Chapter One

Critical conditions

"I couldn't manage anymore"

Pan Zygmunt[1] is a petite man of fifty-four with a sinewy physique and a trimmed moustache. He looks older than his age to me, but his demeanor and his jeans and thin polo shirt make him seem youthful. We meet at *Centrum Psychoterapii* (Psychotherapy Center, CP, name changed), a mental health center in Warsaw on a warm morning in May 2010. Although the CP specializes in psychotherapy, it also employs a couple of psychiatrists who oversee the medical and pharmaceutical side of its operations and who occasionally see their own patients, who do not otherwise participate in therapy but come in for checkups and prescriptions. P. Zygmunt is one such patient and his psychiatrist, Dr. Kamila Wierzejska, is one of my main interlocutors at the Center.

A friendly and open-minded physician with an interest in my work, Dr. Kamila always made me feel less out of place in the often-awkward environment that a mental health clinic may be to an ethnographer. If her patients consented, I would sit in on their visits and sometimes interview them afterwards. P. Zygmunt agreed to my presence and agreed to stay for an interview with me after his subsequent scheduled visit—just now his wife was waiting for him, and they were headed back home to a small town just outside the city limits of Warsaw.

During his next visit, p. Zygmunt is open and direct. In fact, he reports to Dr. Kamila that his wife has noticed his frequent joking and slightly elevated mood—something the information leaflet that came with his antidepressant (Sertagen, an SSRI[2]) lists among possible side effects. He also wakes up several times almost every night, and sometimes puts himself to sleep with hydroxyzine, a light and commonly used anxiolytic he was prescribed to calm his anxious

states. All of that makes Dr. Kamila suggest—while explaining her reasoning and asking her patient's agreement—that they add a mood stabilizer, Tegretol, to his regimen and gradually take him off the antidepressant. She also changes his diagnosis from depressive episode, F32, to recurrent depressive disorder, F33.[3] After the visit, during our interview, p. Zygmunt will tell me several times how much the treatment has helped him and how grateful he is to the doctor. Things were really not looking good when he first came to see her just a year earlier.

Originally from a village in the east, close to what used to be the Soviet and is now the Belarusian border, p. Zygmunt had come to Warsaw as a young man right after having graduated technical high school and having completed the compulsory three years of military service in the navy.[4] He found a job at a factory where he would work for the next thirty years: FSO, the state automotive company. Successful in the monopolistic shortage economy, FSO produced Polish makes of cars, including the iconic 'Big' Fiat 125p (licensed by the Italian automaker) and Polonez that dominated the roads during the socialist period, but were obsolete and uncompetitive on the liberalized market. Since 1991, the company had drastically reduced production and had been sold as an assembly plant to a South Korean investor who in turn went bankrupt, leaving this formerly large state enterprise practically dead. P. Zygmunt lived through both the good and the difficult times at the company—he had started as a simple worker, and after three decades of gradually moving up the factory career ladder, by 2000 he had reached a managerial position. It was then that the real problems started for him. "Promotions meant greater responsibility," he says, "and I was really terrified of that responsibility."

He had had "nerves" all his life and always worried a lot, he tells me. As a bachelor, he worried about not finding a wife; once married, he worried about finding an apartment. He and his wife lived in poor conditions in the crowded factory dormitories, so-called "workers' hotels," and then in temporary apartments even after their second child was born. They wanted a house in a nearby town.

Housing was one of the main shortages of Poland's socialist economy and, in the absence of a functioning mortgage system and given the limitations put on real estate ownership, wanting a house meant that one practically had to build it oneself, sometimes resorting to roundabout ways to secure permits, materials, and labor. And p. Zygmunt did, with the help of his brothers. All of that, however, was incredibly stressful: "terrifying," he says repeatedly. And feeling constantly that he would fail or do something wrong, he was convinced it wouldn't work out.

The same at work: with each promotion came more responsibility that terrified him even more—but he couldn't quite turn these down, either. On top

of it all, his anxiety and weakness were not something he wanted others to see. "I was suppressing these feelings inside [*dusiłem to w sobie*]," he says. Even the job security of the socialist economy didn't quite shield p. Zygmunt from his worries. "I was continuously worried about work. Back then there was work for everyone and one shouldn't have been worried. But it was in my head, all the time." Ironically, it was after Poland's systemic transformation, when the company underwent several rounds of restructuring, that p. Zygmunt stopped worrying about keeping the job so much. He knew he was needed; his duties included facilitating labor reductions:

> Z. G.: I was in a situation where it was me who had to fire my own colleagues. I wasn't able to make peace with that either … it was terrible, really terrible. To say to someone: "listen, I have to fire you," you know … I couldn't do that.
> G. S.: But did you?
> Z. G.: Well, I had to, I had to … Because that's when the large reductions were happening …

Following p. Zygmunt's final promotion, things really became unmanageable. In the past, although suffering from anxiety and self-doubt, he would still go on, perform his work duties, and pursue family plans, and in the end everything usually worked out well. Now, however, he started experiencing an acute fear of going to work. He became extremely irritable, getting angry at his wife and family (all three of his children were still living at home) for no particular reason. In effect, he would isolate. He also took to drinking—several beers every night, alone. He thought it would help, but over time it only made him feel worse. "I could close myself off and not talk to anyone for three days. And when I laid down on the couch, I could lie like that for three hours and only stare at one point at the ceiling." Staring at the ceiling, p. Zygmunt was constantly thinking about one thing: where, when, and how to end his life. Eventually he did attempt suicide by hanging himself, at home, in the shower. His wife rescued him and after that his family wouldn't let him be alone.

What was it that pushed p. Zygmunt over the edge? The increased responsibility associated with his managerial position is the explanation he himself offers, although he mostly blames the weak nerves that made him especially susceptible to such stresses. After bringing up "responsibility" rather vaguely a number of times, he articulates explicitly the connection between his breakdown and the constant strive for efficiency at his workplace, including the layoffs he himself had to facilitate and his own susceptibility to the demands his work placed on him:

Z. G.: It terrified me. And then the promotions at work. More and more responsibility. And one is afraid one won't manage, but you don't want to say "no" because what would they say, that I can't manage? I can manage—the only thing is the fear.
G. S.: And what was your job after the promotions, what were your duties as the manager?
Z. G.: After the last one, I had the whole storehouse under me. It was all under me: discharging, receiving, receiving exports, you know … *that whole reduction made it necessary, it made my duties so many, that five years earlier there were six people working on the same thing* [*pięć lat temu to sześciu ludzi przy tym chodziło, no*]. And I tell you, another person might go, not even look, but go out for a smoke and not care at all. But I… I was coming home at eight, nine at night. No one would be there [at the factory] anymore but me. … One time a machine broke down and I stayed in the factory for three nights. Just like that, with the employees. No one else would have done that. But I just wanted to show that I could … I wanted to show the executive [*prezesowi*] that I would do it. What [other] boss would sit there with the men and get dirty up to here? Three nights! … And all that played a part in my illness. That's how it happened. But exactly how it happened, I can't tell you precisely. I really can't. Because I don't remember … All I know is that it was getting worse and worse. The last days I was waking up and yelling to my wife that I wouldn't go to work today.
G. S.: But did you go or not?
Z. G.: Hah, I did. I had to. But finally the day came that I didn't. I went to the doctor. And then, you know, I stayed in [on paid disability; *siedziałem za pieniądze*], because I just couldn't manage anything. …
G. S.: You went on sick leave? For what medical reason?
Z. G.: For something spine-related, or something … I told [the doctor] the truth, that I couldn't manage with anything, that I was going to try to leave the job, or something … I thought on leave I would get some rest … but nothing was changing. Because I was already afraid of what they were going to say when I came back to work. I was sick for a month, two months, half a year—how was I going to come back? I was terrified already. And finally that was the decision I made. I went to the director, I came into his office and said I was no longer working there. He didn't even ask anything, because they already knew more or less that I couldn't manage my… stresses, nerves, all of that. … It was in 2002.

After quitting his job, things still didn't get better. P. Zygmunt was at home a lot, depressed, irritable. He registered as unemployed but worked side jobs repairing and building furniture with his neighbor, although he found this stressful, too, and couldn't enjoy it. He wasn't eating much, his sleeping was poor, his dark moods and morbid thoughts had not left him. The thought of

seeing a doctor—*that* kind of doctor, a psychiatrist—was unacceptable to him, although those who knew about his states, like his wife or the priest in confession, tried to convince him to seek professional help. Since the introduction of the Psychiatric Act in 1994, which brought Polish psychiatry in line with democratic standards, only the patient him- or herself could sign up for a visit. It took years before he got to a point where he no longer resisted. His wife had found the phone number and even dialed it for him, but it was he who had to make the call. The earliest available time at Centrum Psychoterapii, a public clinic, was in a month. His wife made sure he went.

P. Zygmunt's diagnosis was less ambiguous than that of many of the patients I saw during my fieldwork, where depression proved as elusive as it seemed ubiquitous. At the same time, his case was still characteristic of the kind of depression that seems to have become more frequent over the last decade or two. As Dr. Kamila explained to me, it did not appear to be the severe, "biological" disease that used to be called "endogenous" depression, a distinction (endogenous vs. exogenous, caused by 'internal' or 'external' factors) formally erased from today's diagnostic classifications, but still commonly used by Polish psychiatrists. But neither had his breakdown been simply a "depressive reaction" to adverse life events—such as the death of a loved one, or a sudden loss of job—nor, Dr. Kamila assured me, was it a manifestation of a personality or neurotic disorder (e.g., obsessive-compulsive disorder or social phobia), as was the case with many of the Center's patients.[5] Surely, she conceded, his disorder had an anxiety component, but not pronounced enough for a diagnosis of mixed anxiety and depressive disorder, F41.2. Finally, his illness was not organic, in the sense of being caused by an underlying disease such as, say, a thyroid dysfunction. And yet, several years of increasing inability to handle the stresses of his work, his increasing irritability, loss of appetite and interest in things he used to enjoy, the periods of isolation when he would hardly leave his bedroom, his deepening sense of hopelessness, and finally his suicide attempt, had all been undeniably real.

Real, too, was the relief he had found in his treatment. While by his own account what had brought him to his breakdown were his worsening "nerves," the psychiatrist saw a recurrent depressive disorder. But both the patient and the physician agreed that the worsening of his condition was precipitated by external conditions: the increasing pressures of his workplace, where the ongoing cutbacks had increased his responsibilities to a level he could no longer endure. For his "nerves" had been just that for decades—"nerves"—making him "nervous" and "a worrier," but never quite pushing him over the edge. Work culture in the socialist economy, centered on full employment and central planning rather than efficiency and competition, had been for many people relatively free of the stress of overwork[6] (Dunn 2004; Kornai 1992; Verdery 1996). For p. Zygmunt,

work-related stress only became severe in the early 2000s, following another round of restructuring and downsizing at his company.

Idioms of distress

P. Zygmunt's story reflects the transformations of depression as a lived experience and an idiom of suffering that mark the limits of tolerability of what has come to be considered normal in today's Poland. In this chapter, I approach the rise of depression as a practical category in popular discourse, personal experience, and clinical practice as a response to *urealnienie*—realification—in its economic, political, and symbolic forms. If realification was by definition a change in the way realness was produced—involving greater immediacy, apparent naturalness, and therefore increased legitimacy—then it also foreclosed critical approaches; in the wake of the economic and political failures of state socialism, critical engagements with free market ideology and practices were largely relegated to subjugated spaces. Viewed in this light, depression, when it started to emerge as an object of public concern in Poland, came to be positioned as a limit or a hindrance to the legitimacy of the new reality. It fell short of critique, but cutting across different realms (discursive, experiential, clinical) and scales (intimate, interpersonal, population-wide), it held an implicit critical potential.

This chapter argues that depression emerged in Poland in part as a response to realification—and that it did so both as an element of popular discourse and an embodied experience in need of clinical attention. It was a response that held a critical potential in so far as it helped to articulate new problem spaces and mark the limits of what was tolerable within those spaces. As a new idiom of distress, depression started to emerge in the 1990s in the new problem space of the ongoing transformation, marked by rising unemployment, insecurity, and impoverishment, all initially understood as necessary costs of the transition to capitalism—part legacy of the "pathologies of socialism," part a temporary feature of the chaos of transition.

In that space, depression was primarily the experience of the "losers of the transformation," as the popular discourse had it—those who had failed to adjust to the new reality. However, in the 1990s depression remained a marginal issue; there were other idioms that reigned supreme: predominantly alcoholism, but also dependence, learned helplessness, and, marginally yet dramatically, suicide—all of which the category of depression would later begin to subsume. Those other idioms sought to diagnose the dysfunctional characteristics of "the Soviet man," *Homo sovieticus*, a symbolic figure used to make sense of the social problems of the transformation years.

Depression's success—its rise to prominence as an object of public concern in the media and as a diagnostic category used by clinicians and patients alike—came later, in the 2000s, and was possible because depression had come not only to thrive but, importantly, to thrive in a different problem space. This was the problem space not of collapsing state enterprises and their dependent populations, but of the new and intense work and consumption regimes introduced by the competitive market as a central form of socio-economic organization. Depression was now understood primarily as an affliction not of those who had failed to adjust, but of those who had adjusted successfully. In other words, it became a problem not of *maladaptation* to the new reality, but *of that reality itself*.

The emergence of depression not only produced an idiom of distress that replaced a discourse of maladaptation with one of implicit and immanent critique but also constituted a move beyond the distinction between "abnormal" and "normal" as the fundamental parameter of what counts as a mental health problem. In place of the normal as the normative measure of life, it offered the pragmatic criteria of functionality and desirability. In other words, depression, while debilitating or at the very least undesirable, could now be perceived as a fundamentally healthy response to the "new reality." In effect, "what is" was no longer beyond critique.

In what follows, I first show how depression began to emerge in the problem space of "new reality" in the 1990s alongside then dominant idioms, such as alcoholism—a category deeply embedded in history and heavy with meaning. I describe the main elements of the "ecological niche" (Hacking 2002a) in which depression arose and in which such broader forces as pharmaceutical and diagnostic innovation played out. I discuss the changing position of the suicide rate as a way of understanding the historical present as it gained a new meaning as an expression of economic distress rather than moral conflict. I then shift my attention from public discourse and social imagery to clinical and individual experience. By looking at patients' and doctors' accounts, sometimes spanning long medical histories, I show how Poland's new reality produced new kinds of distress and rendered old ones visible.

Where socialism's insulating fictions had sustained an inhabitable (if sometimes only barely) stability, the disruptive and destructive nature of realification would now translate into experiences of being "pushed over the edge"—and this applied to the "losers" as well as the "winners" of transformation. Thus, I show that depression came to designate the distress that previously had been kept below the level of decompensation and the radar of medical diagnostics. The former parameter changed in Poland during the early 1990s with the pressures of economic reality check; the latter, diagnostics, shifted around 2000,

with the diagnostic and financial realification of mental health care (discussed in detail in Chapter Two). I conclude by tracing depression's trajectory into the 2010s and by suggesting a way in which depression may constitute what I call "implicit critique"—immanent in its relation to its object and not fully articulated in form.

A time before depression

"Some time ago," Dr. Zbigniew Komorowski told me, in a conversation in 2007 that partly inspired this ethnography, "no one was writing about depression, no one had heard about such a disease. … Today … it turns out that 'everybody' [has it,] has had it, or is going to have it." Indeed, a short paragraph prefacing one of the longer articles that appeared in one of Poland's major newspapers in 1993 to "introduce" readers to the problem of depression calls it "a disease unknown among the populace, but merciless [and], it would seem, so unobvious—as though invented. But for some it becomes a more or less tangible, painful reality" (Kurkiewicz 1993).

Although the word "depression" had been used both in everyday language and in very infrequent press articles concerning psychiatry, its relative obscurity is evidenced by the fact that in press publications from the early 1990s it is qualified with a descriptor: "*psychic*" or "*mental* depression," or sometimes "*nervous* depression" (*depresja psychiczna, depresja nerwowa*), as if to distinguish this depression from the word's other meanings, primarily "an area situated below sea level."[7] A decade later, such qualifiers would sound redundant and odd.

Before it started to appear as a new idiom of distress in the 1990s, the prevalence of depression was largely unknown but presumed to be minimal. This was partly because of the psychopathological definitions of the day; many of the experiences that, by the 2000s, would be considered episodes of depression "triggered" by life events, had been before thought of as "normal" reactions to life events, similar in form to depression but not implying an underlying disease. At worst, if considered disproportionate reactions, they were seen as signs of neuroses. The "nonexistence" of depression was, therefore, to a degree only relative. For instance, a 1968 study conducted among sales employees in Warsaw found that only ⅓ of their sample did not exhibit diagnosable symptoms—tellingly, symptoms of neuroses. "The prevalence of neurotic disorders is considerable," the authors conclude, "but most people do not feel they have an illness and do not seek medical assistance." (The sample comprised 272 salespersons, of whom 20.9 percent showed evident neurotic disorders, 39.3 percent "weakly manifesting neurotic disorders," and seven percent "organically based alleged neurotic disorders" [Leder 1968].)

If much of this epidemiological invisibility was due to "unawareness" on the part of people failing to become patients, the existing distress was also going medically unregistered because diagnostic categories and practices were not fine-tuned to capture episodically lowered mood. Neither was there much appropriate treatment available. Medications were few and heavy, not adequate to ease mild or moderate symptoms. Psychotherapy was practiced marginally and in few medical centers, resulting in highly limited and unevenly distributed access.

While telling me about her early years in the profession, Dr. Hanna Bugajska, a senior psychiatrist in Warsaw, is still visibly distressed about her inability as a young doctor to help a specific group of patients with anxiety and depressive neurosis: women, fifty and up, "ill with life" ["*chore na życie*"], women like those she today treats with antidepressants and anxiolytics:

> There had always been plenty of such women. But they were not being treated. … They would come, but we had no drugs [to give them], because the first available drugs were antipsychotics, Fenactyl, Largactyl [brands of chlorpromazine, the former produced in Poland since the 1960s]. Those were totally unbelievable. Nothing can take away the joy of seeing how those could work! But for neurotic disorders there were no drugs. And when I was working for a very short time, maybe two months, in the countryside, doing my "banishment" ["*zesłanie*"],[8] there were those simple women who would come and say: "here" [pointing to her chest right below the neck], "I have it here." I'm terribly sorry for sending them away. I was very young. "I have such unrest ["*niespokój*"], such unrest [here]." But there was no psychosis, no nothing… [they were] lucid [*rzeczowy kontakt*]. … If they ended up getting Relanium [Polish brand name for Diazepam or Valium, a benzodiazepine sedative], that was the top. … Whereas after antidepressant drugs were introduced—or, actually, much later than that, because at first they were used only in the treatment of *real* depressions, that is, the *disease*, like the depression of manic-depressive illness… and only later did it turn out they also help against light depression, anxiety, and some even help against compulsions.

The women Dr. Bugajska remembers were ill with life—not a disease per se, but they were experiencing symptoms that clearly fulfill diagnostic criteria for anxiety and depression (back then the categories of reactive depression, sometimes related to depressive neurosis, or anxiety depression). Although theirs were not "*real*" depressions, that is the heavy, debilitating, "biological" depressive phase in the course of bipolar or unipolar disorder, Bugajska wishes she could have recognized and treated their suffering—and had had the pharmaceutical means to do so.

Before "depression" entered the popular lexicon, there were a number of other words—such as "*chandra*"—and other concerns, observations, questions, and postulates that set the stage for its appearance. They referred to various registers of experience ranging from the economic to the existential and demarcated a terrain within which depression would start to arise. The main manifestation of "social pathology" here, however, was alcoholism, which was now increasingly linked to concerns with dependence more broadly (i.e., on the state and welfare) as opposed to independence and taking care of oneself. These new words and linkages that began to circulate widely in the 1990s denoted other phenomena that, like depression itself, seemed "unobvious, as though invented," not yet unquestionably real, their meaning and gravity not yet congealed and fixed.

First came the new vocabularies for describing new realities that were related to the more prominent concerns of the transformation years. And those were many. A 1993 article in *Gazeta Wyborcza* discusses at length another new and unknown problem—unemployment—apparently, until recently, a matter of belief:

> There are … ever fewer people that don't believe in the unemployment plague. Three years ago [1990] hardly anyone believed in unemployment because it was illogical—everyone could see how much there was to be done. The Employment Act was passed a year later offering such broad welfare benefits entitlements that, in the first months, it did more harm than good. Ennoblement to the rank of unemployed [*nobilitacja do miana bezrobotnego*] was first sought by those who until recently had been at risk of being sent to [perform obligatory public work in] Żuławy for "persistent avoidance of work."[9]
>
> In the first years of unemployment, many saw in it a positive role [*upatrywało w nim pozytywnej roli*]. It was supposed to teach people how to work. It was supposed to play a sanitary-hygienic function. Cleanse enterprises of those who were just lazing around anyway and living at the expense of others.

In the mainstream discourse of "the new reality," unemployment seemed a necessary evil or perhaps not an evil at all, but rather a necessary corrective and source of motivation, a "reality check" that would push people to work better or retrain. Depression became one of the elements of the experience of unemployment that complicated this picture. In some areas, especially around liquidated state enterprises or collective farms, where unemployment was devastating entire social worlds, depression and a related psychological notion of stress helped to problematize the attribution of causality: was this suffering caused by people's inability to adapt due to their "Soviet" dispositions—their dependence, passivity, and ubiquitous drinking? How is this problem space to be understood? How is it to be addressed?