The Biopolitical State's Seizure of Psychiatric Medicine

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In the Winter of my sophomore year at university I began seeing a psychiatrist at the insistence of my father, who looked on with distress as, quite unable to sleep, I shed weight at the same alarming rate at which my grades dropped, misplaced my lightheartedness and took up an uncharacteristically chilling cynicism, and generally seemed more morose than one could expect from even a grungy liberal arts student in the gloomiest, greyest corner of the country. Upon meeting me, my psychiatrist was quick to prescribe a benzodiazepine for insomnia and a medication (which I will refer to as my primary medication, as I took it daily at carefully regulated doses) for related health reasons. Early that Summer, several months into my treatment plan and feeling much improved, I woke up from a grand mal seizure in a California airport mere steps away from boarding a plane out of the state. Dazed and disoriented, I could not recall what city we were in nor what year it was. I subsequently spent several hours in the emergency room with all sorts of tubes and wires sticking out of me like a broken kitchen appliance, completely convinced that the whole drama was a cunning, if uneconomical, conspiracy arranged by my significant other to get us off the hook for a missed flight. I had no memory of the incident, but was more unsettled by the fact that I woke up a stranger to the world around me. It was an uncanny flavor of feeling that I had the pleasure of experiencing once more the following September when I found myself back in the urgent care unit after a second seizure.

Urgent care physicians in the emergency room and psychiatric professionals with whom I interacted prior to my seizure differed in their understandings of the event, and their respective medical backgrounds resulted in varying diagnoses and prescriptions. Foucault's theory of

medicalization and the biopolitical state aptly uncovers the process by which I came to understand myself as a mentally ill patient with abnormal behavioral patterns to be surveilled and treated, and to piece apart the therapeutic and dangerous personalities that medication can take on within and without professional supervision. More specifically, I aim to understand what happens when medications escape the regulatory realms of biopolitical actors and become addictive substances subject to unregulated consumption. What are the structures in place to deal with these misalignments in state disciplinary technology? What are the limits of state power, and what are the dangers of dismissing the personalities and subjectivities of patients? To explore the latter query, I borrow from Lisa Stevenson's 2014 analysis of biopolitical regimes of anonymous care that statisticalize Inuit people. She writes about the ways the Canadian state erases individual Inuit identities and instead quantitatively measures its success in its mission to regulate the mortality of the Inuit population as a single entity. Kleinman's work demonstrates how care professionals use limited information to arrive at conclusions about cause and effect and analyzes how, despite psychiatry's own clean alignment with biopolitical regimes of care, psychiatric care can serve as a more effective, personalized, and accurate mode of treatment.

Foucault and Kleinman both define terms that relate to how the psychiatric patient experiences regimes of medicalization. Foucault traces the emergence of a biopolitical state, contrasting it with the traditional sovereign state. In the biopolitical regime, the state's power lies in its ability "to make live and to let die" (2003, 241). The body becomes the site of discipline and regulation, and the population, subjected to increasingly imperceptible and pervasive mechanisms of control, becomes the "object of surveillance, analysis, intervention, modification" (1980, 171). The perfect health of the people ensures their maximum economic utility and so becomes the priority of the state. Foucault argues that the "essential function of society or the

State, or whatever it is that must replace the State, is to take control of life, to manage it, compensate for its aleatory nature, to explore and reduce biological accidents and possibilities" (2003, 261). The burden of health management is in part transferred to the people themselves, who take up the biopolitical ideology and reproduce it as their own. Health is "at once the duty of each and the objective of all" (1980, 170). Various social institutions are absorbed into this framework in a process Foucault calls *medicalization*, whereby increasingly remote corners of human social and personal life come to be understood as issues of health and medicine. In his work on the culture of care in the Western medical tradition, Arthur Kleinman (1995) brings Foucault into conversation when he asserts that "biomedicine is not just any bureaucracy and profession, it is a leading institution of industrialized society's management of social reality[…] This process of *medicalization* is responsible for certain of biomedicine's most controversial attributes. Biomedicine's sector of influence continues to grow as more and more life problems are brought under its aegis" (38).

A patient's experience of medicalization is further indicated by personal content found on apps such as Moodtracker. The patient, with her mental illness diagnosis and subsequent prescription, takes on a new understanding of herself: an understanding of her emotions and behaviors as symptoms, of her mental disposition as biologically diseased, of her environment as potentially triggering or as therapeutic. The patient's emotive and cognitive self comes to be conceptualized and described, both self-referentially and by authorities, using clinical, well-defined terms, listed in the Diagnostic and Statistical Manual of Mental Disorders and legitimized by an extensive bibliography of scientific studies and trials. She learns to attend to her emotions in a new, careful, conscious way, sorting them into ambivalent categories of natural, authentic, human, and healthy; or triggered, diseased, extreme, unreasonable,

unauthorized, and therefore not of the authentic self, a self which emerges when the psyche is chemically balanced through a prescribed medicinal regimen.

But how does one achieve balance, a stable baseline, when normality is a notion just as subjective as that of pain? I examined content on Moodtracker in an attempt to piece apart some common definition of normality among individuals. Moodtracker allows users to create anonymous, public "diaries" where they post entries that have a title, body, and rating of mood (a rainbow scale from one red star for "Worst" to five yellow stars for "Best"). Mood ratings are arranged in a visual chart that tracks shifts in mood across time, allowing patients to analyze emotional patterns, trends, and progress. Intuitively, three blue stars would seem to indicate a baseline mood or some measure of normality. However, the kind of entries marked as three-star moods varied hugely. Some users would describe feeling down, depressed, overwhelmed, or anxious, while others wrote about feelings of euphoria, fulfillment, even extreme and inexplicable happiness. Similarly, how people calibrated other ratings provided insight into the deeply subjective formulations of emotional health. Some might use five-star labels exclusively to describe exceptional elation, while others would attach it to entries where they simply share that it was a fine day. What might be marked as a four-star mood for one might be marked a two-star mood for others.

These observations led me to believe that there is little clear consensus for a definition of normality in mental health. Indeed, in psychiatric situations patients are often expected to reach an understanding of "what feels right." Definitions of illness are complicated by a measure of ambivalence despite their careful documentation in the DSM. Is an antidepressant doing its job if the patient no longer feels sad, but in fact feels very little at all, even numb? Or if the patient is

not anxious, but experiences increased lethargy and sleepiness? Are side effects sometimes just an inconvenient but inescapable fact of medication?

As the patient is taught what does and does not qualify her as mentally unwell, she begins to surveil and report her behaviors. The types of questions asked at psychiatric appointments (What did you eat today? How have you been sleeping? Are you getting your work done?) train her to be attentive to certain patterns in her daily life. The patient is made responsible for tracking and documenting behaviors as symptoms, knowing she will have to report them retrospectively in the thorough interrogations that characterize her meetings with the practitioner. Here, she becomes complicit in the very regimes of surveillance that form the biopolitical state. She monitors her dietary consumption, sleep patterns, hygiene, sociability, energy levels, ability to focus, and academic performance—seemingly all aspects of waking (and sleeping, for that matter) life are medicalized. The patient willingly and unconsciously becomes a perfect secretary of the state. Following Foucault, one finds that the diagnostic methodology of psychiatry requires "a politico-medical hold on a population hedged in by a whole series of prescriptions relating not only to disease but to general forms of existence and behavior (food and drink, sexuality and fecundity, clothing and the layout of living space" (1980, 176).

While I argue psychiatry trains individuals to surveil and police their own bodies, I mean to make it clear that this is not necessarily always a negative quality. It serves to build a largely well-informed profile of the patient for a physician aiming to provide highly personalized and contextualized care. This form of treatment appears all the more laudable when juxtaposed with the work performed by urgent care physicians constrained by time and instilled with values of efficiency, professional distance, and skepticism of poorly informed patients. When I found myself in the urgent care unit in June, I was tended to by a nurse who asked a series of questions

about my own and my family's medical history, my consumption of alcohol and illicit drugs, and my mental and physical state on the day of the event. In this interaction, I found Kleinman to be quite accurate in his claim that "the rule of efficiency governs the lived time of the patient-practitioner encounter" (1995, 37). Here, Lisa Stevenson's work (2014) on anonymous care also provides an insightful theoretical tool for piecing apart the differences between care by psychiatrists and medical care by physicians in the urgent care unit.

After several hours spent waiting for lab results regarding my seizure to come back (none of the results were outstanding), a doctor came in briefly to speak with me. He asserted that my medication had likely reduced my seizure threshold and made me more susceptible to the more severe side effects of alcohol hangovers and benzodiazepine withdrawals. He went on to suggest I take my benzodiazepine more regularly, predicting that if I had taken that medication the night before, I might have avoided the seizure entirely. At this point in my medication course I had been taking the drug very infrequently. The physician felt, however, that the seizure may have been the result not only of a heavy night of drinking to celebrate my twenty-first birthday, but of benzodiazepine withdrawals as well. He insisted that I take my prescription that night and every night thereafter. As the sheriff of my body and secretary for the state, there was the implication that I was irresponsible in my irregular consumption of a prescription and therefore responsible for the incident. The World Health Organization reports on their international website on mental health that "[depression] treatment should be regularly monitored, with special attention to treatment adherence" (World Health Organization). This mandate speaks to Foucault's observation that the biopolitical state fosters, at both institutional and familial levels, "a dense, saturated, permanent, continuous physical environment which envelopes, maintains and develops the child's body (1980, 172-173).

The suggestion by the urgent care physician to take the sleep aid more regularly, despite a very superficial understanding of my treatment course and my general mental health, serves as an apt example of medical practitioners turning to medication in the face of problems with medication. As Kleinman points out, "it is not surprising then, that therapeutic hubris is commonplace. Physicians are not educated to… place limits on the utilization of powerful technologies" (1995, 34). He continues, "an institutionally efficient technical fix (a drug) can be applied in place of a humanly significant relationship of witnessing, affirming, and engaging the patient's and family's existential experience," (1995: 36) speaking to the prioritization of scientifically grounded professionalism over a personalized, attentive understanding of mental illness.

Stevenson would add that in the name of efficiency and in the attempt to maximize the number of individuals made to live, physicians accomplish this institutionalized distancing by engaging in a statistical, depersonalized, and population-oriented understanding of the patient. For the physician, I existed as a unit of a published figure (0.1%) enumerating the very small population of people who have experienced seizures as a result of my primary medication and also as a member of a population known more widely to be at risk for seizures from benzodiazepine withdrawals (Rissmiller 2007). The physician reached the conclusion that I was more likely part of the latter group by looking at my medical history, which stated that I had been taking a sleep aid for several months, and I was on a relatively small dose of my primary medication at the time. He knew that abrupt cessation of benzodiazepines could result in dangerous and well-documented side-effects, including seizures, and so fixated on my identity as a segment of that at-risk population (Petursson 1994).

With both my psychiatrist and the emergency room physicians engaged in a "reconstruction of the person appropriate to the medical gaze" (Good 1994, 73), my psychiatrist's careful and meticulous monitoring of my treatment proved to construct a much more effective model for treatment. She knew that I was taking a benzodiazepine irregularly and in small doses. In our conversations, she came to understand the environmental factors that were linked to my health issues and so recognized when I was more or less likely to need the medication. Aware that I was out of school enjoying the first liberating, stress-free weeks of summer, she knew I had less reason to take the medication at this particular point in time. Moreover, weeks before, she had given me a combinatorial pharmacogenomic enzyme test to learn which medications were compatible with my gut flora. We found that my primary medication was on the list of substances with a moderate gene-drug interaction. She proceeded with her original treatment plan, explaining that these kinds of biological tests were far from comprehensive and were occasionally inaccurate. But when she heard about my seizure, this data provided her with the groundwork for developing an individualized diagnosis. Her intimate knowledge of both my social and biological lives led her to an entirely different analysis of the seizure's onset than that of the emergency room doctor, whose name and face I can't recall and who was neither privy to nor interested in any of that information. In contrast with psychiatrists, physicians do not often address environmental factors as causes of mental upset and sources of trauma, but instead categorize social and cultural factors as *symptomatic;* reactions to the environment are assessed as problematic, unusual, or indicative of biological deviations.

With my second seizure, which had no apparent cause and could not be attributed to careless use of a prescription, the physician prescribed an anti-seizure medication. In both

instances, the physician's first impulse was to increase medication. Neither doctor suggested I decrease my dosage of my primary medication, though I explained that it had been found to be incompatible with my body. In their eyes, I should continue to take a prescription even if it meant the addition of another to offset side effects. The authority of the initial prescription, which had been mandated by a fellow—and therefore trusted—medical professional was much stronger than my own authority. This falls in line with Kleinman's analysis that "the patient's and family's complaints are regarded as *subjective* self-reports, biased accounts of a too-personal somewhere," (1995, 32) while "expert judgment is further legitimated over and against that of the generalist and the layperson" (1995: 38). For Foucault, this represents an instance in which "the doctor wins a footing within the different instances of social power" (1980, 176).

Emergency room personnel were not able to provide the kind of empathetic, well-informed relationships of care advocated by Kleinman; the advice and treatment that I received were misleading and potentially dangerous. My psychiatrist ultimately determined that my primary medication was the cause of the seizures, and we began to wean me off the drugs. Meanwhile, I had been following the initial physician's advice and was taking my secondary medication, the benzodiazepine, nightly, though my psychiatrist was alarmed when she learned this, chiding me about the dangerous interactions that could occur between the two substances in an already vulnerable nervous system. Kleinman's work allows us to assess the limits of care that can be provided by physicians operating in a framework of hubris and sterile insensitivity. My experiences demonstrated that the treatment by physicians was not nearly of the same substance as that provided by my psychiatrist, whose approach to care was highly personalized and deeply probing. How do we reckon with a psychiatry that simultaneously depends upon a deeply personalized, intimate understanding of a vulnerable patient and upon a hierarchical, professional

authorization of cognitive and bodily symptoms? What are the merits and dangers of the self-conscious medicalization of one's own body and behavior according to arbitrary standards enacted by a biopolitical network of medical authorities?

Medications can escape the grasp of the biopolitical state, a sterile regime of biomedicine, and take up animate personalities of their own. What role does addiction play, as the quintessential manifestation of un-regulation, outside the realm of disciplinary powers? On Moodtracker one finds many accounts of addiction to prescribed psychiatric drugs, most notably benzodiazepines. These medications, which some might argue serve as state mechanisms of control, develop chaotic personalities and become themselves uncontrollable, like a pair of handcuffs tangled unto itself or a traffic light that flickers. In this instance, the biopolitical state seemed to *not facilitate enough* regulatory power. But this may not exemplify a failure of a state that, in collaboration with pharmaceutical industries, demonstrates a vested interest in cultivating certain forms of addiction; instead, it may serve a function to *let die* those who cannot be made to live (Rose 2001). We are left again attempting to grapple with a biopolitical regime that is able to obtain much of the information it desires and direct behavior in many regions of society, but reveals fractured regulatory power when its structures of disciplinary control do not align with the idiosyncrasies that differentiate individuals.

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