i vores vestlige tradition for at overlade ansvaret for udredningen og behandlingen af emotionelle lidelser til lægevidenskaben. I praksis finder diagnosticeringen af psykisk ubehag sted hos lægen, der kategoriserer symptomerne på samme måde som udredningen af de fysiologiske sygdomme. Det ligger i den naturvidenskabelige diagnosticeringstradition, at man må udrede og give en (sygdoms)diagnose for at igangsætte en behandling, der reducerer symptomerne.”

(Politiken.dk, 2013)

As the quote indicates the GP is trained to diagnose the patients’ physical illnesses by characterizing the symptoms and offer proven means to help remove these symptoms. However, when it comes to diagnosing emotional reactions, the method can have serious consequences if natural emotional reactions are labeled as diseased and diagnosed as depression. The GPs’ pathological strategy in assessing the patients marginalizes the psychodynamic or psychological discourse that sought ‘behind’ the patient to understand
the underlying structures and relationships that created the symptoms of dysfunctionality and failure to thrive. This means that if the cause of depression is not biological but due to other circumstances, by having the GP to examine the patient, it is more likely that the patient will end up being offered anti-depressants that fit into the biological understanding of how to treat depression. Likewise, when depression is viewed as biological the patient’s self-perception is constructed through this. Thereby the individual becomes a constructed patient in the meeting with the GP. The pathological and biological approach thereby becomes a central part of the self-governance which also makes anti-depressive medicine into a more suitable choice for the individual to make. However, the power works in both ways; the GP must pathologize in order to treat, and the patient must accept to be pathologized to receive medical treatment. Thereby, labeling the patient becomes a process in which both stakeholders are dependent on and that is one of the reasons to why the process repeats; it is constantly confirming its own legitimacy. Diagnostics is therefore a form of power mechanism used in the Danish health care system that objectifies the patient’s symptoms and since the use of pathological diagnostics does not account for fluctuating emotional reactions or other circumstances it increases the possibility of labeling natural emotions as depression.

The Power of Normalization

How did it happen that the concept of normalization is used in the assessment of depression and does it cause more Danes to be labeled as depressed?

According to Foucault any doctor, psychiatrist, psychologist or other professionals who assess the patients will become judges of normality:

“The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the ‘social worker’-judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements.” (Foucault, 2002, p. 304).

As the analysis has shown, there has been a constant but yet different distinction between normal and deviant. Great thinkers and theorists within the field have constantly been replacing each other’s contributions and been judges of normality with their understanding of the deviant depressed. At the same time the medical field has constantly at any given point in history tried to adjust the depressed to ‘normal’. We have seen how Hippocrates has worked on creating a normal balance, how psychotherapists have advocated normality by working on the self, and how contemporary medical doctors have performed
comparative analyzes of normal brain functions. The concept of normalization is, therefore, relational and contextual. Due to the knowledge of the patient’s physiology doctors becomes enable to regulate the patient through the medical profession’s understanding of ‘normal’ in conjunction with the patient’s deviant characteristics. In relation to depression, the use of the concept normalization is a widely-used way of thinking in the treatment system and thereby a form of power:


When the medical profession is trying to pursue a strategy of gathering information about the depressed, the establishment of a certain standard of normality is built; some are categorized as deviant and thereby depressed. This means that the medical profession must constantly distinguish between who is normal and who is deviating. The rationality behind the term ‘normal’ is however fundamentally paradoxical (Villadsen, K., 2012), due to the fact that a distinction between normal and deviant has an unlimited usability; a fixation of what or who is normal will constantly change depending on how the medical profession observe ‘normal’ compared to the ‘deviant’. Something that at one point can be seen as normal can be observed as deviant in relation to a different standard of normality (ibid., p. 65). This means that one patient can by one GP be considered normal and then he or she can be evaluated again by the same criteria by another GP and be regarded as deviant. This is obviously a paradoxical situation for the patient and his or hers self-perception. However, being labeled as depressed does not only influence the individuals’ self-perception, it can also limit the possibility of finding the cause:

“Sygeliggørelsen afgrænser problemet til at have rod i det enkelte menneske, mens normaliseringen af reaktionen åbner for, at årsagen kan befinde sig uden for mennesket. Det åbner for muligheden, at den emotionelle reaktion kan være et signal om, at der er noget i det omkringværende system, der ikke fungerer.” (Politiken.dk, 2013)

As this quote indicates a broader definition of normalization of human emotions can help to figure out the cause by being curious about why the symptoms occur. As the analysis also showed, normality decreased when the condition went from the term melancholia to depression and likewise by the entry of the anti-depressives, where natural emotional reactions, for instance PMS, homesickness and even pets scratching, became deviant and thereby treatable. Determining what is understood as normal in our society as a power mechanism that is widely used by the medical professional. In Foucault's understanding, normalization, or
homogenization, is also viewed as a form of power that promotes a particular behavior of people in a particular context (Villadsen, Magtens former). The huge awareness showed within the analysis, both in regards to depression and anti-depressive medicine, becomes a governance object through the power technology of normalization. The patients’ attitude towards both the possibility of depression and the treatment option of anti-depressive medicine are influenced by the surrounding world and also the patients’ perception of his or hers appearance to in relation to other people are determined by the definition of normality (Villadsen, 2004, p. 11). This means, that the power of normalization, which in regards to depression is determined by the medical field, can be used by the GP to promote the patients’ self-governance. When shyness and other natural emotional reactions are considered as deviant, then the distinction between normality and deviant becomes so limiting that many Danes are labeled and diagnosed with depression. Thereby, the narrow definition of normality becomes one of the explanations to the increased number of Danes using anti-depressant medication. This also means that the way we are considering the terms of normal and deviant and the way we label people with depression today is not a truism.

The Power of “Knowledge”:

- How did it happen that the contemporary communication of knowledge became a way to govern the patient and does it have an impact on the increased use of anti-depressants?

Modern governance rests on knowledge, where the exercise of power finds support and justification in the scientific categories (Villadsen, Magtens former, p. 21). Any communication of knowledge is a way of trying to shape a certain way of thinking and viewing the world, which thereby aims to regulate the patient. According to Foucault one of the consequences with the connection between power and knowledge is that power becomes close related to discourse. In a Foucauldian term this means that the discourses regarding the anti-depressive medicine helps to produce the subjects (Ibid.). The way WHO, the medical field including the Danish Board of Health and other authorities based on “knowledge” of the normal defines depression not only becomes a truth, but it also helps to govern the patient. This means that when they define depression to be when a patient has been sad for more than two weeks, and articulate depression as one of the most common diseases not only in Denmark but worldwide – and when the disease is connected with words like “sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration” (WHO, 2014) that many people often experiences, it is easy to believe as a patient that you are in fact depressed. For instance, when the WHO and the Danish Board of Health explain:
“Although there are known, effective treatments for depression, fewer than half of those affected in the world (in some countries, fewer than 10%) receive such treatments.” (WHO, 2014)

“Næsten hver tiende, der søger læge, har en eller anden form for psykisk lidelse - herunder depression.” (sundhedsstyrelsen.dk, 2005)

“For sen eller manglende behandling af angst og depression er en vigtig årsag til, at mange mennesker i dag ender på førtidspension. Derfor er det positivt at have særligt øje for, at nogle mennesker er mere udsatte for at blive ramt af en psykisk lidelse.” (www.læger.dk(a), 2012).

At the same time when it is defined as a serious health condition that at its worst, can lead to suicide (WHO, 2014) and that the anti-depressive medicine that the GP recommend can “prevent” that, the knowledge that are being provided is thereby a way of trying to gain power over the patient’s definition of reality. The statements shown above are accepted as meaningful. Likewise there are statements that are considered unacceptable due to the dominant medical discourse. For instance, when senior physician Peter Gøtzsche in spring 2014 expressed:

“Vores borgere ville være langt bedre stillet, hvis vi fjernede alle psykofarmaka fra markedet, fordi lægerne ikke er i stand til at håndtere dem. (...) Der er ikke nogen kemisk ubalance til at begynde med, men når man behandler psykiske lidelser med lægemidler, skaber man en kemisk ubalance, en kunstig tilstand, som hjernen forsøger at modvirke. Dette bevirker, at man får det dårligt, når man forsøger at holde op med at tage medicinen”. (politiken.dk (a), 2014).

This type of knowledge is not only outside discourse, it also led to a heated debate, and both doctors and psychiatrists turned against this statement. President of the Danish Psychiatric Society Thomas Middelboe stated:

Consequently, the way the medical profession and others communicate to the depressed is what determines if and to what extent regulation of the depressed occurs. When the highest authorities in society articulates anti-depressants as the right form of treatment through the use of specific words, the knowledge and language becomes a power mechanism that shapes the understanding of the citizens. The power of the medical discourse becomes dominating. It becomes difficult to look beyond and due to the historical events and continuities it is regarded as natural and normal. By providing the patient with the information about the medical options, the interaction between the patient and GP in the medical room also shows the relation between power and knowledge. Knowledge about depression and anti-depressive medicine as a treatment option is used as a power technology to process patients’ self-governance.

Conversation as a Control Mechanism:
- How did it happen that the conversation with the GP became a way to govern the patient and does it limit the treatment options?

The analysis showed that throughout history the view on the psychiatric patient changed and a greater focus on the patient’s self-development emerged. As the previous has shown this has led to that self-governance has become a dominant form of power in the treatment of depression, where governance through conversations with the GP are used in order to guide the patients. The patient is then viewed as a person without knowledge of the actual possibilities, and the GP's task is to give the patient the knowledge needed in order to make "independent" and "realistic" choices. On one hand, the patient is viewed as a unique person the GP needs to meet without prior notions. On the other hand, the patient appears as a universal category, which contains some general characteristics.

If the GP assesses the need for testing for depression the questionnaire ICD-10, developed by WHO, is often used. Questions that the patient is asked during the conversation are for instance:


At the same time the percentage of how often the feelings occur is determined:

> “Hele tiden, det meste af tiden, lidt over halvdelen af tiden, lidt under halvdelen af tiden, lidt af tiden, på intet tidspunkt” (Sundhed.dk, 2011).
A number of “objective” factors are assumed to create a detectable 'diagnosis system' in order to determine depression. The most noticeable is that within the medical room there is talked far less about the cause of the depression and more about the patient's symptoms. However the questionnaire is indicative, which means that regardless of the result it is the GP’s assessment that matters.

The procedure in relation to the questionnaire is an example of what Foucault determines as pastoral leadership as the individualizing power (Foucault, 2000a, p. 300). In order for the GP to guide the patient, the patient must tell the truth about who he or she is. The point of this form of power is that it binds the individual in its own words, and the patient is maintained by what he has told. The GP is thereby given authority to determine the patient's suffering, deviations or suppressed potentials (Villadsen, Magtens former, p. 18). This type of personal clarification is also a form of power which is suitable for navigating between control and autonomy, as it can be argued that it is not about taking responsibility for the patient, but to enrich the individual with information to be able to make a confident and independent choice (Villadsen 2004). Conversation as a technology can thereby make up for the tendency of the over steering and pacifying form of governance, which is claimed to have influenced the relationship between the GP and patient. The introduction of the dialogue can be viewed as freeing the subordinated patient, but the conversation technology can also be seen as a way to reconfigure the medical room. When the patient is asked to speak, he or she produces statements with which they can be made accountable for and be reminded of. The patient can be controlled with reference to the self-produced knowledge (Villadsen, 2007). According to the new Law of Health that came into force in September 2013, the GP’s are forced to put diagnoses to every inquiry and provide the patient with a treatment based on guideline instead of individualized treatment:

The GPs are dealing with a diagnostic system where the category *normal* does not exist and where reactions to ordinary life events easily can be classified as depression. The problem is that these diagnoses can never be erased from the patient record, and if it is a stigmatizing diagnosis as for instance *recurring depressions*, it can harm the patient. Hans Jørgen Thomsen an Associate Professor of the University of Aarhus was some years ago asked by Psykiatrifonden to write an article about depression due to his personal experience with the condition. Not only did they refuse to convey his statement regarding the treatability of depression, due to the belief that it would make the Foundation redundant, he also regretted his publishing of his former diagnosis, which he struggles to escape from:

“At have offentliggjort min psykiske sygdom har jeg dog inderligt fortrudt. Jeg har opdaget, at offentliggørelsen var det samme som at melde sig ind i et offerselskab. Det har betydet, at jeg til stadighed i de andres omgang med mig er stigmatiseret. Stigmatiseret som syg. Også selv om jeg som sagt er behandlet frem til normalitet og er dette ligeså kronisk som min underliggende sydom, endogen depression, er kronisk.” (Information.dk (c), 2014)

The technology of the conversation is thereby not only a technique that one party uses to control the other, it is also a power technology that shapes certain subject positions. Power and knowledge in conversations with the GP, works in a way so that within the room the GP seeks to direct the patients to specific ways of thinking of themselves, govern themselves, and regulate their relation to others (Raffnsøe, 2000). According to general practitioner Anders Beich, patients need to look out for themselves when visiting the doctor:

“Hvis du skal tale med lægen om følsomme emner, så skal du inden konsulationen anmode om, at oplysningerne ikke journalføres. Giv for eksempel aldrig oplysninger til journalen om livsstilsfaktorer, uden at du har fået bekræftet, at de ikke bliver journalført.” (Information.dk (d), 2013).

This can off course have a profound impact on the GP-patient relationship that should be based on confidentiality, trust and mutual knowledge. He proposes a precautionary among doctors:

“Samtidig må vi være uhyre varsomme med at journalføre oplysninger, som har med stigmatiserende forhold at gøre, herunder usund livsstil, overvægt, kriser, depressive episoder, angststilfælde og andre psykologiske problemer.” (Information.dk (d), 2013).

The medical consultations enable certain limits to what can be said and also by whom. When some patients accept the medicine, sometimes only after few minutes of conversation, there is two primary reasons. One, that the GP is an authority and two, that the patients are already governed by the dominating discourses.
Due to the medical discourse based on a biological approach, there are only a certain number of options within the medical room. The conversation technologies used in the medical room creates certain subjectivities and the subject is constantly in the process of taking form both in regards to control technologies aimed at individuals and as the individuals' own self-governance. In the conversation with the GP a diagnosis is provided based on the information giving by the patient and the diagnostic system within the medical field. Knowledge about depression and anti-depressive medicine as a treatment solution is then provided by the GP. This discursive regime within the medical room is not only limiting the treatment options it is also showing that by using the technology of conversation the power is formed into self-governance as a control mechanism. By controlling through personal clarification by open information, advice and dialogue, where individual autonomy is respected the exercise of power becomes more legitimate and less suppressive. That makes the well informed choices possible for the patient – and it is more likely that the patient choose anti-depressive medicine.

The current diagnostic system, the limiting definition of normality, the knowledge provided in our society and in the conversation with the GP is thereby primarily focusing on a single story about depression and the treatment options. In the following the danger of this single story will be outlined.
"Vi overbehandler i så høj grad, at der ikke er nogen som helt fare for underbehandling. Behandlingen med antidepressiv medicin har sin berettigelse, men generelt er vi alt for ivrige efter at handle med medicin."

Tidligere formand for de praktiserende læger, Henrik Dibbern
Chapter 5: Conclusion

We tend to think that we have moved on from the barbaric, inhumane and irrational ideas of the past and that we now know better. However, the genealogy have made it possible to see that a lot of our contemporary practices is due to the historical events and some of them can still be identified in today’s practices. Maybe we do know better, but it is still difficult to prove that the way we understand and treat depression is better than the way we used to. We cannot “prove” it by higher cure rates, like we can prove that relatively fewer die of infections. That is one of the biggest dilemmas within the Danish health care system. For the supporters of the biological view every new breakthrough of treatment and diagnostics seems to be an opportunity to claim the justification of the use of medicine regarding depression – and for the critics it is an opportunity to stress the need for a stronger focus on social issues, such as the lack of discussion of the pharmaceutical industry’s role in modern biological psychiatry.

This thesis is a critical examination of the treatment of depression in the Danish health care system. The question is if it is an expression of a distanced indifference to the people who actually needs the help that the medical profession can provide? And also, if it is a hidden insult to the health professionals in the Danish health care system that work hard every day with the best intentions to help other people? This is certainly not the intention. As mentioned, the aim of this thesis is to make a critical analysis of what makes certain governance strategies possible at certain times and the hope has been to help open up for new opportunities for reflections, activities and critical questioning to a central practice in our modern society.

The treatment of depression has turned out to be a highly relevant field of study in order to uncover the dominant ideas about what our society consists of. The research question for this thesis has been;

How did it happen that 450.000 Danes currently are using anti-depressive medicine and that the use of anti-depressive medicine has become an extensively used treatment solution in the Danish health care system?

Through the genealogical method, I have illustrated that what seems natural, obvious and necessary today, is actually a product of the past. The genealogy has helped to uncover how a number of specific governance problems that have required the treatment of depression to be transformed - and continues to transform.

The presentation of the historical transformations in the treatment of depression is simultaneously a presentation of the battle between various discourses that seek to create a society of healthy, working individuals. I have shown how the Danish health care system’s treatment of depression with antidepressants is due to historical dynamics and challenges. Based on the analysis, the Danish health care system’s treatment of depression consist of different rationales based on economic, political and medical
incentives that together provide a very uniform way of viewing the treatment of depression and thus, have a huge impact on the decreased use of anti-depressive medicine.

The genealogy presented many reasons to the increased use of anti-depressive medicine. As showed the dominant biological discourse has had a great influence, which also led to the development of the psychoactive and anti-depressive drugs. Not only did the medicine contribute to the legitimization of the biomedical disease concept it also helped the psychiatric field to become acknowledge within the medical field, which it had been struggling for ever since the beginning. At the same time it was a cost-saving solution that made it possible for the medical field to treat the patients ambulatory instead of by hospitalizations. With the available medicine it became possible to treat a lot of people – whereas without the medicine we would, for instance, not have the capacity to hospitalize 450.000 Danes. Also the huge media coverage and awareness in the public made depression and the use of anti-depressive medicine normal and acceptable. This led to that the GPs prescribed more medicine – and the patients were both demanding it and accepting it. Another reason to the decreased number is that not all is treated for depression. The Danes is prescribed with anti-depressive medicine for all kinds of reasons – anxiety, shyness, PMS etc.

The genealogy also made it possible to discover how governance in our society takes place by the control of the individuals' self-governance explored by the term governmentality. The state and Danish health care system use certain power technologies in order to govern the patient through concepts such as diagnosis, normalization, conversation and knowledge, which have co-existed throughout history and thereby, have had a great influence on the understanding and treatment of depression, which the second part of the analysis showed.

When the medical field is using the pathological diagnostic system as a power mechanism it not only objectifies the patient’s symptoms it also construct the patient’s self-perception, which increases the possibility of labeling natural emotions as depression. At the same time, by the technology of normalization the treatment of depression is considered as a form of governance strategy through its numerous problematizations of human behavior, which is presented by the standards of what it means to be a healthy and normal person. However, since the distinction between normal and deviant is never stable, the medical field’s fluctuating perception of depression has a profound impact on the individual. By emphasizing the patient's behavior and condition as sickly it becomes legitimate and necessary to provide medical treatment in order for the individual to once again become a responsible and competent citizen. Thereby, the way the medical profession and other authorities communicate makes it possible to regulate the depressed. On one hand the new form of governance is empowering the patient by the increasing use
of dialogue-based technologies within the medical room; on the other hand the dominant biological discourse is limiting both the understanding of depression and the treatment options which is questioning the patients’ free choice.

The analysis has also shown how the Danish health care system’s understanding and treatment of depression have developed parallel with the way to observe the patient as an individual. In the 1800s, the depressed was primarily observed as a subject with special needs for improvement. This change significantly with the emerging of the psychoanalysis and psychology where the self-relation became the object of possible intervention. Using techniques as normalization and knowledge where the patients are invited to relate to themselves and their behavior it was possible to minimalize the need of hospitalization and increased the self-help by providing medicine.

The genealogical analysis has captured how it happened that 450,000 Danes currently are using anti-depressive medicine. Also, that the use of anti-depressive medicine has become an extensively used treatment solution in the Danish health care system and that the treatment has very little to do with therapy and a lot more to do with the depressed self-governance.

However, there are other aspects than shown in the analysis. Some of them will be illustrated in the following epilogue, where the treatment of depression will be discussed and where the dangers of the unilateral treatment in the Danish health care system’s treatment of depression in the year 2014 will be presented.

Therefore, this thesis contributes with a reflexive and critical view on the treatment of depression. It shows how the understanding and the treatment of depression have evolved through history and thereby, it shows that it can be different today. Hereby, this thesis has tried to make the reader questioning the discursive regime and I have attempted to move the limits of what can be imagined about the treatment of depression.
"Der er ingen tvivl om, at i de generationer, der er i tyverne og trediverne i dag og er vokset op med ecstasy, der er angsten for den lille hvide tablet ikke nær så stor. Billedet af misdannede børn i forbindelse med Taladomid-skandalen i 1960'erne, som har gjort de ældre generationer mere angst for at tage medicin, står ikke længere på nethinden. Derfor er angsten for bivirkninger langt fra så håndgribelig for de unge."

Claus Møldrup.
Epilogue: The Danger of a Single Story
Even though depression has existed as long as mankind, we only seem to be at an early stage in our continuing efforts to understand it and, thereby, provide the proper treatment solution. However, maybe the solution is that there is no solution. Maybe, the solution is that there is not a single solution, but several solutions. What is certain is that the history of depression is in fact the history of fragility. People have been suffering for thousands of years, and still are. Some had a lobotomy and others are being medicated because they act shyly. The medical profession has been struggling to find the proper treatment and there have been said and published so much about depression and the treatment that the situation is fairly chaotic, to put it mildly. However, as the genealogy showed the existing truism regarding the use of anti-depressive medicine is simply a perspective as any other. A single story.

So, are we on our way towards the era of mental health or mental breakdown? In my opinion, we are heading towards a mental breakdown faster than we are even aware of and I will in the following outline the dangers of the single story.

Another miracle ending as a huge mistake?
As the genealogy showed the psychiatric field has been experimenting with a lot of different treatments. Every time with an optimism, and presented as a miracle until the opposite was proven. The question is if anti-depressive medicine is an exception or exemption? Anti-psychiatric movements have always tried to influence the dominant discourses, and especially since the anti-depressive medicine entered the market - but without success. At least not so far. However, several studies that are worth mentioning are challenging the dominant discourses and the single story.

One study published in *The New England Journal of Medicine* found that drug companies selectively publish studies on antidepressants. The researchers reviewed all the studies; 74 studies involving 12 different drugs and over 12,000 people. They discovered that 37 of 38 trials with positive results were published, while only 14 of 36 negative studies were published – and those that showed negative results were, in the words of the researchers, "published in a way that conveyed a positive outcome". This means that the results were twisted, leading us to think that they work when they do not. The study also showed that most patients using antidepressants either do not respond or have only partial response and instead significant side effects. At the same time, the positive studies hardly showed any benefit; 40 percent of people taking a placebo (sugar pill) got better, while only 60 percent taking the actual medicine had improvement in their symptoms (nejm.org, 2008). Another study done by researchers from the Nordic Cochrane Centre has showed that antidepressant causes addiction (videnskab.dk, 2013).
Suicide has always been a known side-effect of depression. Shakespeare showed it with the character of Hamlet, and Kraepeler described it more clinically in his writings, and anti-depressants have been used in order to prevent suicide. However, after six years on the market and due to several cases of suicide the American Drug Administration, FDA, decided that antidepressants should have a warning against increased suicide risk in the leaflet (dagensmedicin.dk, 2014). Recently, the Danish National Board of Health tightened the recommendations to provide prescriptions for depressive medication to young people, after a 20-year-old, took his own life. He had been prescribed with anti-depressive medication based on an eight-minute conversation with his GP (jyllands-posten.dk, 2014). So far there have been 12 cases in Denmark where antidepressants have been recognized as the fatal reason of suicide (politiken.dk (e), 2014). From this point of view, we are providing depressed and suicidal people with drugs, which have no efficacy other than addiction, and where suicide is an actual side-effect. This is one of the dangers to the single story about the treatment of depression with anti-depressant medicine.

**Lifelong medication**

Recurrence of depression seems not only to be a common assumption, but also an accepted characteristic for the condition. According to the Danish National Board of Health:

> “Depression er en sygdom, der oftest vender tilbage. Har man haft én depression, er der omkring 60 % risiko for at få en ny depressiv episode. Har man haft to depressioner, er risikoen for en ny depressiv episode omkring 80 %. Blandt patienter, som første gang er indlagt for depression, vil ca. 70 % udvikle flere depressioner, og godt 60 % vil udvikle tre eller flere depressioner. Ydermere tyder undersøgelser på, at depressionernes sværhedsgrad hos mange patienter øges med antallet af depressioner, ligesom intervallet mellem episoderne bliver kortere og kortere.” (sundhedsstyrelsen.dk, 2007, s. 17)

The treating regarding recurrences is by many professionals recommended to be done by continuing the medical treatment at least six months after the end of the depression and by each depression it is recommended that the patient should proceed an additional six months. This means that after three depressions, the medical treatment should continue at least eighteen months after (netdoktor.dk, 2013). However, I have come across many medical professionals who recommend lifelong treatment. Bodil Andersen, specialized in psychiatry states:

> “Er det første depression fortsætter man med at tage medicin et år efter, at symptomerne er væk. Har man haft to-tre depressioner tidligere, fortsætter man med medicin i ca. fem år. Har
man haft flere end tre depressioner, anbefaler jeg livslang behandling med antidepressiv medicin, evt. med stemningsstabiliserende medicin.” (depressionsforeningen.dk, 2011)

One could argue that the tendency of recurring depression is due to that the medical treatment is only symptomatic and that the person will maintain in the suffering by not being offered treatment that focuses on the cause. At the same time, there are a lot of evidence pointing towards the benefit of psychological treatment in general and also in relation to recurrences. In 2005-2006 a study with psychological treatment to depressive showed that 60 percent of the patients were completely free of depression during an average of ten appointments. Cand.psych. Rita Fjelsted who helped to develop the evaluation said that therapy also reduces the risk of relapse:

“Tilbagefaldsprocenten for dem, som kun får medicin, er højere end for dem, som får enten kombinationsbehandling, medicin og terapi, eller kun terapi.” (Information.dk (f), 2009)

Likewise, psychologist Irene Oestrich explains that opposite medicine that does not work when it is no longer in the body, through therapy the patient learns to cope with the problems, and is provided with tools that can also be used afterwards (netdoktor.dk (b), 2002).

The lack of focus of the cause and the recurrence of depression that can result in lifelong use of medication is, therefore, not only one of the reasons to the increased number of Danes using anti-depressive medicine, it is also a second danger to the single story about the treatment of depression.

Money over lives
The GPs are often accused of too many prescriptions, especially for patients with mild to moderate depression. According to GP, Morten Møller Andersen:

“Det er ikke alle praktiserende læger der kan tilbyde samtalerapi, og adgang til psykolog kan være begrænset i forhold til patientens egen økonomi og sygesikringens tilskud. Derfor er medicinsk behandling en gang imellem den eneste behandling, de praktiserende læger har mulighed for at tilbyde.” (depressionsforeningen.dk, 2014)

As the genealogy showed and as this quote indicates, the increased use of medicine and the lack of psychological treatment is also due to economic rationales. And with good reason; Danske Regioner estimates that depression costs the Danish society about DKK 14 billion a year. However, not only is there evidence indicating the benefit of psychological treatment, studies have also showed that by providing subsidies to psychological treatment the society could eventually be able to save billions each year in the
payment of sickness benefits and early retirements. Chief Adviser in Danske Regioner Mikkel Lambach reports that it has been a struggle to address depression at the political agenda:

“Vi har gjort politikerne opmærksomme på det de sidste to år. Vi har aldrig haft en psykisk lidelse, hvor den samfundsøkonomiske effekt af behandlingen har været så dokumenteret.” (Information.dk (f), 2009).

According to Lene Agersnap, representative of the Association of General Practitioners, the GPs urgently need assistance:

“Vores arbejdspres er massivt på grund af de her problemer. (...) Vi kan ikke sidde i almen praksis og drive kognitive terapeutiske tilbud i det omfang, de efterspørges. (...) Det er stensikkert, at hvis du havde nogle flere kvalificerede behandlere, så ville du spare riget for en masse penge i den lange ende.” (Information.dk, 2013a).

This means that some of GPs are also looking for other and better solutions, which indicates that the reason towards the increased number of Danes using anti-depressive medicine is even more complex. As mentioned in the genealogy anti-depressants have been used by millions of people all over the world. This means that the pharmaceutical industry makes a lot of money – especially on lifelong patients:


Within the pharmaceutical industry the term pre-diagnoses also exists. The word suggests that people who are healthy still have a diagnosis due to the risk of developing a given disease and no one is, therefore, completely healthy (politiken.dk (b), 2014). This might lead us to believe that we must protect ourselves from potential illness by using preventive medication like, for instance, by using anti-depressives against the feeling of depression, the fear of depression or the fear of the recurrence of depression; lifelong patients mean a lot of money to the industry. That is a third danger to the single story about the treatment of depression and also why we should question the authorities, instead of ignoring the obvious.
The system kills the system
Like we saw in regards to the women in the 1800s-1900s, perhaps falling outside the norms of the culture is the timeless issue that still can be addressed today when it comes to depression and the increased use of anti-depressive medicine. The fact that more women than men are being diagnosed with depression provides a good reason to look deeper into the social and cultural context and to see the individual as a product of one or more cultural discourses, than as an example of a diagnosis. One of the alternative treatments to anti-depressive medicine that has been trying to break with the dominant biological discourse many times throughout history is the psychological treatment. According to the recommendations of the Danish National Board of Health:

“Ved depression af let til moderat grad bør det overvejes at tilbyde patienten psykologisk behandling, der specifikt fokuserer på depression, fx kognitiv terapi, problemløsningsterapi eller interpersonel terapi” (sundhedsstyrelsen.dk, 2007, s. 15).

According to the executive order that came into force on 1st of July 2012 by the Ministry of Health, in accordance with § 69 and § 72 of the Health Act, Consolidation Act No. 913 of July 13th 2010 it states:

“§ 1. Gruppe 1-sikrede og gruppe 2-sikrede personer har, jf. § 2, ret til tilskud til behandling hos psykolog, hvis de: 10) har en let til moderat depression, jf. bilag 1, og på henvisningstidspunktet er fyldt 18 år.” (retnsinformation.dk, 2012).

However, there are certain criteria that must be fulfilled in order for patients with mild to moderate depression to receive psychological treatment. Since the GP is the gatekeeper the patient must have a written or electronic referral from the GP before starting the treatment according to § 2.2 (retnsinformation.dk, 2012):


This means that the psychological treatment is only available if the GP rates it as needed. One may then wonder what right the depressed really gain, or if it is a form of communicative strategy in relation to obtain a picture of that the depressed has more rights than in the past. The question is whether the legislation on the right to subsidies for treatment by a psychologist works in a way so that the depressed observes it as a right?

This means that we are back to the point of the complexity of diagnostics, where the process repeats and confirms its own legitimacy; without a diagnosis, no psychological treatment and with a diagnosis, no chance of getting rid of it. This is a fourth danger to the single story of the treatment of depression.

**Waste of lives**

As a consequence to the dominating discourses and the power technologies in our society many Danes are diagnosed with depression and provided with anti-depressive medicine. Evidence is showing that a large number of people receiving treatment for mental health problems do not fulfill the diagnostic criteria and, therefore, do not have an actual mental disorder (Jørgensen, Bredkjær, & Nordentoft, 2012). Since the GPs treat more than 90% of the common mental disorders including depression it is striking that the process of diagnosing patients remains unexplored and that the GPs’ approaches to psychological interventions have been little studied. As a consequence many patients have experienced how their GP have labeled them with depression and prescribed anti-depressants after sometimes only short conversations. One of the interviewees Kathrine, 31 year old, explained how she at age 24, went to her GP because was feeling sad. Within minutes she was diagnosed with major depression and received a prescription for anti-depressants:

“Jeg blev fejlbehandlet i et par år, havde træelse bivirkninger og ingen effekt. Jeg fik en anden medicin hos en psykiater, men havde heller ikke umiddelbart den store virkning. (...) Dengang skulle lægen aldrig have givet mig medicin, så havde jeg ikke været på det i dag. Jeg giver lidt ham skylden.” (Appendix 2).

Likewise, 34 year old Karin has on and off since she was 20 years old been using anti-depressives and has hardly been in contact with the GP ever since:


28 year old Joy has been using anti-depressive medicine in one and a half year, explained:
Statements like this indicate that there are patients that are using or have been using anti-depressive medicine that either should not or would have preferred other treatment opportunities. Listening to each and every unique story made a huge impact on me. These women (no men volunteered) had been diagnosed with depression after a short conversation with the GP and almost none of them were in contact with their GP afterwards. Even though they had been using the medicine for many years, none of them were cured. However, they did not feel worse, neither did they feel any better – they were numb. The profound consequences for each person are the greatest danger of all, to the single story about the treatment of depression.

Another story
In the spring 2014 another story reached out to many Danes during prime time; BS & recepten på lykke. Within few months, former elite soldier B.S. Christiansen helped four women out of their daily use of anti-depressive medicine. Through physical and mental training, nutrition and psychological support the women learned to manage their lives without medication (depressionsforeningen.dk, 2014). Natalie Gaardboe, 31 years old, had been receiving antidepressants in two stages. The first time she 19 years old and had heartaches that triggered depression. The second time was due to stress, which also was accompanied by depression. Altogether, she received antidepressants for 4.5 years:

“Jeg synes bare, det er ærgerligt, at jeg fik medicinen i så lang tid, og at min læge ikke fulgte op på sagen eller tilbød terapi som supplerende behandling. Selvfølgelig kan jeg kun tale for mig selv, men jeg synes, at systemet svigter i den forbindelse” (tvtid.tv2.dk, 2014).

Also Camilla Schutt Nielsen joined the program. Before she was a timid and anxious girl:

“Jeg har fået et helt nyt liv, hvor jeg tør være til stede og være den, jeg er. Jeg tør snakke med folk og tro på, at jeg selv er god nok. Så der er en helt ny verden, der har åbnet sig for mig, Jeg er meget taknemlig for den store hjælp, jeg har fået af B.S” (tvtid.tv2.dk (a), 2014).

As a result the debate in Denmark peaked and despite the positive results the program also received a lot of criticism. Many were suggesting that because it was a television program one could not rely on it and
also that we cannot afford to send all depressed to Canada with B.S. Christiansen. According to Head of Secretariat Kasper Tingkjær, DepressionsForeningen:

“Vores bekymring er fortsat de mange tusinde, som er meget deprimerede, som behøver medicin. Dem hjælper man ikke ved at sige, at de blot skal tage sig sammen, tage i vildmarken eller i et motionscenter. Tværtimod.” (mx.dk, 2014).

Even though these four women feel better than ever before, the need to make a statement of the need for medicine seems necessary, showing that the dominant discourses are still controlling our understanding and treatment of depression. This story tells us that if we dare listening to other stories, and not allows a single story to be the only story; we can use all the different learnings to help others – to help each other.

Life is a double-edged duet – should it be lived with or without anti-depressants?
The political, economic and biological discourses put forth by our government, GPs, the Danish National Board of Health etc. and the distinction that our modern society sets between normality and deviance based on the contemporary knowledge becomes the populations’ way of viewing the world and themselves, which means that when the GP recommends anti-depressive medicine, the patient tends to accept.

Anti-depressive medicine has become a quick fix solution that fixes everything from depression to pets scratching as the analysis showed. However, like Burton emphasized, depression has many faces. To think that one pill can fix them all is very simplistic. But when researchers, psychiatrists, GPs, and others tries to shake the fixed truisms, the existing way of thinking and acting is immediately codified. Due to the fact that the truth is created discursively it is possible to see how medicine in today’s treatment of depression has become a discourse that we understand and that we accept as meaningful. However, it is only telling a single story. A single story about our society where quick fix solutions are preferred so that we can quit being sad and start being productive and continuing our stressful lives. A single story about normality that lies so close to perfection that most of us fall out of line. 450.000 Danes using anti-depressants is a symptom of a depressed society. If we look beyond the individual and instead change the structures of our society, I am positive that the number will decrease immediately.

The danger of the single story is that it prevents us from learning more about depression and it certainly prevents us from finding the cause linked to each individual. Thereby, it prevents us from providing the best treatment solution to those who are being depressed or simply feeling depressed. Each and every person that I have interviewed and talked to during this work has a unique story. If we open up to more stories, if
we dare to view depression as Aristotle did, we will find that within each unique story there is a gift, learning, and knowledge that could benefit all of us.

In this sense, the power mechanisms in this society is used as the ability not just to tell the story of a person’s condition and options, but to make it the definitive story of that person.

The Palestinian poet Mourid Barghouti writes that it is easy to blur the truth with a simple linguistic trick; “Start your story with "Secondly," and the world will be turned upside-down” (Barghouti, 2003). Start the story of depression with the psychological or societal factors, and not with the biological, and we will have an entirely different story. Start the story of the treatment of depression with therapy, and not with anti-depressive medicine, and we will have an entirely different story.

And maybe – not 450,000 Danes using anti-depressive medicine.

When we reject the single story, when we realize that there is never a single story about anything, we regain the possibility of finding the proper treatment for each person.

Life is a double-edged duet, and the danger of the single story about depression and the treatment is, that it makes people believe that life cannot be lived without anti-depressants – even though it can.
“When diet is wrong, medicine is of no use. When diet is correct, medicine is of no need.”

Ayurvedic proverb
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Appendix
Appendix 1

Sofie

- Kort om din historie - hvordan startede det?


- Hvilken betydning det har haft for dit liv?

At det ikke er kronisk, betyder at jeg nu kan vælge selv og jeg kan se at uden diagnosen så havde mit liv været bedre. Jeg har ikke haft et normalt liv.

- Hvad du tænker om den medicinske behandling som du modtager?

Jeg har fået rigtig meget medicin gennem tiden – bla. lithium blandet med en masse andet for at tage bivirkningerne fra lithium.

- Hvilke effekter/bivirkninger det har haft for dig at benytte anti-depressiver?

Medicinen virker sløvende. Den tager toppen af de negative følelser. Jeg kan se nu at medicinen er med til at fastholde patienten i forløbet.

- Hvordan ønsket om at stoppe med medicinen bliver imødekommet og håndteret?

Det har været et problem. Min psykiater siger at jeg skal have en stabil periode på medicin, men jeg vil trappe ud og mener jeg er klar – også til at det bliver hårdt.

Jeg har på intet tidspunkt følt at mine behandlere har behandlet mig ligeværdigt. Og gruppe-terapi er ikke noget for mig. Jeg har følt mig som en interressant case for psykologen. Det er sgu den måde vi behandler på der gør os syge!! Folk tør ikke stå frem med deres sygdom – de er bange for omgivelsernes reaktion og fordomme og at det vil forfølge dem resten af deres liv.

- Har du prøvet anden behandling end medicinsk og er der noget du kunne tænke dig at prøve?

Jeg har prøvet kognitiv adfærds terapi – og det kan jeg klart anbefale. Ud fra et narrarivt perspektiv så havde min situation været bedre.
Heidi

- Kort om din historie - hvordan startede det og hvor er du nu?

Jeg vil sige at jeg er lidt af en mønsterbryder. Jeg er 41 år – og har levet i overhalingsbanen


Så kom jeg i et coachforløb gennem kommunen. Jeg begyndte at arbejde fra juli igen. Jeg har sagt til mig selv at om 5 år, så vil jeg ikke være på medicin mere. Nogle siger at jeg skal regne med at tage det resten af livet.

- Hvilken betydning det har haft for dit liv?

Anderledes. Jeg ville ønske at nogen havde hjulpet mig med at acceptere det – det er trukket i langdrag fordi jeg ikke ville indse jeg var syg.

Blevet klogere på mig selv – hviler mere i mig selv – jeg pleaser ikke folk på samme måde – tager mig selv alvorligt

- Hvilke effekter/bivirkninger det har haft for dig at benytte anti-depressiver?

Jeg har taget 20 kg på 1 år – og sveder meget

- Har du prøvet anden behandling end medicinsk og er der noget du kunne tænke dig at prøve?

Større mulighed for at få de pårørende involverede – tilbud til mand og børn. Og så har man har brug for at vide at der er en vej ud.
- Kort om din historie - hvordan startede det?


- Diagnose? Hvordan blev den stillet?


  - Hvad du tænker om den medicinske behandling som du modtager?

Det har været en god oplevelse for mig at være på medicin – jeg tror ikke jeg havde jeg havde været her i dag uden medicin. Hvis ikke jeg kan klare udtrapningen – så fortsætter jeg resten af livet

  - Hvilke effekter/bivirkninger det har haft for dig at benytte anti-depressiver?

- Kort om din historie - hvordan startede det?


- Hvilken betydning det har haft for dit liv?


- Har du prøvet anden behandling end medicinsk og er der noget du kunne tænke dig at prøve?


- Hvordan bliver ønsket om at stoppe med medicinen imødekommet og håndteret?

Sidste gang jeg sagde det, tog han mig lidt mere seriøst. Jeg regner med at lægen tager mig ind til samtale for nedtrapning. Men jeg ved ikke om det kan lade sig gøre.

Jeg kender en der har taget citralin i 17 år – det vil jeg ikke. Jeg har spildt mange år af mit liv på at leve bag en mur, følelser har været gemt væk.

Der mangler viden, det hele er nødløsninger. Der er mangel på forskning. Jeg har gået gennem to graviditeter på cipramil og ingen ved hvilken indflydelse det har på mine børn.
Joy

- Kort om din historie - hvordan startede det?

Jeg er 28 år nu og har været halvandet år på medicin

Jeg er ikke helt afklaret, hvad der har startet det.

Min far valgte mig fra da jeg var lille ca. 2 år – jeg boede sammen med min mor og mormor. Min mor fik en ny mand, som så fungerede som en far for mig. Jeg havde kontakt til min biologiske far ind i mellem – men kender ham ikke.

Da jeg var omkring 10-11 år frabeder mine bedsteforældre kontakt med mig, formentlig pga. min fars beslutning.

Forældre bliver skilt og mormor dør lige før konfirmation – så der var rigtig mange svigt.


Det hele ramlede da jeg som færdig pædagog arbejder under dårligt psykisk arbejdsmiljø. Jeg er der et år og skifter så arbejde. Så i dec 12 starter jeg så på medicin

- Hvordan foregik det?

Jeg havde været hos læge mange gange – der var de her 4 perioder hvor jeg har haft det svært. Men jeg ville ikke på medicin selvom jeg blev tilbudt det. Jeg mener der er en udvej og er imod at man skal have medicin. Det er skræmmende at man ikke bliver tilbudt andet.

Sommeren sidste år kommer jeg så til at give noget forkert medicin til en patient, og der ramler hele korthuset. Som jeg ser det har jeg været under for meget pres – og der kommer endnu flere angst tanker, og jeg har ikke lyst til at leve.

Efter episoden – steg jeg i medicin og det gjorde at jeg ikke kunne sove eller koncentrere mig

- Hvordan er din situation nu?

Jeg er begyndt at trappe ud – efter 12 ugers gruppeterapi i Hillerød

I starten var jeg meget skeptisk og ikke begejstret for sådan et tilbud, kan ikke rigtig overskue andres problemer. Men det er bedre end forventet – og nogle dygtige psykologer der er tilknyttet

Jeg kan godt føle at jeg altid kan komme tilbage til der, hvor var det svært – så jeg prøver at aceptere at jeg ikke bliver det gamle jeg, men det nye jeg.

Og også lære at acceptere at jeg har dårlige dage – og det har andre også.

- Hvordan bliver ønsket om at stoppe med medicinen imødekommet og håndteret?

Udtrapningen foregår i samarbejde med overlæge og så er jeg startet hos en psykiater også.

Mit store ønske er at trappe ud – det er mere min mor der er bekymret.

Overlægen spurgte ind til hvorfor og ønsker – jeg synes hun tog pænt imod det.

- Hvordan har du det for tiden?

Jeg er på et stabilt niveau – når der er gået 2-3 mdr hvor jeg er raskmeldt, så prøver vi nedtrapning igen. Det er meget rart at have noget at stå imod med, hvis nu tankemylder dukker op igen og frygten for om jeg nu kan klare det.

- Hvilke effekter/bivirkninger har det haft for dig at benytte anti-depressiver?

Jeg er rigtig træt, fordi jeg har store søvnproblemer. Så er jeg ikke så sulten i kortere perioder ved optrapning, hvilket er ubehagelig i sig selv.

Ift. effekt, vil jeg gerne trappe ud for at finde ud af om det har nogen effekt – ved nemlig ikke hvor meget medicine har gjort. Det var fint nok i starten men nu hvor det er stabilt kan det være svært at vide om det er det er det værd.

- Hvad tænker du om den medicinske behandling som du modtager?


Overlæge Jeanne Molin – psyk amb i Hillerød – hun forklarede at man skulle se det som sukkersyge patienter – nogle kunne undvære og andre skal tage det resten af livet.

Det var et møde hvor de pårørende var med – jeg havde min mor med. Hun forklarede at hvis min hjerne kun mangler kemi for at have det godt, så bliver min hjerne bliver doven og stopper med at producerer de naturlige stoffer. Derfor vil det være sundere med medicin og dermed undgå for mange ujævnheder. Hun mener nemlig ikke at man bliver afhængig.

Jeg ville dog hellere have psykologhjælp end piller – og derved få bearbejdet tingene hurtigt og tidligt i forløbet.

Jeg ved at mange af os at, hvis vi havde fået tilbud om anden hjælp end medicin, så ville vi hellere det. Det er dog traumatiske oplevelser der skal til før det kan lade sig gøre.

- Hvilken betydning det har haft for dit liv?

For mig var det at tage medicin at gå på kompromis med mig selv. Men det var en udvej jeg var nødt til at tage, for jeg havde ikke råd til psykolog en gang om ugen

- Er der andre ting som du finder relevant at belyse?

Det ville være rart hvis de bare ville give tilskud. Det er lidt mere overskueligt at betale 200 kr. pr. konsultation end 800.
Karin

- Kort om din historie - hvordan startede det?


Da jeg fortsat havde det svært som 20 årig fik jeg medicin af min praktiserende læge.

- Hvor hurtigt fik du medicin?

Det var efter første samtale. Han gennemgik et spørgeskema og sagde at jeg havde en moderat depression. Så fik medicin samme dag. Der ikke nogen andre tilbud.

Så gik der to år og så ville jeg gerne trappe ud. Jeg bad om at blive henvist til en psykiater der også arbejdede terapeutisk. Og der fik jeg en tablet oveni.

- Hvor ofte var du i kontakt med din egen læge på det tidspunkt?

Jeg var kun i kontakt med lægen efter 14 dage og ellers ikke. Jo kun når det var på mit eget initiativ eller hvis jeg alligevel skulle noget andet.

- Hvordan blev dit ønske om at trappe ud imødekommet og håndteret?

De gange jeg har har villet trappe ud er det ikke blevet imødekommet. Da jeg blev gravid som 24-årig, blev jeg rådet af alle til at trappe ud af medicinen pga. risiko for fødselsdepression. Lige siden har jeg været on off og selv trappet ud mange gange. Det at starte med gik det altid fint, så fik jeg det dårligt igen og blev rådet af lægen til at starte igen. Min psykiater sagde at det ville være sådan her resten af livet.

Uden støtte fra systemet har de nok på den ene side ret. På den anden side, hvis de havde hjulpet, så tror jeg sagtens jeg kunne være fra for medicinen.

- Hvilke effekter/bivirkninger har det haft for dig at benytte anti-depressiver?

I starten havde jeg meget med kvalme og ubehag de første par uger og så har jeg taget meget på i vægt.

Når jeg er på medicinen, så er jeg flad følelsemæssigt. Det er det jeg savner aller mest. Man er ligesom bare neutral, og seksuelt forsvandt lysten og har ikke kunnet få orgasmer.

Når jeg har haft det rigtig skidt, så var bivirkninger mindre betydelige, fordi der ikke var andre muligheder. Har små børn, så det har også været den nemme løsning.

Men det værste er at der ikke er nogen der stiller spørgsmål til medicinforbruget.

Sidst jeg trappede ud, tænkte jeg det kan ikke passe, der må være nogle mere langsigtede løsninger. Igen har jeg gjort det på eget initiativ, jeg har det stadig godt og prøver at lægge mit liv om ift. mere motion, finde en psykolog, gå ned i arbejdstid osv.

- Hvilken betydning har medicinen haft på dit liv?

Diagnosen, medicinen, hele historien, det har stor betydning for den måde jeg ser mig selv på.
Nogle gange har medicinen gjort det bedre men omvendt har jeg følt mig i en kasse, overvåget og sat i en bås.

Under sidste graviditet tog jeg ikke medicinen og følte mig fri. Medicinen har hjulpet mig op af et hul, men det har også haft mange negative konsekvenser

Derfor vil jeg vælge at tale med nogle andre end lægen fordi der ved jeg godt hvilket svar jeg får.

Min mand lovet at hjælpe med nedtrapningen, men det bliver ikke nemt.

- Hvad tænker du om den medicinske behandling som du modtager?

Jeg tænker på medicinen som et afsluttet kapitel.

Det er uholdbart at man skal blive ved med at tage medicin uden at blive taget op til revurdering. Der var ikke andre tilbud, det var noget jeg selv skulle finde.

Det ville have været meget bedre at sende mig i gruppeterapi med andre unge, når jeg nu havde det svært med medicinen. Der er mange andre muligheder, med fokus på angstgennemstrømte strategier og som heller ikke er så meget hokus pokus. Det burde være tilbud som lægerne kunne tilbyde.

- Er der andre ting som du finder relevant at belyse?

Ikke andet at jeg synes det er grotesk at der på samfunds niveau hersker normen, at hvis det er hjernen der er noget galt med, så skal man have en pille. Og lægerne sidder hårdt på det – og det er et stort marked.

Det der snyder er at man skal gennem sin læge for at få hjælp.

Og hvis det skal være sådan så burde der være nogle faste standarder for, hvordan man starter behandling og trapper ud.
Appendix 2