GRZEGORZ SOKÓŁ

WORKING THROUGH WHAT IS

Depression and the Predicament of Reality in Poland

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Introduction:

The realness of reality

"New reality"

On July 30, 1989, less than two months after the first partly free elections which showed nearly unanimous support for the democratic opposition and became a milestone in the rapid dismantling of state socialism in Poland, the main edition of the news bulletin on national television aired a public announcement of great importance. The government, still an extension of the Polish United Workers' Party, had decided to take a crucial step towards the marketization of the economy. Faced with apparently insurmountable difficulties with the provision of food to the market, the Council of Ministers decided to deregulate the trade of agricultural products and liberate their prices.

Up until that point, only state-run buy-up centers could purchase produce from farmers and only at officially set prices (before distributing them to shops or food processing plants); from now on, meat and crops, as well as processed foods, could be bought and sold by all market participants and at market prices (official prices were to be maintained only for two-percent milk, lean cottage cheese, baby formula, and regular bread). At the same time, food rationing was lifted—meaning no more ration cards for staple foodstuffs, such as sugar, meat, flour and kasha, candy, alcohol, coffee, and cigarettes.[1]

This decision was among the first acts of "*urealnienie cen*," or "*realification of prices*": the replacement of a system where prices were set by fiat and provision of goods centrally controlled with one where prices would reflect the relationship between supply and demand, and trade would be decentralized and deregulated.[2]

Urealnienie was one of the keywords—and key elements—of Poland's systemic transformation:[3] the *realification* that started in the summer of 1989 with prices of food was soon carried out in full by economic "shock therapy" reforms (Sachs

2005) which rapidly transformed Poland's economy from a socialist to a market model. The reforms consisted of other key *realifications*: of the currency exchange rate (allowing the Polish złoty to become exchangeable on the international market and stopping hyperinflation) and of the interest rate (in order to create the conditions for commercial credit). Each was designed to do away with one or another *fiction* of the socialist economy. The term *urealnienie*, then, strongly suggested that the ongoing changes were, at their core, about a "return to reality," making reality *more real* than it had been under the arbitrary, centrally controlled, and by that time excruciatingly inefficient economy of socialism.[4]

Urealnienie, importantly, was used almost synonymously with two other words, *urynkowienie* (marketization) and *uwolnienie* (liberalization, setting free). Taken together, they made up a triad of *reality*, *market*, and *freedom* as opposed to *fiction*, *central planning*, and *dependence*—an opposition, more generally, between *rationality* and *normalcy* that the free market and democracy were expected to bring and what was commonly described as the *absurdity* and *abnormality* of state socialism (Skultans 2007; Verdery 1996: 204–205).

This supposed "return to reality" was not only a matter of economics. In politics, the end of the single party system also carried a promise of greater *realness*. As the outcome of the 1989 election made blatantly clear, the Polish United Workers' Party was no longer able to sustain legitimacy of its rule.[5] The pretense of representing the people, whether defined as the working class, the citizenry, or the nation, was commonly perceived as a lie, even by those who actively participated in party politics—a lie brought to light for all to see by the June elections. The idea of representative democracy, in which citizens could vote for a variety of options and themselves run for office, or could organize a "civil society" under conditions of freedom of speech and assembly, again juxtaposed lie and truth, dependency and freedom, and promised that reality—the way things *really* were—would be brought to bear on official discourses and politics in a new, more immediate fashion. Similarly, the end of censorship not only allowed subjugated and excluded oppositional discourses to enter the official sphere, turning it into a liberal public sphere, but also meant that previously silenced historical events could be publicly discussed,[6] as was rapidly becoming the case. In other words, the term *urealnienie*, or realification, can be taken to denote a broader process central to postsocialist transformation in Poland: the closing of the gap between experienced reality and its official representation. Or, as I discuss below, between reality as experiential and referential.

Two decades after the "shock therapy" reforms, I embarked on an ethnographic project trying to make sense of the apparently soaring rates of depression in Poland. Exploring knowledges and practices in the social field of depression, from its public representation to clinical practice to doctors' and patients' own narratives,

I gradually became aware of the different ways in which *urealnienie* also permeated the treatment and conceptualization of this increasingly common disorder.

Many depressed patients' problems were framed as basically problems *with reality* and relating to it. I found it striking. Questions of reality in psychiatry would seem primarily to concern psychotic disorders, which involve delusions and hallucinations. The problems of depression, however, were largely of the explicitly non-psychotic kind. While they did not have a distorted perception of their surroundings, it was still patients' relationship to reality that was at issue in their illness and their recovery. Reality and the challenges of relating to it had long been very much at stake in a variety of psychotherapeutic schools, but the practice of psychotherapy had itself only started to become widespread in Poland, mostly among the emerging middle classes, in parallel with the economic and political realification. Reality, in other words, was taking on a new role in the changing field of mental health just as it was being called upon and brought out by the postsocialist reforms.

Newspapers and psychiatrists tend to agree that the "new reality" of the market has since its arrival added to the overall burden of stress leading to depression (Czabała et al. 2000). In clinical practice, it is clear that, for many, reality has become unbearable, either in harshly materialist terms of lost job security or in insidiously phantasmic terms of always coming short of expectations and hopes and things not being right. Yet, it holds an ambiguous position. "Entering reality" can shatter a person's mental wholeness, but it is also held as a crucial element of healing, in so far as avoidance, or refusing to accept "what is," is often proclaimed to lie at depression's very root.

My contention here is that there is more to these figures of reality looming across different fields of discourse and practice than merely a metaphoric semblance. Indeed, this book argues that Poland's rapid postsocialist transformation and protracted capitalist formation must be understood in terms of changing modes of producing reality and that psychiatry at once *registers*, *administers*, and *is itself the object of* a change in the ways that reality is constituted and related to. It *registers* it in the form of increased rates of mood disorders—patients who fail to function in the competitive and desire-driven market economy; it *administers* it via treatment that seeks to transform patients' relationship to reality, whether by medication, psychotherapy, or both; finally, it *is the object of* that change as a biopolitical discipline whose forms of expertise, practice, and organization become increasingly formalized and technicized.

Sociologist Nikolas Rose observed in the 1990s that the end of socialism in Eastern Europe and the construction of liberal democracy in the region would likely, just as it had in "the West," give a special political role to the technologies of psychology and psychiatry, that which he calls the "psy-" disciplines:

> As the apparatus of the party and the plan is dismantled, other forms of authority are born, other ways of shaping and guiding the choices and aspirations of these newly freed individuals. … Perhaps the transition to market economies and political pluralism will require … not just the importation of the material technologies of liberal democracy but also their human technologies. (Rose 1996: 100)

My research explores this abstractly and hypothetically described importation in ethnographic detail and shows the ways in which it has and has not converged with formal understandings of "liberal democracy" and how it continues to play out in the specific political, economic, and cultural circumstances of people's lives. Moreover, placing these "human technologies" in the broader framework of the locally salient claim to realness, I detail how this claim, central to Poland's historical present, has inevitably frayed and transformed over time and in practice.

In this book, I understand reality not as simply "what is," but as socially available and practicable ways of relating to "what is." In other words, I am not concerned with reality as such so much as with the *realness* of reality and the ways that realness is produced. In contrast to the socio-phenomenological tradition that defines reality as the taken-for-granted, transparent, and passive environment of experience (see especially the classic study by Berger and Luckmann 1966), to speak of the *realness of reality* means seeing reality in terms both dynamic and active; as having a demanding, corrective, and confrontational dimension. To speak of realness, therefore, means to see reality as what inevitably and stubbornly just *is* and, at the same time, as something always mediated and usually approached in more or less roundabout ways.

If *reality* is typically understood as independent of our recognition and running its course whether or not we are "in touch" with it, *realness* comes with the recognition of the demands it places on us. As a concept, realness denotes the quality of reality that renders it recognizable as such (rather than transparent), that is, as binding, impossible to effectively avoid. Realness becomes an issue when it is in deficit; it is then that it may produce a dissonance—and it is as such that it comes up in the context of depression. When realness is not lacking, it may be understood as productive of a "reality effect" that naturalizes a state of affairs, allowing it to fade into acceptance, turning it into the unquestionable. In this aspect, realness bears resemblance to hegemony in the tradition of Gramsci and the Frankfurt School (Williams 1977a: 108–114). Thus understood, the production of realness was a challenge to the socialist state—it left a gap through which its legitimacy was constantly escaping. And thus understood, it seems again a challenge to the current market technocratic regime.

The "yawning gap" between what was proclaimed to be and what actually was is a recurrent theme in analyses of socialism that note and explore descriptions of life as absurd, abnormal, or replete with fictions (Burawoy and Lukács 1992; Havel 1985; Kharkhordin 1999; Sloterdijk 1987; Žižek 2008; c.f. Yurchak 2006: 16–18). Against that backdrop, the "new reality" of postsocialism was offered as decidedly more real than the previous one: socialism had failed and now it was going to be everyone's own responsibility to take care of themselves rather than rely on the state for care, protection, and provision of basic resources, such as housing and income. Poles were to become masters of their own fate, for better or for worse—but *for real*. In that respect, *urealnienie* amounted to equating reality with capitalism, a conflation Mark Fisher has called "capitalist realism" (Fisher 2009).[7]

This "new reality" was not only new but also constituted as real in a new and more binding way. At once a top-down imposition and a bottom-up unconcealment, it was effected through confrontational, self-legitimizing disclosure: the occurrence of layoffs meant that layoffs were necessary; budget cuts were only to bring reality out from underneath the fictional "soft" financing of institutions and enterprises; the sharp decline of domestic purchasing power was a consequence of realification of the currency. In other words, it was the reality of a "reality check," of a crisis as a "moment of truth" (Roitman 2013: 3).[8] If, however, that shift in realness produced distress (which it did), that distress was not yet being registered in psychiatric diagnoses—these, as Chapter One below shows, came later, with the imperfect formation of the category of depression and its displacement of other idioms of distress.

The revealing of reality through economic "shock therapy" gradually gave way to a different modality of realness: one of formalized, technicized, and sustained production in which reality was constituted and known predominantly by reference to free market mechanisms and via a number of stabilizing operations (economic calculation, technicization of budgeting, application of international formal standards and predictive data). These stabilizing operations, characteristic of neoliberal governance (Rose 1996; Collier 2005a, 2011), served to translate the demands of market rationality into objective "reality plain and simple," thus naturalizing and legitimizing them. Over time, these stabilizing operations began to produce their own "fictions" and "absurdities," but of a new and different kind. Their strong hold on reality—their claim on objectivity, novelty, and faceless technicality—rendered new fictions hard to name and critique. This is where depression as a problem of a relationship to reality arises.

The "reality gap" of late socialism, the "reality check" of revelatory confrontation, and the "neoliberal formalization" were three modes of producing realness. They also offer a chronology: the "reality gap" was characteristic of late

socialism of the late 1970s and 1980s in Poland; the "reality check" was the dominant mode of producing realness during the economic and political reforms introduced between the late 1980s and late 1990s, particularly during the peak of the transformation from 1989 to, roughly, 1993; the third, formalization, in the particular case of mental health care, became predominant in the 2000s, following important diagnostic and financial reforms of the health care system (discussed in detail in Chapter Two).

This chronology complicates periodizations of popular political and economic histories of Eastern Europe that center on the iconic year 1989 as *the* turning point. Certainly, 1989 was rich in symbolic moments of transition: from the roundtable talks and the first semi-democratic elections in Poland to the fall of the Berlin Wall. I recognize the significance of symbolic and ritual acts in political life (e.g., Kubik 1994), and I also heed to the sweeping reforms that fundamentally and concretely reshaped the economic and political system and ushered in what was commonly called the "new reality."[9] At the same time, however, such chronologies obscure other, more subtle processes of both change and continuity. It is those that I bring out in this historically informed ethnography of depression in Poland that keeps its analytic focus on the modes and techniques of producing realness from the 1990s into the second decade of the 21st century.

While the notion of "reality" as used in the context of economic "shock therapy" and psychotherapy may seem to have rather different referents, I argue that it refers to essentially the same imagined gap and warrants comparable symbolic and material operations. The "new reality" meant that Poles' *relationship* to reality needed to change. Psychiatry and psychology are crucial sites where this need is registered as a problem and where new subject dispositions, new ways of relating, are produced. Thus depression, as the most common complaint bringing Poles into mental health treatments today, simultaneously functions as a new idiom of distress and demarcates a space in which realness works to remake subjectivity and reality in contemporary Poland.

Reality in psychiatry and psychotherapy

In my fieldwork with physicians, therapists, and depressed patients in Warsaw, reality appeared repeatedly, and in several ways. Trying to account for the rise of mood disorders since the 1990s, many psychiatrists, apparently combining their professional experience with culturally available narratives of the transformation, explained that under socialism people had been insulated from reality by artificial job security in the fiction of full employment; they had been kept in an unreal—unsustainable—relationship of childlike subjection and

dependence opposite the state. With that dependence came ignorance—insulation not only from risks and insecurities but also from desires and expectations. The painful confrontation with reality marked a "coming of age" of a populace that was separating from the paternalist state and becoming mature, responsible, and independent. The theme, recurrent in my research, of immaturity as a characteristic of individuals and society as a whole, testifies to it.[10] This confrontation produced social costs, of which depression was a part, as when brought on by the stress of unemployment. The more demanding reality of today has caused many to break down and rendered them unable to cope. Treatment and recovery are conceived of in terms of managing the relationship to this reality, typically by helping the patient or client to see it "adequately" and to accept it, sometimes by supporting them in enduring the pressures put upon—and pushing upon—him or her.

Consider the following quotes from psychiatrists and therapists referring to the new reality and to reality as such. The first comes from a 1992 press article from *Gazeta Wyborcza*, the leading liberal daily supportive of the market and political reforms. It features Dr. Jerzy Pawlik, the director of a psychotherapy center in a psychiatric clinic near Warsaw that is at risk of being shut down due to budget cuts—very common at the time. He describes what he calls "social depressions" (*depresje społeczne*), that is, cases of patients "with a healthy psyche" (*o zdrowej psychice*) who are nonetheless in deep depression. These are patients with "life problems," or whose problem is coping with the surrounding reality. These "social depressions," he says, first appeared during the socially, politically, and economically trying period of the martial law in the early 1980s, but now, in the new post-1989 reality, they are not only back, but have become harder to diagnose. Dr. Pawlik is quoted as follows:

> In the past [before 1989], reality was psychologically simpler. Its structure was clearly black and white. Today, there no longer is such polarization. It is hard to find one's place in reality, and that produces frustration. New problems arise that didn't exist in the past: related to losing one's job, lacking success. (Staw 1992)

This brief and anecdotal mention in a newspaper is characteristic of the way the difference between old and new realities and its bearing on depression were described in the difficult and disorienting time of the early 1990s—not only by psychotherapists, but also in public and popular discourse more generally. This change in the order of reality and its interpretations produced experiences that matched the symptomatic manifestation of depression; people, at once healthy and "in deep depression," came to seek professional medical help with their "life problems."

Here is another short fragment, this one from one of my conversations with Dr. Hanna Bugajska, a senior psychiatrist with nearly fifty years of clinical experience. Although formally retired, at the time of our meetings she still works part-time, dividing her commitments between a public and a private mental health center in Warsaw. She starts with a description of the socialist past, then moves on to compare this past to her work with patients today—now in a private clinic, which caters to better-off clientele:

> I think there used to be less of that [of people seeking help with life problems]. You know, there was job security [*bezpieczeństwo pracowe*]. And most people were able to earn their daily bread. And there were none of those drastic layoffs. I think families were more stable, too. There weren't such sudden crashes. And people were so naïve, they didn't know that somewhere out there was the rich world. … I always find it funny … because now people see that one can have [things]. … But back then, apparently, people weren't aware of that … and so they didn't have such [aspirations] … they didn't take such risks. But today, these young people go to work and: take out a mortgage loan for a house, because it's not cool to live in a housing project; take out a loan for a car; … buy their furniture on credit, because it also needs to be like this or like that … —and they have their directorial jobs—it's not a fairytale, that's how it is. And when they lose their jobs, they stick their thumb in their mouth and cry! A mixture of terrible annoyance and great compassion always comes over me, because the stupidity of their actions is so evident, and they're not dumb people, you know? …

Varying notions of reality meet in this fragment. First, there is the insulation from a certain kind of harsh reality of life that the socialist state provided in the past—albeit at the cost of economic inefficiency. It was that "unsustainable fiction" that made the painful "reality check" appear as a necessary corrective and condition of recovery after 1989. People who lived in that "artificial reality" were, predictably, naïve, unaware of the greater ambitions, desires, and *things* and experiences—in other words: lives—they could be having. Their limitation was the price of their security. Now, the security no longer there, reality itself, along with its constitutive burdens, responsibilities, and risks, becomes the source of life problems that produce depressive symptoms. But this life, supposedly more "real," is immediately described in terms of its own fictions; reality is inevitably wrapped in a veil of illusions the successful navigation of which is what mental wellbeing hinges on, illusions fueled by those very aspirations and desires the lack of which defined the socialist fiction of yesteryear. What Dr. Bugajska sees as people's naïveté and immaturity, rather than an element of their social and existential security, is what puts them at risk:

> Losing one's job, which, as you know, is quite [common] in those better firms, banks—[those young people] make very quick careers there, have high positions, also probably in a fraudulent way [*w sposób załgany*] each is a director, an executive, or whatever, and they really believe it!—and then in five minutes they have to pack up and leave, like in an American movie, they can't even get access to their computer and some are walked out by a security guard or something. … I understand that that's a [source of] serious stress, however it's still a pretty long way from a psychiatrist's office. But they do seek that kind of help, both psychological and medical.

Dr. Bugajska admits to being old-fashioned and critical of the expansion of diagnostic categories. These patients, she contends, are not *really* ill. Still, they have symptoms and feel they can't go on. Reality "gets them" because they lacked critical distance and failed to recognize it, failed to recognize their own disposability, the instability of their credit-financed consumption reflecting the instability of fictitious capital, or the burden of stress that the achievement of success would put on them. Depression can be an effect of a confrontation with reality as well as of *avoiding that confrontation* (as I discuss later, in such cases the diagnoses often combine depressive episodes with a personality disorder). Following the introduction of new diagnostics, the category of depression has been broadened to apply to cases like these, making both the disorder and its treatment modalities more prevalent.

Below is another experienced physician, psychiatrist, and psychotherapist Prof. Jerzy Matej, describing a change he had noticed in his patient population since the early 1990s. Again, we see here an emergence of a new kind of patient, a patient whose problems—"life problems"—have to do directly with their relationship with "reality." Matej segues between different registers—that of particular patients and society at large, that of clinical practice and economic and political transition. He, too, paints a picture of life under communism as conducive to greater psychic stability, but also resembling infantile fantasy as opposed to reality and maturity, which capitalism demands (here discussed as hope as opposed to hopelessness):

> J. M.: [The statistical increase in rates of depression] concerns those patients who are unable to function; [it] concerns people who have personality disorders … and people who … well, what is going up is also the number [of people] coming in [who use] psychoactive substances, but they, in my judgment, are mostly people who [similarly] decompensate depressively in a situation that is difficult for them. That's how I see it.
> G. S.: And those situations are more frequent than before, in your opinion?
> J. M.: Of course. In communism [*w komunie*] there was nothing to do in the

> afternoon, one didn't have the option to take extra work, everyone had their "social" ["*socjal*," social insurance/security], there was not such great stratification [*rozwarstwienie*], you know, at most one person had a Big Fiat, another a Little Fiat,[11] and a third didn't have a car, but there were no greater desires and therefore frustrations, possibilities …

Life under socialism, in other words, was less likely to produce difficult circumstances that would precipitate mental crises. There was less opportunity, but also fewer challenges and risks. There were also, Matej suggests, fewer objects of desire and less inequality of socioeconomic and cultural status. This image, however, brings up the notion of hopelessness—a lack of horizon and prospects of a better future associated with late socialism with its political and economic crisis and largely futile attempts at reform. Asked about hopelessness, Matej disagrees:

> J. M.: I think the opposite—that there was more hope during communism. In my opinion the whole phenomenon of "Solidarity"[12] came from the fact that people had great hope that someday—no one knew when—everything would change, and we would be in paradise. And now we are in that paradise, and we see that it's no paradise at all, but a situation in which everything depends on each person and no one else will do anything for us. And [yet] attitudes such that the Pope, or whoever, will fix everything for everyone, such demanding attitudes [*roszczeniowe postawy*] that communism—incapacitating people as it did—[had produced, persist]. … The phenomenon of the people [who used to work on state farms] and now, after the state farms were dissolved, do nothing, because they had been shaped [in such a way that it is] someone else [who] organizes their life. … Here there is freedom, but there is no welfare [*opiekuńczość*]. Everyone's on their own, and a lot of people are not capable of that. And so before there was the hope that when communism came tumbling down, things would be different and it'd get better, or that the system would change, ease off or something. … But now there is no [such] hope anymore. … Because those who are more entrepreneurial, the new generation, yes, they have hope and are able to draw from that [*czerpać z tego*], but most people are, as I call it, not satisfied but adapted [*nie zadowolonych a zaadaptowanych*]. But, well, they don't have hope. The retired don't have hope they'll start vacationing in the Canary Islands every year, my generation doesn't have hope either that they will receive a decent retirement pension from the state. I have to manage my money myself so that I have a pension. I alone need to [make sure I have] some resources.

Matej paints a familiar picture: under socialism, life was dull and limiting but safe. However, it wasn't "real." It was an artificially sustained fiction which

left people free to fantasize about a better future modeled on an idealized image of Western reality. Now, that reality appears to be here—but it's difficult, different than expected. It was all an infantile dream. Now, it's time to grow up, pull ourselves together, and take responsibility for our own lives. But not everyone can do it because of the way the past shaped them. In his references to the paradigmatic figure of the state farm worker, Matej conjures a stereotypical image of the *Homo sovieticus* (discussed at length in Chapter One) and attributes the "demanding attitude" to people rather than to reality itself. Reality just "is." This repositioning, as I will show, is one of the ways in which reality is negotiated and constituted in the diagnosis and treatment of depression.

Similarly, confronting reality like a mature person is understood by mental health practitioners as a necessary element of successful treatment. One of the many therapists who explained that to me was Dr. Antoni Orłowicz, a psychologist and psychiatry Ph.D. in his mid-thirties, trained under Prof. Matej at the Psychiatric Clinic of the Medical University of Warsaw.[13] Dr. Orłowicz, a psychodynamic therapist[14] with a few years' experience, was the lead physician of a depression therapy group whose meetings I observed daily over the course of two months. Accounting for the suffering of many of the patients who experience various manifestations of depression, he very generally described the nature of their condition and their healing as a matter of their relationship to reality:

> A. O.: Psychic pain stems from a kind of refusal to accept *what is* [*wynika z pewnego niepogodzenia się z tym, co jest*], from an inability to work through mourning, loss, [from] an inability to accept that things are like this and not otherwise, and from fighting it in some way … [from] something being unacceptable. I don't know—a limitation one has, one's situation of one kind or another. A loss or something …
> G. S.: And now therapy as you understand it … what is its role?
> A. O.: First, it is to show and name what that is … what that thing really is against which … which I don't accept. Because on the surface it may look completely different from what it is in reality. The point is to understand it concretely and to know it and name it just as it is and on these three planes: in terms of the story of your life, of biography; in terms of the current situation here and now; and in the sense that it also reappears in the therapeutic relationship. It is to be able to see from that perspective and in that broader context what it is I don't accept, why I don't accept it, what part within me it touches, what it concerns, what it is I am afraid I will lose—that whole context. But it also most often, or even always, happens that it turns out that it's a kind of fraud [*oszustwo*]. Because in order to move on and make some kind of a change, well, you've got to let go of something, which is a utopia anyway, which is impossible to realize. … Well, it's sort of like this: Let's say I have an image of an ideal parent, or, I don't know,

of the realization of something I don't have and never have had. And letting go of that, in a way, is like accepting that I'm not important.
G. S.: Not realizing it, you mean?
A. O.: Yes, accepting the fact that I wasn't given enough attention, I didn't have that ideal parent, is to me equivalent to my being unimportant; that I wasn't important enough to receive that sufficient amount of care. But, well, in reality it is so that on the one hand, yes, there is the need of attention and care, but it is not being realized exactly because I keep insisting on the unrealistic fulfillment of that need. And that in fact it will never be fulfilled. Because there is no ideal partner, ideal person, who would be capable of filling such a hole, filling something like that. That, in fact, paradoxically, only letting go of it might create a possibility for that need to be realized on a different level, adult level, but …
G. S.: So that vision of therapy is one of it being a lesson in humility rather that some kind of "you can do what you want"?
A. O.: Well, yes, yes. It is about support in working through what is.

Here, a confrontation with reality is not necessarily something that happens due to dramatic life events where "what is" reveals itself emerging from underneath the rubble of a collapsed fantasy. Rather, it is something one has to achieve in therapy through the sustained work of coming to see and coming to accept the ways in which "what is" continues to fall short of "what could be" and "what I want it to be." The notion of "working through what is," as I use it in this book following the mental health professionals I worked with in Warsaw, refers precisely to this often prolonged and difficult process. In a more exact psychoanalytic sense, "working-through" (*Durcharbeitung*) refers to dwelling, within the analytic relationship, for a time and with effort, on the resistance underlying the symptoms. As Freud put it, "[o]ne must allow the patient time to become more conversant with this resistance with which he has now become acquainted, to *work through* it, to overcome it, by continuing, in defiance of it, the analytic work …" (Freud 2001: 155; quoted in Thompson 1994: 197–198).[15] As Dr. Orłowicz articulates it, the "working through" happens at three planes—one's life history, current situation, and the therapeutic relationship—and, as this book shows, it extends into personal narratives and public discourse, reshapes one's relationship to oneself and others, as well as to the state. It thus contributes to producing new subject positions at the intersection of socioeconomic conditions, political relations, culturally specific ethics, and forms of selfhood, experienced as an existential position in the world.

What neoliberal economic reformers referred to when calling upon reality may not have had the exact same referent as what a therapist treating depression means with that word, but the unyielding, demanding nature that defines this

reality is, I argue, similar. Invoked as that with which all that is feasible, sustainable, and true must stay in accordance, reality is how the world makes demands on us; its realness the inevitability and legitimacy of its demand.

Realification as an analytic concept, reality as an ethnographic object

"Realification" is a somewhat awkward neologism in English (its use in mathematics aside). In Polish, "*urealnienie*" is not a common word, either. It entered the public discourse of the transformation period from the vocabulary of economics and is rarely used today. While it is not a very common term in psychotherapeutic and psychiatric practice, I borrow it and use it as an analytic concept capable of detecting the dynamics whereby the depressed patient's relationship to reality is reshaped. As a noun of action, "realification" emphasizes that realness is an *effect*; that "what is" is actively produced and this production can take different forms.

Outside psychiatry, in the vernacular of socialist economics, the precise term "*urealnienie*" had been used before 1989 as a euphemism for "price increase." Bridging the gap between supply and demand (the latter generally exceeding the former in economies of shortage), between prices of consumer goods and real production costs, and between domestic market pricing of commodities and corresponding global market prices was a constant challenge in the centrally planned economy. Increases of consumer prices—made by decree, often significant, and invariably unpopular—were explained as necessary adjustments of prices to economic realities. Because of their recurrent nature, these government-administered hikes should properly be referred to as *urealni**a**nie* rather than *urealni**e**nie*, the change of a single letter marking a grammatical difference between the imperfect mode expressing a continuous or repetitive activity of "making real" and the perfect verb suggesting a completed, final act of "having made real." In 1989, the difference was significant: *urealnienie* was final and meant the end of price control once and for all.[16]

A good example of the explicit use of "*urealnienie*" in the economic context can be taken from a June, 1989 interview with one of the economists working on the reform plans during Poland's "roundtable talks"—negotiations between the "Solidarity" labor union and the communist government:

> Limiting [budget] expenditure must entail, first of all, cutting subsidies to state enterprises, which inevitably will produce negative consequences for many employees. And here, the Solidarity ethos, which says "We must defend all" is at

> odds with economic logic, according to which we must save only the most efficient enterprises and shut down the inefficient ones. …
> Q: You suggest that we withdraw subsidies. What would that mean?
> A: A *realification of prices*, which, in the economic sense means removal of price brakes [*hamulce cenowe*]. Some prices may go up by as much as 800 percent, others by 30. In *a world of falsified indicators* [*sfałszowanych wskaźników*] in which we live today, a dispute over, e.g., the profitability of the Gdańsk shipyard is not possible to resolve.
> Q: But a price increase would have to be followed by an increase in salaries. We are in a circle.
> A: Again, the Solidarity ethos is here in contradiction with economic common sense. We must get to what both sides [the *nomenklatura* on the one hand and Solidarity on the other] are so afraid of: to the pressure coming from worker teams to finally set the price of labor at a market level. In effect, the share of labor in production costs will go up significantly. What's more, a labor market will emerge, the squandering of labor will end [*skończy się marnotrastwo pracy*].
> From the economic point of view, it is better to direct a part of the budget towards unemployment benefits or bonuses for the underpaid than towards subsidies for inefficient enterprises.
> Q: Are there no other ways? And will this program suffice?
> A: There are none. And anyway, any program different than this would not be approved by the IMF. (Pacewicz 1989)

Above, the substantive and social ethos of Solidarity is shown in contrast to the procedural and economic mechanics of the market against a backdrop of state socialist fictions and artificiality, the anticipated explosion of unemployment, and the rigidity of reality ("'Are there no other ways?' 'There are none'"), represented here, tellingly, by the IMF controlling the relief options of Poland's massive foreign debt.[17]

Following the way in which the word was used in 1989, I use realification here to refer to the closing of the "reality gap" of late socialism. Reality here, it may be noted, has two distinct meanings. On the one hand, it refers to the actualities of everyday life, to the experiential side of the gap that incessantly revealed official proclamations to be false, plans unfulfilled, and goals unmet. Reality is, in that sense, experiential and immanent. On the other hand, reality floats as a fantasy whose claims to realness seem stronger than those of the actual surroundings; a fantasy of how things should be, how they could be, and how they in fact are otherwise and elsewhere (a slot occupied, first and foremost, by the figure of the West). In that sense, it is referential and transcendent. In both senses, what grants it the status of "reality" is that it is posed against the fiction of "actually existing socialism," as that which is failing to produce sufficient

realness to appear legitimate. In closing this gap through Poland's "transformation," the experiential and the referential were collapsed: "fictions" were to be erased, thus ushering in a "new reality" in which everyday actuality and the imagined reality of elsewhere would be brought together. This shows realification in its both destructive and productive dimensions—both as confrontation and as sustained production.

While I use *realification* primarily as an analytic concept, I approach reality—as it traveled alongside and emerged through my ethnographic pursuit of the diagnosis and treatment of depression—as an ethnographic object. Importantly, however, I am interested in reality less as a "thing," a "space," or "environment" than as a "quality"; my focus is on the claimed and pursued *realness* of reality that grants it legitimacy. Theoretically conceived of in opposition to "fiction," "ideology," and "fantasy," the ethnographically pragmatistic way I treat reality nevertheless accepts its inconsistencies and accentuates its unchangeably fictional, ideological, and fantastic nature. I show it to be an effect achieved, in the context of mental healthcare, through different techniques, which I discuss throughout this book: objectivism, technical formalism, confrontational disclosure, emotional self-analysis, and an ethics of powerlessness.[18]

While the ways in which *objects* of knowledge are constituted have received a great deal of attention in anthropology—generally in constructionist analyses concerned with epistemology (Bowker and Star 1999; Daston and Galison 2010; Hacking 1990; Poovey 1998) and, more recently, ontology (Holbraad and Pedersen 2017; Mol 2002; Latour 2004; Viveiros de Castro 2015; see also Holbraad and Pedersen 2014)—the question of *reality* as such poses a distinctly different problem. I understand it precisely in juxtaposition to objects of knowledge in that while objects are fashioned as bounded, reality lacks such boundedness and is fashioned as such; objects are to reality as "figure" is to "ground." And though "what is" may manifest itself in particulars, its claim is always to the general background.

Thus understood, reality and the production of realness have been the explicit question of classical social constructivism (e.g., in the work of its pioneers at the New School for Social Research, Berger and Luckmann 1966), drawing on social phenomenology (Schütz) and symbolic interactionism (Mead). It has also, as a problem of representation, been addressed in cultural studies and literary theory (Barthes 1989a; Eagleton 1976; Lukács 1964a; 1971; Williams 1977a; 1977b). More broadly speaking, questions pertaining to the realness and binding nature of reality have been raised in the tradition of Marxist theories of ideology, especially in the realm of their intersections with psychoanalysis (Althusser 2001; Salecl 1994; Žižek 2008). The short discussion that follows will situate my use of "reality" in relation to relevant concepts of social theory.

Phenomenological and constructionist sociology that took up the question of reality directly (Berger and Luckmann 1966) construed it as the taken-for-granted, transparently clear air of sociality that we all unknowingly breathe. Berger and Luckmann's important intervention at the time was the expansion of the object of sociology of knowledge to include not just scientific ideas, but also "what people 'know' as 'reality' in their everyday non- and pre-theoretical lives. In other words, common-sense 'knowledge,' rather than 'ideas,' must be the central focus for the sociology of knowledge" (27). Effectively, the object of their study was "the knowledge which guides conduct in everyday life" (33). As they put it, "[t]he reality of everyday life is taken for granted *as* reality. … It is simply *there*, as self-evident and compelling facticity. I *know* that it is real. … This suspension of doubt is so firm that to abandon it, as I might want to do, say, in theoretical or religious contemplation, I have to make an extreme transition" (37).[19]

While I do build on the conception of reality as something constructed and maintained, and thus relative across context, time, and culture, the notion of reality I work with is not equivalent to "the world of everyday life," a reality that "requires no additional verification over and beyond its simple presence" (37). Rather, following my ethnographic material, I am interested precisely in such verification and the forms it takes when reality is shown to run short of realness. Crucial to my understanding of the notion of reality is its corrective and demanding nature.

Roland Barthes coined the term "reality effect" (1989a) to address the ways realness is produced in realist literature. He argued that it is achieved by way of small, apparently insignificant, seemingly superfluous details—a barometer atop a piano in a character's chamber; the size and location of a door upon which a gentle knock is delivered—whose referent, he argued, is nothing but realism itself: "they say nothing but this: *we are the real*; it is the category of the real (and not its contingent content) which is then signified" (Barthes 1989a: 148). More important still is Barthes' contention that in the modern convention (in literature, in historiography, and, he seems to be saying, in signifying practices more broadly), "[t]he pure and simple 'representation' of the 'real,' the naked relation of 'what is' (or has been) … appears as a resistance to meaning" (146).[20] In other words, modernity defines reality as *objective*, not driven by any purpose or intention other than its own being: "the 'real' is supposed to be self-sufficient, … strong enough to belie any notion of 'function,' … the *having-been-there* of things is a sufficient principle of speech" (147).[21] The techniques of realification I analyze below and throughout this book similarly connote (signify) their own realism and claim objectivity. Being practical and social rather than textual, however, their "reality effect" is produced in ways that fall beyond the scope of literary criticism (see Chapter Two).

This move from textual analysis to social critique is more explicit in the work of Georg Lukács. If the multiplication of descriptive details is one of the ways of summoning up objectivity, that "objectivity," observes Lukács in his study of realism (1964), is quite literally a consequence of "thingification," *Verdinglichung*, or reification of life, that is, a consequence of alienation which cuts the human person off from the world she inhabits.[22] Such an increased degree of alienation is what sets naturalism apart from realism—the latter still drawing on a sense of recognition of life and world, the former all but having lost it.[23]

As Michael Taussig has observed, Lukács' Marxist analysis moves away from the realm of literature as cultural representation to attack the concept of objective reality as an illusion fostered by capitalist relations of production, based in what he called "commodity-structure." The basis of the latter was "that a relation between people takes on the character of a thing and thus acquires a 'phantom objectivity,' an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature: the relation between people" (quoted in Taussig 1992: 84; cf. Žižek 2008).

Marxist thought offers a rich vocabulary for analyzing forms of concealment of reality: fetishism, ideology, and hegemony being only the most prominent of such concepts. As Marx observed, the capitalist mode of production has the ability to appear "as self-evident as the laws of Nature" (quoted in Taussig 1992: 22).

"Real socialism" and the reality gap

Reading ethnographies of socialism and postsocialism with an eye to the question of the realness of reality reveals "reality" to have been one of the central concepts all along, though never explicitly problematized or extensively theorized.

Consider the term "real socialism" (*realny socjalizm*). Coined by Party propaganda in the 1970s as a response to critiques of socialist state systems from essentially Marxist perspectives, the phrase was an attempt to come to terms with the fact that "actually existing socialism" was quite far from the proclaimed Marxist-Leninist ideals. It highlights the way in which the real was also already fictional.[24] It was an explicit *concession to reality*, an admission that, at that point at least, achieving true socialism (or, if you will, *real* socialism) was not realistically feasible.[25]

As socialist ideals started to lose hold as the goal, reference, and measure of socialism, what came to define the parameters of reality for socialist countries in East Central Europe were increasingly Western capitalist economies and the global financial market they were shaping. The West was becoming the point

of reference for both the people and the ruling elites. In popular discourse and imagination, life in Western Europe and the United States, as the reverse of the Eastern Bloc, was not only incomparably better and easier, but *normal*, arranged in a much greater harmony with human nature (Lampland 1995: 13) and the "nature of things." As anthropologist Vieda Skultans points out, the sense of absurdity and abnormality of life under socialism, and the attribution of normality to elsewhere, had been a theme running through many scholarly accounts:

> Stukuls-Eglitis describes how the imaginings of Latvian nationhood imply "that a state of normality was something that needed to be consciously (re)created." … Fehervary notes that luxury goods rarely seen in Hungary are described as "normal." … Thus we find ourselves in a semantic domain in which normality belongs elsewhere, in another time and another place. (Skultans 2007: 35)

That "elsewhere," clearly, was the West:

> The entire settlement, and, by implication, Soviet Estonia, was not normal in comparison to [the] imagined construction of the normal. … The normal was rather associated with the solid ordinary comforts of Northern Europe, which, of course, were anything but ordinary on the collective farm. (Rausing 2004: 36)

Here the difference between normality and abnormality must be understood in the normative rather than descriptive sense: normal is how things should be, not merely how things are, what is typical (Canguilhem 1991: 122–123). Similarly, an elsewhere place may be perceived as more real in the normative sense—have a stronger hold—than the here and now that is directly experienced. Normality and reality have a close relationship; the abnormal undermines the naturalness and legitimacy of the arrangement of everyday life (see Fig. 1, next page).[26]

On a different level, the reality of the West—mainly, of the market—attained a dominant position because of socialist countries' increasing reliance on foreign loans. The subsumption of their initially more isolated economies into the world system also created a field of very general reference and commensurability. Poland's realification had in fact started in the early 1980s with efforts to bring prices of goods in Poland closer to global prices of commodities.[27] Analyzing similar processes in Hungary, Melegh (2011) argues that not only was Western reality taken by many state officials and especially economic planners as more real, more binding, and legitimate, but it was also idealized and misrecognized: the ongoing crisis in global capitalism was largely disregarded, and Hungary's economic problems, in part related to that crisis, were understood as local and inherent to socialism.

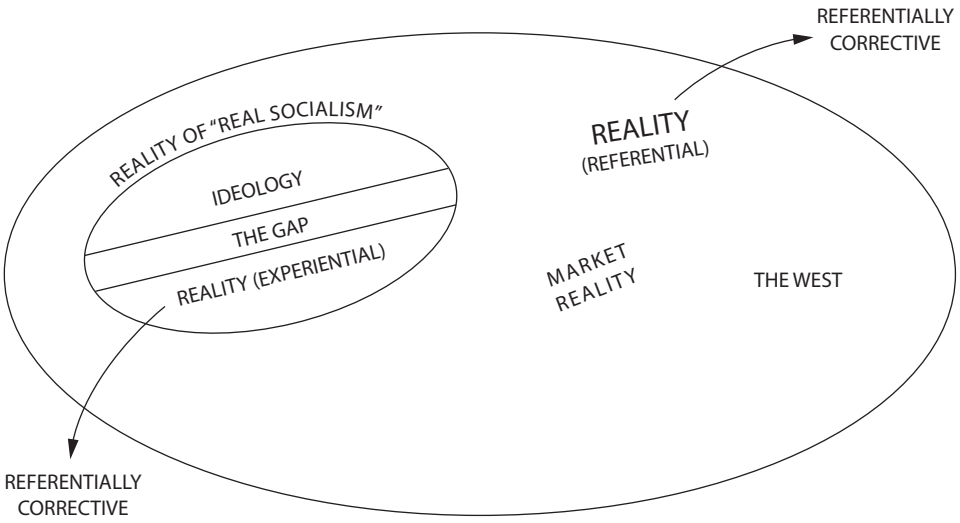

Figure 1. The reality of "real socialism."

> In public discourses, the world outside Hungary was portrayed as some kind of unchangeable reality. The dynamics of the world economy were described as "external conditions" and/or "requirements." … [T]here were some direct interest groups that pushed very hard for "getting back to reality" as exemplified by the title of a 1983 book on the speeches of János Fekete, at that time President of the Hungarian National Bank. … This normative market element and the need to get more fully integrated into world capitalism was seen (very tellingly) as a move "back to reality" which could not be questioned. (Melegh 2011: 269–270)

The power of the call to return to reality was clearly pinned on the accepted realness of the destination.[28] But it also hinged on the concurrently widening reality gap at home. In their analysis of ideology and reality in state socialism, also in the case of Hungary, Burawoy and Lukács (1992) point out the "yawning gap" between "ideology and reality, between proclamation and experience, between the affirmation of justice, democracy, and efficiency and the ubiquity of injustice, dictatorship, and inefficiency" (82–83).[29] This gap, they argue, was so stark because of the particular role ideology played in socialism. They juxtapose the "painting of socialism," which produces dissent, with the ideological manufacturing of consent in capitalism:

> Everyone is called on to "paint socialism" as the radiant future at the same time that everyone knows that the everyday "reality" is anything but radiant. Through these rituals, ideology assumes a reality of its own which everyone is compelled to recognize—a game that everyone is compelled to play out, but which everyone

> sees through. The painting of socialism only impresses on people the failure of socialism to realize its promises. It engenders an imminent critique of state socialism, a negative class consciousness, dissent if you please, right at the heart of society in the process of production. (21–22)

Capitalism, they say, is different:

> Workers are not called on to build capitalism, they are exhorted to pursue their own interests and in so doing deny themselves a critical systemic understanding of the world—an understanding so natural to their socialist colleagues. Instead of painting capitalism, they manufacture consent. Far from being unimportant, capitalist ideology insinuates itself unnoticed into microstructures of power. (139)

In other words, capitalism, seemingly by its very nature, is more efficient in producing consent because ideology does its work quietly and invisibly, as if from the back seat. It is ideology in the Althusserian sense, something people have without knowing it (cf. Marcuse 1964), which becomes hegemonic (Williams 1977a), whereas for socialism, where ideology is, as it were, overt, legitimization is a constant concern and challenge. Ultimately, they argue, the demise of socialism was precipitated by its failure to live up to its own promises to the extent that even the dominant class and the ruling elite rejected it. That rejection, I suggest, centrally entailed recognizing market capitalism as reality, as testified to in the choice of the word "realification" to describe the marketization of prices.[30]

This is not to say that capitalism turned out to be more *real* in any absolute sense than socialism was. They both produced their realness differently and both generated their fictions and legitimacy crises, albeit differently distributed. (In the words of the political scientist Adam Przeworski, both were irrational, but socialism turned out to be infeasible—as quoted by Burawoy and Lukács, who, however, disagree on the feasibility of capitalism [1992: 194 fn. 5]). Rather, what I am describing is a shift from a socialist mode of the production of realness to a neoliberal one.

While Burawoy's and Lukács' analysis of ideology is a thoughtful one, their notion of reality is blithely simple. For the most part, reality is treated as "what is." Sometimes it refers to "economic reality," meaning, the details of the actual operation and efficiency of an enterprise. It is, by and large, simply the opposite of ideology. This seems to be a general problem with the strand of Marxist analysis in which "reality" takes on a strongly material meaning. My approach is different, as it does not take for granted the fundamental distinction between reality and ideology. In this I follow Foucault (Foucault 1971, 1972, 1980a; see

also Dreyfus and Rabinow 1983) and, on the other hand, theories of ideology influenced by Lacanian psychoanalysis (Salecl 1994; Žižek 2008).

All this brings us to the observation that the ways of producing realness in "socialism" and "capitalism" are different. But they also keep changing. Over the last three decades in Poland, the modes and techniques of producing realness have been undergoing a deep transformation—both because of the "new reality" of capitalism and because capitalism itself and the forms of life it engenders in different locales continue to transform. The difficulties experienced in the relationship to reality, as well as the ways those difficulties are addressed in depression diagnostics and treatments, are a dimension of that transformation that has been playing out at the individual and intimate level as well as in the bureaucratic, technical, and expert apparatuses in Polish mental health care. This is what this book is about.

A world lost

In his ethnography of poverty and continuous practices of subsistence and world-making in economically degraded areas of Poland, anthropologist and physician Tomasz Rakowski explores in depth the existential toll of unemployment (Rakowski 2016 [2009]). Rakowski depicts the predominantly male world of subsistence activities in areas where large state enterprises, previously sustaining local communities, were liquidated, and where buy-up guarantees in agriculture had been lifted. Those activities vary from illegal small-scale coal mining in makeshift pits to scrap metal collecting to berry and mushroom picking. The image that emerges is that of a dense fabric of symbolically and economically meaningful activity where mainstream discourse and imagination sees nothing but passivity and dependence on minimal welfare.

Rakowski, building on Merleau-Ponty's phenomenology and Gadamer's hermeneutics, but also drawing on Berger and Luckmann's notion of reality as the taken-for-granted dimension of everyday life, describes the loss of reality experienced in the postsocialist transformation:

> The violent impact of the system change brought the experiences of unemployment, degradation, and sudden impoverishment to many people and to many social and professional groups. It also ushered in new images of reality—many began to have the impression of submerging into dangerous and uncontrolled chaos. … Moreover, this occurrence was essentially external, unanticipated, "swift and sudden," and consumed all of social life. (2016: 5)
>
> …

> Many of my interlocutors functioned and built their world in the phantasmagoric structure of the socialist economy, and, in a sense of daily practice, *believed* in the system; … what later transpired was for them a "vacuum" of sorts, an incomprehensible and terrifying process. The disintegration of an old world so deeply rooted in the previous economic system of some social groups (laborers, working villagers, state-farm workers, independent farmers) triggered unpredictable social processes and unanticipated phenomena. … These people have lived from day to day and have made an ongoing effort, if not only to gain a better tomorrow or to survive, then at least to comprehend, and to find an answer to a question: How is it that things changed so much? How is it that things are the way they are? (36)

The "what is," then, appears as a mystery: it is not experienced as the taken-for-granted reality of everyday life, and in that way it seems alien, external, chaotic, unreal. Yet, it is undeniably this reality that sets the rules, dictates conditions, and makes demands one cannot ignore. One is both excluded from it and still under its reign.

> There appeared an entirely new world with new regulations (such as the experience of the free market economy), one that was incomprehensible to many. Most social groups continued to live according to the old reality, and thus came clashing up against the new and (subjectively speaking) unpredictable post-transformation reality. (27–18)

I quote extensively from Rakowski's ethnography because it speaks about the realness of reality in ways at once compelling and poignant—if seemingly at odds with the way I use the term. Admittedly, Rakowski's notion of reality is rooted in phenomenology, both in Merleau-Ponty's and in Berger's and Luckmann's, and as such remains rather different from the concept I rely on in my argument. But the variance is illusionary, or, at best, very shallow.

The fact that people used to experience their now lost life-worlds as real does not mean they did not at the same time perceive the socialist reality as absurd, sustained by an economic fiction and torn apart by the gap between the proclaimed and the actual, between what they empirically saw and what they believed to be normal. Indeed, Rakowski (e.g., 2016: 95) states that the communities he studied had been generally critical of the very system that granted them their existential stability. They were initially very hopeful about and supportive of the changes that eventually destroyed their everyday worlds. The "degraded" lives Rakowski describes are of those who the new reality hit the hardest and at the same time excluded, cast outside its normative realm. It is because of that exclusion that they remained locked between a reality that

had been dismantled because it lacked sufficient realness and one that failed to materialize into a form they would have been able to inhabit.

Infantile fantasies

Though the split between experienced reality and proclaimed ideology has received considerable scholarly attention in studies of socialism and postsocialism, it does not provide a sufficient framework for my analysis. If we understand "ideology" in the sense of attending party meetings and actively engaging in ritualized speech acts, or even witnessing such practices, it accounts for only a fraction of what the "new reality" came to correct (especially in Poland, arguably the least ideological society of the Eastern Bloc). Similarly, if we understand "reality" in the simple sense of "what is," (people's *actual* political beliefs, or the *actual* industrial output as against planned goals, or the black-market value of the U.S. dollar as opposed to the official exchange rate, and so forth), it cannot serve my analytic purposes, either. My goal is to explore historically changing ways of relating to reality. In this context, more important than the "gap" itself was that the force of demand wielded by the socialist reality was different from that of the "new reality," which sought to close the gap, bringing discourse and reality into what seemed to be a much tighter relationship.

Late socialism was not perceived as an artificially sustained fiction only because of the gap between reality and ideology. There were other "abnormalities," other ways it was "out of touch with reality," which directly or indirectly lend themselves to description in terms of either psychopathology or developmental psychology. They come up in the interviews with psychiatrists and psychotherapists I quoted earlier: reality used to be black and white, simple, as opposed to complex and ambiguous (infantile rather than adult); job security under the full employment model insulated people from a basic kind of uncertainty, but also prevented them from pursuing, or even entertaining, greater ambitions and from making risky, daring decisions (causing dependency and discouraging mature self-responsibility in the real world); the state's role as a caretaker and provider, its insulative paternalism, created a form of dependence, an inability to take responsibility for one's own life, sometimes called a demanding attitude (ditto).

These observations by mental health care professionals, which mix professional experience and stereotype, paint an image of the Polish society, manifested through its patient population, as essentially infantile and immature. Such characterizations were common in physicians' conversations about patients in medical offices and in diagnoses (in such labels as "immature personality" or "dependent personality disorder"). At the same time, they resonate with narratives

of the country's historical present and recent past, common over the last two decades, which portray Polish society, or parts of it, as immature: not mature enough for democracy or the free market; unwilling to take on the responsibilities of liberal citizenry; escaping freedom for the care of the state. Such attitudes are depicted as products of the artificially sustained conditions of socialism.[31]

In her lucid analysis of socialist economies and societies, Katherine Verdery (1996) discusses what she calls "socialist paternalism." The Party, having assumed control of the entire social product and having claimed the ability to take care of people's needs,

> acted like a father who gives handouts to the children as he sees fit. The Benevolent Party Father educated people to express needs it would then fill, and discouraged them from taking initiative that would enable them to fill those needs on their own. (24–25)
>
> …
>
> Socialism "aim[ed] to increase dependency of those within"—the point was not profit, but the relationship between the dependent people with their needs, and the Party, controlling the distributable resources. (25)
>
> …
>
> Subjects were presumed to be … grateful recipients—like small children in a family—of benefits their rulers decided upon them. The subject disposition this produced was dependency, rather than … agency." (63)

Since this paternalism "dovetailed perfectly with patriarchal forms" (79), it contributed to shaping a gender system where, as Susan Gal and Gail Kligman (2000a) have observed, female and male images contrasted with those in the West: the socialist man "acted as the 'big child' in the family: disorganized, needy, dependent, vulnerable, demanding to be taken care of and sheltered, to be humored as he occasionally acted out with aggression, alcoholism, womanizing, or absenteeism" (54). As I will show in later chapters, both in therapeutic groups and in self-help programs, reworking immature, dependent, or demanding ways of relating to reality that are understood to produce depression contributes to a reformulation of reality and fantasy in highly gendered ways.[32]

For many a depressed patient, then, the path to recovery is imagined to require facing reality, growing up, and "engaging with what is." It means letting go of what is anyway impossible to realize. Or, to recall Dr. Orłowicz:

> Accepting the fact that I didn't have that ideal parent. … That I wasn't important enough to receive that sufficient amount of care. … But, well, in reality … the need for care is not being realized exactly because I keep insisting on the unrealistic fulfillment of that need. And in fact, it will never be fulfilled.

Depression as idiom, problematization, and assemblage

In her study of the psychoanalytic culture in France in the 1960s and '70s, Sherry Turkle (1992) describes how psychoanalysis—its specifically French, Lacanian version—transformed from a professional and intellectual movement into a culture, involving "the ways psychoanalytic metaphors and ways of thinking enter everyday life" (xiv). For a theory to be able to generate a culture out of a movement, it needs what Turkle calls "appropriability," an ability to offer "objects to think with" and to "incite people to play with them in an active way" (1992: xvi).

One such object was the Freudian slip of the tongue, which allowed people to think about their own and others' sexuality in a sexually repressive normative environment; another: a computational notion of the "self as a machine" in an increasingly technological age. But such appropriability also requires that a given context or world is ready for a psychoanalytic culture to arise. That readiness occurs in a "moment of deconversion" (Philip Rieff's term), "a time of rapid mobility and social dislocation, a time when the old rules and traditional, collective ways of interpreting experience no longer seem to apply" (1992: xx).

Describing the infatuation with psychoanalysis during such a moment of deconversion in the Soviet Union around 1990, Turkle points out that the available theories at the time were the conservative one of the Orthodox Church on the one side, and on the other, "classical models of free enterprise, Social Darwinism, and a range of psychologies of the individual, among them psychoanalysis. In the Soviet Union today," she writes in 1991, "psychoanalysis is perceived as an ideology for the invention of a new kind of person who can make it alone and who has meaning alone, without Party or State" (1992: xxi).

A culture can be generated, Turkle suggests, when a theory resonates on two levels: the large social processes of deconversion and the way that ideas come to connect with individuals; the "'inner history' of sciences of mind." "Deconversion creates the context for individualistic ideologies to flourish," but if these ideologies are to gain traction, they must "be able to present a formulation that helps people think through a historically specific problem" (1992: xxiii).

While Turkle's observations are highly relevant to my study, my approach to the rise of depression and its treatment is different. No psychoanalytic culture is taking root in Poland today, although a psychotherapeutic one is certainly on the rise. Instead, I argue, it is *depression* as an ambiguous problem that has become "an object to think with"—and its very ambiguity and malleability are part of its appeal. No single theory seems able to dominate the definition—it is accounted for in terms of biomedical psychiatry and neuroscience, as well as behavioral and cognitive psychology, religion and spirituality, all articulating

with economic and cultural changes. All these approaches come into play in popular, clinical, and patients' own subjective understandings and practices of depression.

The historically specific problem which depression helps people to think through, I suggest, is market reality itself, or rather, the question of what counts as reality and how its realness is generated in market-liberal conditions. Not only does depression offer a formulation of a problem that imbues modern objectivity (economic as well as bioscientific) with a tenor of moral concern, but it also provides an experiential and experimental site where the individual's relationship to reality may be reworked.

In order to distinguish among the different dimensions of depression, I approach it in this book through different analytic terms: as an idiom (cf. Skultans 1995, 2007; Kleinman 1988); as an assemblage/thing (Ong and Collier 2005; Latour 2003, 2004, 2007); and as a problematization (Foucault 1984, 1988). In Chapter One, I show how depression became a new idiom of suffering particular to Poland's new reality; Chapter Two focuses on depression as an assemblage, a drawing together of heterogeneous elements, both objects and practices, in order to stabilize it—indeed, in order to grant it realness—as a clinical category; Chapters Three and Four explore the practices of subject formation in response to depression as a problematization of the relationship to "what is," comprising the state as a provider of care, ideologies of self-help and personal independence, and Catholic ethics.

Methods in the ethnography of depression

My use of the term "depression" does not follow any particular diagnostic category but rather takes seriously the "affective disorder," in the dual sense of the term, I found in the ethnographic practice as I followed it across different social and psychomedical spaces and different methodologies: from curious, skeptical, and then alarmed media reports to an informal Depressed Anonymous self-help group, to a closed ward, to an outpatient office where depression was reported and diagnosed (yet where it was believed to be largely a manifestation of other underlying problems), to a therapy group specifically started for patients with depression (where no one actually had depression, as the lead therapist told me).

Depression is everywhere, and yet hard to find; it's both over-diagnosed (when the *actual* problem is of different nature) and under-diagnosed (it is believed there are many undiagnosed cases "out there"). I explore the overlaps between different diagnostic categories (depressive episode, anxiety, personality

disorders) and show how depression operates as a selective umbrella category that includes some cases while excluding others. Such categorical disorder—and at times outright disavowal—poses the question of the kind of realness the category of depression itself possesses. I argue that the malleable nature of this category, registered for example in its dramatic official diagnostic revisions (see Chapter Two), is important and is part of its "success."

In my research, which started as a project about the medicalization of mood in postsocialist Poland, I followed "depression" across a variety of social spaces where it appeared or spaces that had come into being around it as a problem. One of the premises of my research, however, was that the very definition of depression continues to change and that what I wanted to observe was how its practical uses operate in particular social contexts and settings. My ethnographic object was therefore by default blurry and unstable; indeed, depression seemed to be everywhere in the psychiatric field, but when I tried to come near it, it would begin to come apart like a piece of old cloth.

As I show in this book, this at times frustrating pursuit of depression as an object quite closely mirrors what I came to understand about techniques of realness, which, even as they seek a tighter grip on reality, find it maddeningly slipping away. Depression was everywhere and nowhere. Depressed patients turned out to not "actually" have depression; what the word and diagnostic category even meant varied and was disputable; epidemiological figures were unconfirmed or contradictory.

Studying depression ethnographically is a difficult and delicate task. For one thing, as an object it is shapeshifting and unstable; second, research with persons living under the diagnosis, whether in clinical or non-clinical settings, means working in a social and communicative space marked by limited expression, discomfort, and inhibition. It requires a mixture of inquisitiveness and restraint that is both epistemologically and personally difficult. As such it calls for reflexivity and transparency relative to both interlocutors and the readers.

Including preliminary and follow-up field trips, my research spanned several years between 2007 and 2013, the main continuous fieldwork conducted between the spring of 2009 and the summer of 2010.[33] The access I was able to gain seemed to me extraordinary and might not have been possible had I not been conducting fieldwork "at home" (Jackson 1987)—in my country and city of origin, where I held significant social capital, compensating native, or naïve, cultural intimacy for a relative shortfall in the "view from afar."

In the summer of 2007, I conducted preliminary research in which I was able to spend a significant amount of time observing daily work at the affective disorders ward in one of the clinics of the Institute of Psychiatry and Neurology. It was made possible by the help of Dr. Iwona Koszewska, a family friend of

a Polish friend of mine, who worked there at the time and put me in touch with her colleagues and superiors—among them Dr. Łukasz Święcicki—who were kind and open enough to invite me to watch their work over a period of a few weeks. I had also contacted Dr. Maciej Myszka, a psychiatrist and therapist working at the Nowowiejski Hospital in Warsaw, who similarly introduced me to his colleagues and allowed me to talk to a few consenting patients. Those initial observations, along with the ongoing awareness-raising campaigns about depression in Poland and reports of apparently increasing rates of mood and neurotic disorders (see Chapter One), led me to formulate my first research inquiries in terms of "medicalization of mood" and its relation to the political and economic changes I had watched unfold in Poland during its postsocialist transition.

My interest in depression and its intersections with broader historical processes had started several years earlier and was in part rooted in personal experience. At the age of twenty-four, after an apparent depressive episode and leaving a graduate program in Sweden (where my decision was viewed in terms of a burnout, at the time a common and quickly spreading diagnostic category, see Friberg 2009), I followed the advice of family and friends and went to consult a psychiatrist and therapist. I had earlier experienced what I thought of as part of "the pain of growing up," but didn't consider it a mental health problem. Now, in 2002, depression awareness raising campaigns having started in Poland and the media full of educating and destigmatizing reports about antidepressant drugs, it was easy to make a different decision. It was Dr. Myszka, before he became my first research contact in the psychiatric circles in Warsaw, that saw me in counseling for well over a year and prescribed an antidepressant. As is the case with many freshly initiated patients, the situation left me with some ambiguity: seeking relief, I was willing to submit myself, within limits, to the authority of available mainstream expertise, and yet I didn't quite find the medical response to be conclusively effective or even unquestionably and absolutely relevant. Rather, it was simply what was most socially available and sanctioned as appropriate. Still, finding myself within the domain of psychiatry was somewhat surprising. That moment of cultural translation and of having my own experience "medicalized" and "psychiatrized," however moderately, motivated an interest that eventually produced this ethnographic study—and informed my own position within it. While I was fortunate to have access to counseling as the main "treatment path," I saw firsthand the spread of the exceedingly popular third generation antidepressants (SSRIs, SNRIs, see Chapter Two below) and watched many of my friends, like myself, weigh their praises against their criticisms.[34] Similarly, I witnessed the rise of psychotherapy in Poland as one of the dominant, though unevenly socially distributed, forms of the "care of the self" (Foucault 1990; Foucault et al. 1988).

What that meant in ethnographic practice was being to some degree personally invested in the very realities I was out to explore and able to relate to at least some of what my interlocutors, both "patients" and "professionals," were telling me about. My own experience, though less severe than many of the cases discussed in interviews, would sometimes help me to establish a sense of trust and understanding in interviews, especially in outpatient and psychotherapy contexts, where it seemed relevant. It also constantly reminded me of the ways one's most personal and intimate experience is embedded in wider webs of expert knowledge and practice intersecting with structures of *habitus*, socioeconomically available life paths, and cultural forms of existential reflection and questioning.

The main part of my research was conducted between the spring of 2009 and the summer of 2010, with additional research trips in the summers of 2007, 2011, and 2013. It involved regular observation in in- and outpatient wards in the public mental health care system in Warsaw, including regular daily observation of a three-months long group psychotherapy. Additionally, over several months, I participated in self-help groups for persons with depression (discussed in Chapter Four). On top of the hundreds of hours of observation, informal conversations, and collecting ethnographic fieldnotes, I conducted over seventy in-depth, semi-structured interviews with patients, physicians, and psychotherapists.[35] Seeking to see the changes in the public discourse surrounding depression, I reviewed the archives of selected press publications going back, in some cases, to the late 1970s, but focusing particularly on the period of postsocialist transformation and the first decade of the 2000s.[36] I focused especially on the archives of the liberal daily *Gazeta Wyborcza*. Starting from 1989, when it was established as the media outlet of the democratic opposition about to take power and introduce economic and political reforms, until the early 2000s, it was arguably the most influential print medium in Poland, with the widest circulation in the 1990s and second-largest (first among "quality papers") in the 2000s (Filas and Płaneta 2009). In qualitative terms, this was the medium uniquely shaping the mainstream imagination, both serving as a forum for key public debates of the time and taking on a specifically didactic mission narrating the many deep and far-reaching changes the Polish society was undergoing.

The chapters that follow provide, in endnotes, further detail about particular methodological choices and challenges, such as those specific to work in twelve-step programs or psychotherapy groups. Generally speaking, the ethnographic pursuit of depression and its growing or decreasing realness required a significant degree of disclosure from participants, the establishment of mutual regard and trust, and high expectations of anonymity. Accordingly, with a few exceptions, such as strictly formal interviews or institutional references, all names of persons

(both patients and mental health professionals) and places in the chapters that follow have been changed to pseudonyms. The anonymization along with all the IRB approvals, did not, however, do away with a lingering sense of intrusion and a pondering of the moral title to the access and insight I was given by patients, survivors, and mental health care professionals alike to conduct a study that could hardly promise any tangible benefits to the people whose experience it drew from (though it hoped to contribute to the broader understanding of depression in relation to social change). This was apparent to me in therapy groups, where I was privy to intimate and often dramatic and emotionally charged details of personal lives without a reciprocity that could validate such intrusion; I was aware of the "ethnographic gaze" to which I subjected the life accounts of patients which they wrote as part of their therapeutic program and gave their approval that I treat those documents as "data," or when I assisted their psychiatrists in interviews and check-ups. That being said, the access I was given was always limited by any signs of the patients' preference not to participate—sometimes expressed directly, sometimes implied in their cancelling or repeatedly postponing interview appointments; it was also limited by my own discomfort in asking too much, touching on subjects that seemed too delicate to bring up, learning what would feel wrong for me to know. Those informal limitations may have constrained the "data collection" most research is inevitably about, but I believe it contributed to establishing relations of trust and a space wherein I was able to witness, listen, and relate not purely on my own terms but with a degree of mutuality, and from which I am now able to write about depression without reducing it to any single way of knowing or purifying it of its personal and political dimensions.

Summary and overview of chapters

If the gap between ideology and reality was one of the things the postsocialist "reality check" was intended to correct, another was the infantilizing and dependency-causing relationship to the paternalist state. Both this gap and this insulation from risk rendered socialist reality less rigid, fixed, and binding than what the new reality would be. Or rather, the respective rigidities and malleabilities of the old and new realities were differently attained and distributed. The more socialism was failing to live up to its own promises, propped up by political and irrational (i.e., at odds with market rationality) decision-making, the more it was drained of realness, which was exposed as "artificial," produced—with a falling rate of success at being real.

The realification in the 1990s had a distinctly hard, confrontational, and corrective character. Its reality was that of a "reality check": it claimed to eliminate

the fictions, absurdities, and irrationalities of socialism. That confrontation had its casualties—a problem space was created in which depression began to take root. Failing to meet the demands of reality was the problem of the unemployed, the passive, the demanding, the maladapted, the holdovers, those with learned helplessness.

This destructive mode of realification, which worked alongside the figure of crisis in insisting that all losses were justified by the restoration of the normal and the real, operated through the technical implementation of rational, formal principles of a market-type logic, as the new neoliberal ideology of reality would have it (Collier 2005, 2011). The new reality came to produce its own absurdities, but its claims to objective, "self-sufficient," autonomous realness made those, at first, difficult to critically apprehend. This lack of criticism is reflected in the emergence of a new population of depressed patients: the successful, who decompensate not because they fail to adjust to the demands of the market, but because they adjust to them too fully and too uncritically.

I divide this book into two parts: I—Diagnostics, and II—Therapeutics. Part I (Chapters One and Two) focuses on the emergence of depression in Poland as an object to think with and as a clinical diagnosis in relation to the multiple ongoing realifications, from the market reform and its socio-economic consequences, to the diagnostic, technical, and financial changes in the health care system. Part Two (Chapters Three and Four) shifts attention to treatments of depression and the ways they contribute to reshaping a new form of subjectivity, or subject disposition, by assisting patients, clients, and self-help group members in transforming their relationship to reality through such notions as "depressive position," "maturity," "emotionality," or "powerlessness."

The first two chapters examine the ways in which depression emerged in a dual form: at first, as a disorder of *maladaptation to* the new socio-economic reality—an ailment that threatened those who failed to thrive in the free market environment. Over time, it came to be perceived as an inherent feature *of* that new reality itself, afflicting potentially everyone, perhaps especially those who had succeeded. On the one hand, then, it began to recode the dysfunctionality of the *Homo sovieticus*, where the reigning pathologies had been alcoholism, dependence, and demanding attitudes. The new market reality both created new problems, like unemployment, inequality, and a new scale and kind of poverty, and reframed old forms of social life so as to render them dysfunctional in ways they had not been in the safe fiction of socialist life, that is, the dismantling of the structures of state paternalism turned people's dependence on it into a dysfunction.

On the other hand, over time, depression came to be perceived primarily as a problem of the new *Homo Economicus*—of a person consumed by the pursuit

of success and avoiding reality in a wholly different way. As such, it came to hold a certain critical potential. By the late 2000s, depression was not only an increasingly established part of the popular discourse—a way in which people were beginning to identify and experience their distress—but also something understood as not just a product of the shock of transformation, but *part of the new reality itself*.

In contrast to established critiques of contemporary psychiatry, which generally make the point that what used to be part of normal life now is pathologized as a disorder (Horwitz and Wakefield 2007; Lane 2008), I argue that in the case of depression's recent career in Poland, a more relevant line of critical social analysis would be the opposite: what the categories of pathological disorder describe is now becoming part of normal life. The parameters of "pathology" and "normality" are redefined, drained of meaning. What matters is the distinction between functional and dysfunctional, and the degrees of (dys) functionality between them.

Chapter One, "Critical conditions," takes a recent-historical perspective reaching back to the late 1980s and shows the formation of a problem space of new socio-economic problems, such as unemployment, where depression would start to take root during the 1990s. I show some of the ways in which the new reality has made new kinds of demands on people (from unemployment and impoverishment to increased workload and pursuit of career success) and discuss the ways depression began to take shape next to alcoholism and suicide as an idiom of suffering specific to postsocialist conditions—eventually partly subsuming them. At first understood as a matter of maladaptation to market capitalism, depression gradually came to be posited as an effect of the new reality itself, and as such a marker of the limits of what's tolerable. Thus, it came to constitute a personal and cultural position approaching but coming just short of critique of the new reality.

Chapter Two, "Affective disorder," explores in concrete detail two modes of realification—confrontational and formal/technical—from the perspective of mental health practitioners and the health care system. The way the "new reality" entered the psychiatric care system was through changes in diagnostics, financing, availability of drugs, and patient population. In financing, the early 1990s meant a transition from "soft" to "hard" financing and significant budget cuts during a dramatic period of growing unemployment, falling purchasing power, and sharply rising suicide rates.

The new diagnostic system, the new generation of antidepressant drugs, and awareness raising campaigns all promised improved detection and treatment. As I show, however, depression only became operational and its statistical prevalence only increased in the 2000s, following a reform that changed the way

the health care system was financed. Instead of substantive central budgeting, where the financed entities were *clinics* as workplaces, the new insurance-based system paid for *particular services* using diagnostic code identification and a set of coefficients and algorithms. In other words, these changes were the effect of changing the organizational parameters of the health care system in such a way as to bring them in a much closer relationship to an objectified reality (services rendered) rather than subjective relationships (employment and care provided). In this section, I rely on interviews with psychiatrists and medical finance analysts as well as press archives. I focus particularly on developing a notion of clinical agency, referenced by my interlocutors as license to control the pragmatics of diagnosis and treatment protocol, which practitioners see as significantly constrained in the "new reality" of formalized, technicized Polish mental health care.

The final two chapters focus more closely on the remaking of subject dispositions by examining the ethical work of patients undergoing therapy and that of participants in the twelve-step based self-help group, Depressed Anonymous.

Chapter Three, "Incapacity and care," examines the ways in which group psychotherapies in the public health care system in Warsaw seek to realify patients and bring them out of dependent positions in their lives and relative to the postsocialist, neoliberal state. I focus on the notions of immaturity, or holding on to a protected status and making demands for care (including the reliance on increasingly limited social insurance payments), on the "depressive position"—for Melanie Klein, the recognition and acceptance that infantile fantasies and demands will remain unsatisfied—and on emotionality, as the way, promoted in therapy, of learning to know and taking care of oneself. Homing in on these aspects of patients' therapeutic work, I show how their psychological positions, as understood by the therapists, map onto a broader psychopolitical relationship between the citizenry and the state and how that relationship is informed by the Catholic Church through the patients' commitment to a religious ethic.

In Chapter Four, "Ethics of powerlessness," I draw on ethnographic work with recovering depressives in a twelve-step program and look closely at the ways they seek to reshape their relationships to themselves (which I refer to as ethics) and the world (which I discuss in terms of agency). Showing how members struggle to attain a particular agentic position in their lives, I argue that, in the Polish context, their experience becomes a way of living with a broader public secret of the "new reality"—that the opportunities and promises of the postsocialist transformation will in many respects remain unfulfilled. These *depresants* learn to see and accept reality "for what it is," a practice of

"powerlessness" that I see as an exercise in failing to fulfill the aspirations of liberal personhood and in accepting the impossibility of willful change of one's conditions as a sound basis for ethical life.

Moving across these sites and tensions—of maladaptation as it was subsumed by depression as a new idiom of distress; of the constriction and reconstitution of clinical agency in the face of technical rigidity; of maturation and the depressive position in making demands upon the state for its care; the cultivation of powerlessness in the face of "what is"—allows me to track many facets of depression as they express and, as I argue, help to produce the pursuit of realness in Poland's postsocialist and neoliberal reality.

PART 1

Diagnostics

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?

The 1993 article is worth quoting at length. An idealized image of the new reality still reverberates in the background: it would finally correct absurdities of the past and, thanks to the naturalness and near-automatism of the market logic, all the things that needed to be done would at last get done. Unemployment seemed to make no sense. Were it to appear, it would surely have a positive function. Now, three years into the transformation, the increasingly entrenched problem of joblessness is causing confusion and disillusionment.

The article begins with an image of an employment office in the industrial city of Radom, which had been shaken by massive layoffs. The office is crowded with people from different social groups and walks of life waiting to be registered or to receive their monthly cash payment. But from this description of the office's corridors, the article moves directly to the question of mood: the starting point for understanding the new phenomenon of unemployment was not economics, but a social psychology of affect and the concept of chronic stress:

> *Chronic stress* [heading original]
> The director of the [office's] department of analysis, a psychologist by training, draws for me the so-called Clarke's curve which shows what happens with the unemployed person and how his mood changes from month to month. At first, there is a sudden breakdown, but it passes quickly because of the relief, the liberation from the routine of daily existence. The mood curve rapidly goes up. The recently unemployed person's euphoria pushes him to action. He takes care of long overdue affairs, bustles around, catches up on what's been going on at home, exhibits artificial activity.
> Unemployment is a steady, chronic stress factor. Its pressure leads to a gradual and inevitable lowering of mood [*obniżanie nastroju*]. The subsequent points on the dropping curve of mood mark the respective stages of slow degradation—frustration, boredom, depression. Then begin financial problems and family conflicts, drinking, until a complete severance of social bonds. "From this moment"—says the psychologist drawing a vertical line across the curve in its still high point—"the person is already lost."
> Clarke's curve comes from Western literature. Our own research on long-term unemployment is only starting.

From there the article goes on to invoke clearly and repetitively several of the coordinates of the emerging problem space that would continue to define the understandings of mood disorders in Poland over the next decade: dependence (economic, psychological, and alcohol), helplessness, entitlement (literally "demanding attitude," *postawa roszczeniowa*), the need to be taught how to live, the rising number of suicides. The axes along which these coordinates are located extend from infantilism to maturity, ignorance to training, market abuse to

market rationality. There is also a time axis on which the old reality of state socialism is quickly receding into the past while the *new* of capitalism and liberal democracy is still emerging, still a thing of the future, and the present constitutes a point of their articulation, of corrective confrontation. The temporalities of individual lives—the stories of actual people—run along these axes and through these coordinates.

> *Inheritable helplessness* [heading original]
> Times have changed. Real unemployment has arrived … [O]ne can't tell whether it is unemployment that has collected its cruel harvest in the form of apathy, alcoholism, and reliance only on the state, or whether it is unemployment that is the result of alcoholism and passivity. …
> Unemployment makes one dependent [*uzależnia*] both economically and mentally, it puts one in a situation where others make decisions for him. Breeding a multi-million army of big children [*dużych dzieci*][10] does not bode well for the country's future development. …
> Three years into unemployment one can say with utmost certainty that it has not served the positive role the liberals had expected. It was supposed to teach solid work—it has taught helplessness. It was supposed to discipline the worker—it encourages employers to break the law. It has increased alcoholism, it exposes society to the pressure of stress, which has already resulted in increased rates of suicide… it only fixes an exclusively demanding attitude, it outright teaches helplessness and passivity.
> Unemployment that turns the rational man into a dependent child does not bode well for the society's future. (Cichocka 1993)

The article spells out the main elements composing the problem space where the transformation and its dominant idioms of distress were intersecting and interacting: unemployment, dependence, inheritable helplessness, and alcoholism that both results from them and in turn breeds them. The image rendered of the unemployed and dependent people themselves is that of a certain human type: a passive, dependent child who does not bode well for the country's future. Depression, at this point, is only a marginal element of the story: the outcome of chronic stress known primarily from Western literature. It isn't clear if Poland's challenges are in greater part the result of the new economic conditions or of the legacies of communism, but it seems clear that the market is real and so are its plagues. Like the elements—they may be cruel, but they're "natural" and inevitable, part of reality's revealing itself to us and correcting the fictions of the past.

As such, they certainly did also strike the hard-working, skilled, responsible, and those with initiative—rational actors rather than dependent "Soviet men."

Still, the destructive side of the "return to reality" was understood as temporary imbalance which would end once the new reality—the referential, idealized reality—was finally achieved and running its course. It was here, in the struggles of the ambitious and hardworking who were seeking to adapt to the market rather than escape it, that depression would eventually find its most fertile place. What follows is a fragment from a plea for greater flexibility (indeed, for a flexible and substantive approach rather than rigid mechanicism) of the tax administration that would help small businesses navigate economic transformation:

> I received a letter from an old friend from my school years. He had recently started a private renovation and construction business. He put into it all his savings, knowledge, energy, and entrepreneurship. He employed specialist bricklayers, carpenters, roofers, and floor layers. For several months, he worked well over ten hours a day. He was doing well and paying well, until the moment when, having finished laying roof on a church, he started renovation of university buildings. The university turned out to be insolvent until the end of the calendar year. Its insolvency, however, was no argument or proof for the tax bureau. In order to pay his taxes on time without fines and humiliating visits from state debt collectors, my friend first began to let his workers go, then sell his equipment, until finally, *on the verge of psychic depression he locked himself up in his home*. He's keeping his family of a few persons from going hungry by taking part-time jobs verifying construction documents for a state enterprise. *His friend, who had to declare bankruptcy in a similar situation, committed suicide.* Each revolutionary change has its casualties. My question is: transforming our economy, can we avoid human casualties? (Kledzik 1990)

This was the landscape in which depression began to appear in the 1990s: one of rapid socioeconomic change and new kinds of challenges, experiences, forms, and scales of both aspiration and failure.

The afflictions of the *Homo sovieticus*

The man turned into a dependent child by unemployment (and, by extension, because of the removal of the state's paternalist protection) resonates with the image of the "big child" as a model of masculinity (see Introduction), but it also brings up the figure of the "Sovietized" man, the *Homo sovieticus*.[11] The term was and still sometimes continues to be used in popular discourse as well as in social analysis to depict and explain the maladaptive practices or mentalities of people who failed to adapt in the new reality—an obstacle on the way to modernity and market democracy. Supposedly a product of the socialist state, *Homo sovieticus*

is characterized by learned helplessness, dependency, a demanding attitude (particularly the demand that those in higher positions protect and provide for him), refusal to take responsibility for his own actions, duplicity, and a lack of concern for the common good. In short, the term conveys the opposite of the ideal type of the market-democratic citizen (Tyszka 2009).

In the 1990s, the term *Homo sovieticus* became a powerful fixture of the Polish social imagery and came up regularly in the context of what I call the problem space of the transformation: it appeared in discussions of the poverty and unemployment that hit hardest those who had been most dependent on the state's social provisions and were least prepared to adjust to economic changes, such as workers at state enterprises and collective farms now being closed down, and who lacked the resources of education, financial and social capital, and access to opportunity. The image would come up repeatedly in my fieldwork as it did in the interview, quoted earlier in introduction, where psychiatrist and therapist Dr. Jerzy Matej explains the rising numbers of depressive decompensations and brings up the demoralization caused by socialism:

> Such demanding attitudes [*roszczeniowe postawy*] that communism, incapacitating people as it did, [produced] … the phenomenon of the people who, after the state farms were dissolved, now do nothing because they have been shaped [in such a way that it is] someone else [who] organizes [their] life. Here there is freedom, but there is no caretaking [or welfare, *opiekuńczość*]. Everyone's on their own, and a lot of people are not capable of that.

Learned helplessness, one of the key features of *Homo sovieticus*, was shorthand for explaining peoples' inability to inhabit the new reality. In that context, it was understood as a product of socialism and a characteristic of an entire, if ill-defined, population. Living in a world of, as it was often called, "humble but secure existence," and having only a limited sense of agency, such socialist subjects were the opposite of what entrepreneurial, success-oriented liberal subjects were imagined to be. They had lost the desire and ability to engage in any independent activity that could improve their situation (Tyszka 2009).

The figure of the *Homo sovieticus* is important to this story because it was the backdrop against which depression as an idiom of distress began to emerge in the 1990s, without, however, immediately finding fertile ground in that postsocialist terrain. The pathology of the *Homo sovieticus* was drunkenness, a social ill associated with the past and implying moral degradation rooted in the dysfunctionalities of state socialism, carried over from the depths of the past and embedded in social forms of life that—just like inefficient state enterprises and 'irrational' agricultural pricing—were supposed to collapse.[12] Depression,

on the other hand, would offer a way of seeing the inability to cope not as a matter of maladaptation, but of having in fact adapted to new reality. It offered a way to think about the systemic and socially induced failures not of the *Homo sovieticus*, but of "*Homo economicus*."

The category of depression was therefore not equally available to those perceived as not fully inhabiting the new reality—those who were not participating in new forms of work, consumption, and treatment, and who were often removed from the urban centers where those forms first thrived. It was a new and modern problem, free of the moral burden of drunkenness, open to new kinds of clinical intervention.[13] As such, it came to occupy an ambivalent and confusing space, apparent in the entanglements and tensions between depression and alcoholism, both in public representations and in clinical practice.

The depressions of those considered to have failed to adapt to market-democratic social forms are often considered to be mere reflections of their excessive drinking or other "social problems"—poverty, unemployment, learned helplessness—or both (cf. Friedman 2009).[14] Meanwhile, the drinking of those who have been successful in the new reality is increasingly thought of as merely "masking" depression, as an influential theoretical approach to alcoholism would have it. This intermingling and separation of two ideal types (*Homo sovieticus* and *Homo economicus*) and their afflictions (alcoholism and depression, respectively), and of moral and economic lines of interpretation, pervade both public and clinical understandings of approaching and crossing the limits of the bearable in postsocialist Poland.

Below I explore two ways in which specific kinds of failure and suffering are culturally constituted—made meaningful—in postsocialist Poland. First, I briefly discuss the popular interpretations of the country's growing suicide rate and the changing attributions of causality in attempts to account for it. In the following section, I show how the limits of the bearable are experienced, expressed, and re-drawn in the clinical treatment of two socioeconomically marginal men whose depression was perceived as deeply tied up with alcohol abuse.

The politics of the suicide rate

The concern with the growing rate of suicides was a marginal but dramatic element of the new problem space. In a Durkheimian spirit, the suicide rate is viewed as a sensitive indicator of the mental and social condition of a society.[15] In Polish press articles form the transformation period, suicidal acts of individuals were described as a result of both increased socioeconomic pressures and of a broader anomie, in which social and moral factors coalesced to dislodge the

individual from his (as per the 6:1 ratio of male to female suicide victims in Poland) safe structural nest of social relations and moral ideas. The growth in self-induced death was typically read through the notion of transformation trauma.

A March, 1993 article in *Gazeta Wyborcza* gives the numbers of the systematic growth of suicide since 1989: 3,657 suicide deaths in 1989; 3,841 in 1990; 4,159 in 1991; and 5,453 in 1992. Why? While statistics cite mental illness as the most common cause of suicide (986 cases in 1992), the article, through the words of a quoted psychiatrist, is skeptical on this point, suggesting that that explanation only makes it easier for us to accept suicide. The author offers a different explanation:

> A new category introduced into statistical data only in 1990 is suicide due to bad economic situation. Last year 357 such cases were documented. Every third person in that category was unemployed, the others were mainly physical workers and farmers. …
> The frequency of suicide in a society reflects its mental condition, scientists claim. Usually, during sudden social and political change, the number of suicides goes up. (Rostkowski 1993)

What the article doesn't state clearly is that, according to the same statistics, Poland's suicide rate had been going up since recordkeeping began in the 1950s, throughout the post-war, communist modernization. There were, however, two significant fluctuations in this rate that invite interpretation. One was the steep drop in the suicide rate in 1980 and 1981, followed by a return to a steady rise in the ensuing years.[16] A similar interruption took place in the statistical records for 1989 and 1990. The somewhat less pronounced decrease in suicide rates in 1989–1990 was also "corrected" by an increase in 1991. (The rate of suicide has generally been growing ever since—a common trend among "developed" nations.[17]) The prevailing reading of these fluctuations connects the growing suicide rate to the country's political turmoil and worsening economic situation, but reads its temporary declines in moral terms, as moments of hope. The 1980–1981 decrease occurred during the "Solidarity" period of social mobilization and greater political freedoms but ended abruptly with the introduction of martial law in December 1981, which crushed the "hopes for a better tomorrow" the movement had kindled. 1989 was similarly a moment of hope, but optimism was quickly overshadowed by the "reality check," when economic "shock therapy" began to take its toll.

As opposed to the fluctuation at the decade's beginning, which is typically read in terms of gaining and subsequently losing "hope" (a notion that resonates with the romantic language of national struggles for freedom), the 1991 "corrective" uptick in suicides is more often interpreted as the effect of more concrete socio-economic "stressors." This suggests, perhaps, as others have

(Janion 1991), that in the Polish political imagination of the 1990s, a poetics of pragmatism was beginning to outweigh one of national romanticism. In conditions of a market economy and a liberal public sphere, the correlation between historical process and people's readiness to take their own lives could be expressed in more concretely causal terms, marking a shift of balance from national-symbolics to market-economics as the primary mode of expounding history. In the public imagination, suicide began to shift from being primarily a moral matter of hope and disappointment to being primarily an economic matter of unemployment. This shift occurred just as a mode of producing realness by applying market logic rose to dominance.

Consider the two graphs below (Fig. 2 and Fig. 3). The first one accompanied the Durkheimian reading of the increasing suicide rate, with the 1981 dip representing the moment of hope during the "Solidarity period" and the subsequent dip representing 1989. The purple line represents self-inflicted deaths in rural areas, traditionally less frequent than among urban populations (in line with the anomie thesis, as per Durkheim and other critics of the devastating effects of modern life, like Simmel), and shows the former clearly overtaking the latter during the transformation period. The second graph, published by *Gazeta Wyborcza* in 2014, juxtaposing side by side the rates of suicide and unemployment, instantiates their connection via economic conditions, and epitomizes the shift in public imagination.

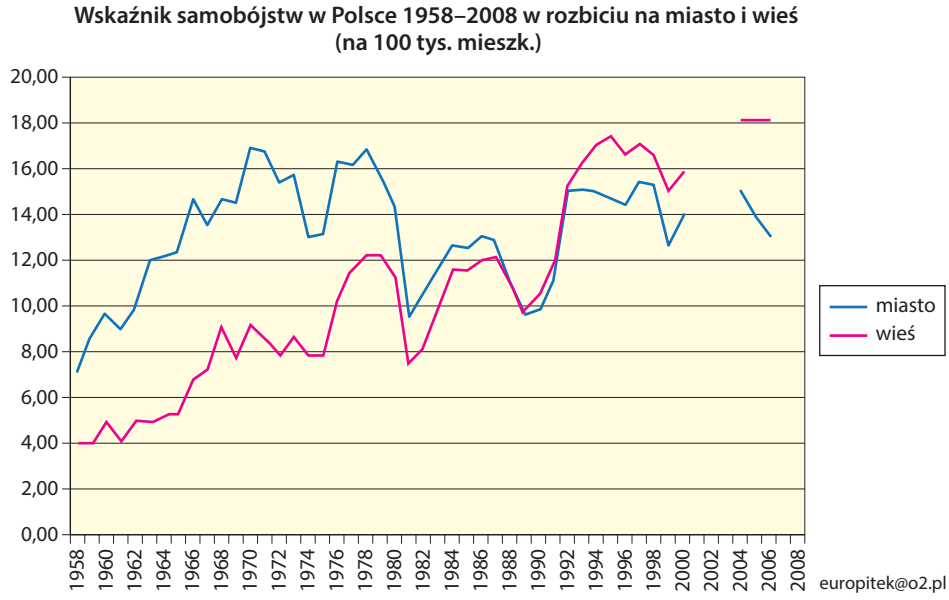

Figure 2. Suicide rate in Poland 1958–2008 divided between urban (blue) and rural (purple) populations. Source: Fotoforum.gazeta.pl: http://fotoforum.gazeta.pl/zdjecie/2012875,5,3,39530,Czestosc-samobojstw-w-Polsce.html

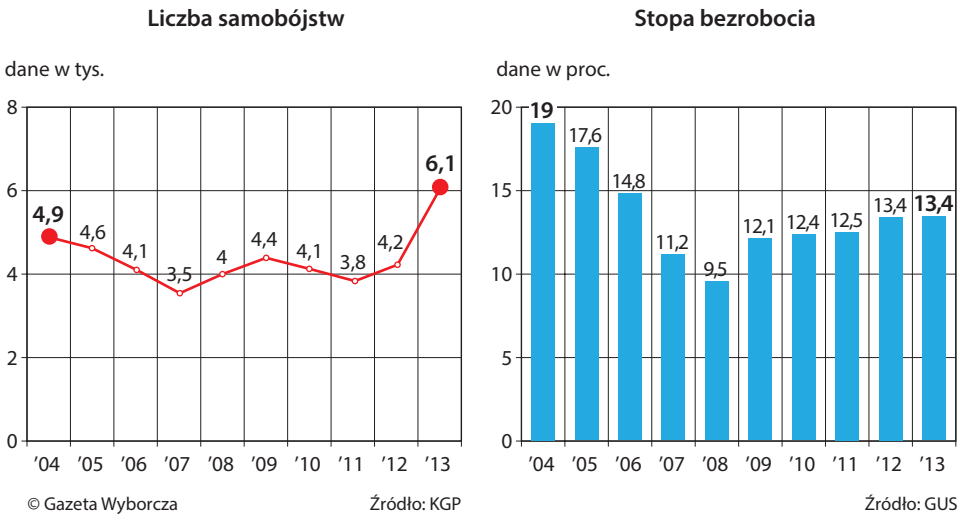

Figure 3. Figure comparing, side by side, the numbers of suicides per year (left; in thousands) and the unemployment rate (right; in percentage points of adult population). Source: ***Gazeta Wyborcza***, http://bi.gazeta.pl/im/94/c5/ef/z15713684Q.jpg

There is, however, yet another account to be given. The rise and drop of the suicide rate around 1981 corresponds very closely to the rate of alcohol consumption. This lesser-known datum was brought to my attention by Dr. Bogusław Habrat of the Institute of Psychiatry and Neurology of the Polish Academy of Sciences in Warsaw.[18] The production of alcohol in 1981 dropped by approximately 40 percent due to economic factors and management problems (Fig. 4). The link between alcohol consumption and suicide was not unknown to the authorities, but as both data were considered sensitive, it was not foregrounded by the state agencies. Dissident analysts, for their part, placed greater emphasis on self-induced death as a result of political oppression, economic hopelessness, and moral dismay (Bugajski 1986).

The intertwinement of mood disorders, social suffering, suicide, and alcohol makes it difficult to consider them separately. Following the social lives of depression, especially men's morbidity of mood, one is bound to encounter both alcohol and the various ways in which psychiatry continues its work of "purification" (to use Bruno Latour's enabling term, Latour 1993a) in order to keep these categories of affliction separate, by using different diagnostic codes, different treatment methods and facilities, etc. Alcoholism and depression appear deeply intertwined as much in occurrence (in the experiences of persons, particularly men, suffering from mood disorders) as in theory (the notion of drinking as in fact merely "masking" the underlying mood disorders, which are the actual problem that needs to be addressed in treatment). Their entanglement also emerges

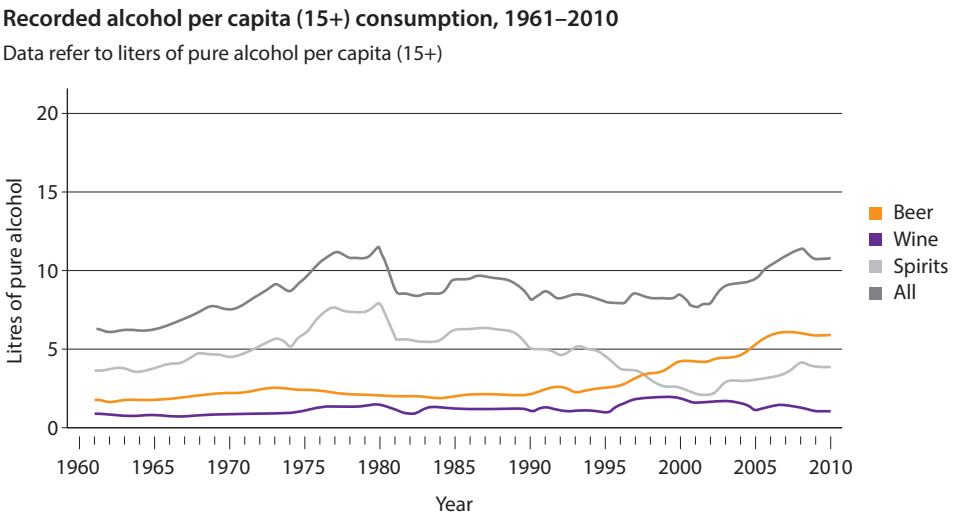

Figure 4. Alcohol consumption in Poland 1961–2010. Source: WHO.

in treatment: as comorbidity and confusion regarding the nature of patients' condition; alcoholic inpatients hospitalized for depression and depressed ones treated for alcohol addiction; twelve-step treatment programs targeting both "diseases"; the proliferation of illness categories and identities related to both alcohol and psychological and emotional problems (such as Adult Children of Alcoholics).[19]

Depression at the margin

The ambiguous interactivity of drinking, depression, and socioeconomic position informs clinical practice. At Nowowiejski Psychiatric Hospital in Warsaw, where I was a regular guest from the summer through the winter of 2009, the depressions of certain patients, even when formally diagnosed, would often still be seen as merely symptomatic and secondary to their drinking, "dependent personality," or "demanding attitudes," and therefore not quite "real."

Pan Henryk was one of several men with similar stories I met in Warsaw. Economically and socially degraded, often in their fifties or sixties, with histories of unemployment, drinking, and sometimes homelessness, I met them in the wards of psychiatric hospitals or in depression self-help programs as opposed to psychotherapy groups, much less private therapeutic or psychiatric practice. They had typically received their first diagnosis of depression sometime in the 2000s, and late in their lives. The problems they had been experiencing frequently had longer histories but had often not been pushed to the point of what psychiatrists call *decompensation*.[20]

P. Henryk agreed to speak with me without much hesitation. There wasn't much to do in the ward during the day, and I often felt that my interviews gave the patients who felt well enough to talk something to do. I also knew that I was sometimes perceived as a staff member or an intern—my explanations of my role largely seemed to leave that perception undisturbed—and his agreement was granted as though a part of the contractual and hierarchical medical relationship. P. Henryk, diagnosed with depression, had been suggested to me as an interlocutor by one of the physicians of the hospital's ward no. 4. Now, we were sitting alone in his hospital room, which he shared with two other male patients: I on a chair, voice recorder in hand; he on his bed, wearing old slippers and a pair of worn-out pajamas.

In appearance and manner—his outgrown hair, deformed, broken nose flattened to one side, his raspy voice—I recognized the features of a man of "*margines społeczny,*" the "social margin"—the impoverished, downtrodden underclass, as it had come to be commonly called in the classless socialist Poland.[21] After our conversation, I would be given his medical history and read and copy it with the usual discomfort that no amount of IRB approvals and informed consent forms ever quite dissipated. P. Henryk had been signed in at the emergency room seven weeks earlier, in July, brought in by two Capuchin monks who knew him from the soup kitchen run by their order. He had tried to poison himself by swallowing unidentified drugs, and, as the document quoted, he claimed he would hang himself because of "failing at everything in life [*nic mi się w życiu nie udaje*]." He "reported intense suicidal thoughts." Initial diagnosis: moderate depressive episode, F32.1.

At the time of his admission, p. Henryk had been homeless for six months since the woman he had been living with, his *konkubina*, threw him out. Just before his attempted suicide, a temporary place had fallen through, and he'd been in and out of a shelter where he had lived in the past for nearly a year. He had just lost his job at a company cleaning industrial halls. "In this crisis," he tells me, "they're laying people off, there's no money, work is gone."[22] Not to mention the upcoming court case for apparently assaulting a police officer. And, yes, with the onset of his depression he has been drinking too much.

What does he mean by his "depression," I ask:

> In the last half year, everything's been just going awry. … [F]amily issues, work issues, issues in general. So I just felt like ending it all. … [A]nd then the drinking, that's for sure, that was the first symptom. One gets drunk and [it] calms the nerves for half a day or so, but it was happening again and again … and, first of all: the sleeplessness. That was the worst monster. The sleeplessness. Because at night, if you can't sleep, you begin to think about different things, all kinds of things.

In the hospital, p. Henryk quickly began to feel better. He was put on an entry-level dose of antidepressants and soon he could sleep without pills, too. It is clear to him that he is better because he has not had to worry about tomorrow. In that way, he says, "the treatment has been ideal." But now he is about to be discharged and the anxiety and the sleeplessness have returned and again—even sleeping pills aren't helping.

> Now it's almost the end (of the hospitalization) and, you know, I'm feeling it more and more because I'm beginning to think more and more. Where am I gonna go to work? Where are they gonna take me? What am I gonna do? You know, these thoughts are coming to me. … So now I'm going out and I'm probably going out on the street.

P. Henryk's drinking, poverty, and marginal status went all the way back to his difficult start and then his life in a socialist "fiction" where even if you sank to the bottom, you wouldn't fall through it; a reality in which a life in the margins would not necessarily entail a confrontation with the hard questions that seem to have pushed p. Henryk to his suicide attempt: "Where am I gonna go? What am I gonna do?" Born an "unwanted child," he told me, and given up at six months, p. Henryk grew up at a state children's home, then a correctional center. He stayed there up until he was twenty, because he was waiting for an apartment, "'cause under communism they were still handing out apartments…" [*bo za komuny to jeszcze mieszkania dawali…*].[23] He had not completed much education and began to work as a construction painter. He married early and soon divorced, but it was he who won custody of the child and raised it. The same happened in his second marriage. His wife was an alcoholic, he said, and he himself is "DDA, or something, I don't know what exactly it's called"—an Adult Child of Alcoholics (*Dorosłe Dziecko Alkoholika*, a category increasingly popular in Poland, see Chapter Four), so during the custody proceedings he had to see a psychologist, join an abstinence club, and attend AA meetings. That was the only kind of therapy he ever received, but abstinence, he admitted, was never his goal. Now he had long been a widower and was estranged from his children.

P. Henryk may sound like a paradigmatic "loser of the transformation," a case of "social pathology" where alcoholism, unemployment, and poverty reinforce one another (re)producing dependence and helplessness, a person only able to live under the paternalistic and all-controlling care of the state. However, his account complicates and partly belies that image. He described his life as one of work—mostly menial and low paying jobs, but jobs that lasted: first on construction sites, then as a hospital orderly, and later autopsy assistant, before

he started working in industrial cleaning several years before our conversation. That job, which he had recently lost, had paid decently: he had been making 2,500–3,000 złotys a month (approximately $1,000).

"I don't know what it will be like when I come out," he says again.

> [A]nd, you know, if still nothing works out for me [*nic mi się nie będzie udawało*], then I'm really gonna go quietly and gonna put a rope around my neck somewhere and that will be it. 'Cause what else? [*wezmę wtedy się po cichu gdzieś na linę się walnę i to wszystko. No bo co?*]

Not knowing what to do and where to go was a theme he returned to throughout our conversation with a casualness that only made the underlying despair more palpable. Talking about killing oneself—a dramatic ending to it all—is also a genre of despair and lament that constitutes a form of communication and accusation of the absent agents held responsible for the suffering the subject endures (Rakowski 2009: 145–154; Ries 1997). I would say that it also creates a livable space at what feels like the limit of the livable, a space where action is still possible. But at a moment of confrontation with the apparent ultimacy of hard reality, such lamentations may no longer be a form of being, but rather fall more in line with their explicit content, speech acts of self-annihilation, preceding actual, physical acts. Uttering his lament before me in a casual voice, p. Henryk appeared to be at once announcing his powerlessness and throwing a provocation in the face of the world, the hospital, and his doctor.

When I talked to his psychiatrist the following day, she immediately questioned the realness of his depression. "Did he mention his drinking habit?" she asked, her look and friendlily ironic tone implying both his dissimulation and my naïveté. I remember my astonishment as I watched my perception of p. Henryk shift after hearing her words. Yes, he had mentioned his drinking several times, admitted it had been getting worse, but our encounter was from the start framed by his diagnosis of depression. In contrast to the diagnostic analysts' medical gaze (Foucault 1973; Mattingly and Garro 2000; Mattingly 1994), the ethnographic default mode aspires to a suspension of judgment, the hermeneutic of suspicion kicking in at a later time. P. Henryk himself had described his increased drinking to me as a symptom of depression, of "something going on," but also claimed it wasn't out of control. Now, for a moment, at least, I was made to feel naïve, almost duped—as if his alleged alcoholism excluded the possibility of "real" depression.

The drinking had been a problem with the homeless shelter, the physician told me—they didn't allow alcohol. But both she and the social worker were making calls and trying to arrange some place for him through the public social

security services. It was hard. Finding welfare institutions of care for patients is a constant struggle for the hospital, especially for patients who drink. But they did what they could to avoid discharging people onto the streets.

The diagnostic tension between alcoholism and depression points to a difference in which these two categories can be used to make sense of a breakdown, a suicide attempt, and a life where everything fails. The drinking of the *Homo sovieticus* is an affliction of state socialism; depression as an idiom of distress emerged in the "new reality," where it was efficiency and achievement that set the parameters of social life. The mainstream social imagery only gradually, and largely in the 2000s, began to portray the toll of the transformation through this new diagnostic lens.

Psychiatrists' recent interest in comorbidity, especially in men, between alcoholism and depression, where drinking is understood to be masking an underlying depressive disorder, brings that complicated diagnostic relationship into further relief. While p. Henryk's drinking had been addressed and treated before, it wasn't until now that he received a diagnosis of depression and began to describe his drinking, his failures, and his temper in terms of depression. And yet the category wouldn't stick. It was repeatedly put into doubt.

P. Henryk was discharged within days of our conversation with contact information to places where he could seek help, but homelessness was a reality he now had to face. He was one of the "losers of the transformation"—unable to benefit from new opportunities while deprived of the life-world sustained by the economic "fiction" where unemployment and homelessness were banned, however artificially. His life had admittedly always been troubled and impoverished—both on the margin and on a minimum. But, in his own account, he had not broken down until the summer I met him in the ward, when the fragile stabilities of his life gave way almost all at once.

A most unfortunate man

Pan Mieczysław is a tall and lanky man of fifty-six, with a narrow, pruney face, a child's eyes, and large, muscular hands. It's an afternoon in February and we have to turn the lights on in the meeting room at the ward where we sit down to talk. He had been admitted two weeks earlier with a severe depressive episode (worsened mental state, lowered mood, suicidal thoughts and tendencies—he was looking for a place to hang himself, his admission file says).

> My depression was diagnosed in 2000. But that was because I'm an alcoholic. I got so low I couldn't walk. I was in dependence treatment at Kolska [a public detoxification

> and alcohol dependence treatment center]. Medically, with detox, and there was also therapy. And they diagnosed depression. Then I got out, I hit the bottle again [*zapiłem*], and, after a year, I went to treatment again, at Goplańska. But I ran away because I was afraid. I didn't want to open up to people, 'cause people there were talking openly and I couldn't. After that, I didn't drink for nine years.

Nine years—until last week. "*Zapiłem*," he says, using the word for breach of alcohol abstinence. But that's because he was so nervous. He had always been nervous and anxious. Recently, around Christmas, working as a night guard and in snow removal, he started smoking more, drinking a lot of coffee, and avoiding people. He had also stopped going to AA meetings and meetings of similar Catholic groups; had stopped taking his antidepressants. His nights were terrible: sleepless or with nervous sleep and bad dreams. Then a misunderstanding happened at work. They took off some hours. He got really scared. Wanted to go back to the hospital—it had been a year since he last got out. Finally, he got drunk. A liter of vodka with a buddy, but he had most of it. Got terribly sick, down for two days. "And then I came here," he says.

P. Mieczysław was from Masuria, the former East Prussia, one of the rural areas with a significant post-1945 settlement and therefore a large proportion of state farms. He grew up in a family of agricultural workers, the flagship category of socialist anomie in postsocialist popular imagination. He drank from young age and spent his twenties moving from job to job in farming, construction, and industry, living between different "workers' hotels," or dormitories provided for workers near state enterprises. Already at twenty-six he couldn't live without vodka, he tells me. He was shaking, losing memory, losing teeth. But there was always a place to stay and, when he needed it, some kind of work to make enough for the next drink.

That changed in the early '90s. There was no work, no place to stay. He went to live with his family. At that time, out of money, he had started drinking *denaturat*, denatured alcohol, methylated spirits mixed with poisonous, nauseating additives to discourage recreational consumption. "Because of *denaturat*, I went down quickly [*szybko upadłem*]," he says. The family threw him out. In 1994. he came to Warsaw, spent the first week in the Central Railway Station, where many of the recently homeless and deprived were staying, and spent the next six years living at a Caritas shelter. Later, they would direct him to a work-shelter in the country, a farm where the homeless would live in exchange for work. But he was drinking and was kicked out again, to another shelter run by a Catholic NGO where he also had to attend therapy—a program based on the twelve steps of Alcoholics Anonymous (see Chapter Four).

It was there that his depression was discovered, he tells me, "so the doctors applied for money for me, a pension. I got 444 złotys" (per month, about $150).

But then other health problems were found: first "some tumor on my lung which they thought was tuberculosis but never confirmed." Then "something was happening with my spine. In the hospital, they found I had seven vertebrae damaged. I couldn't walk for three months."

I ask p. Mieczysław about his depression, what it looked like, and how it was found:

> p. M.: When I came back from the third therapy, in 2000, I wasn't giving myself much of a chance that I would make it without alcohol [*że wytrzymam bez alkoholu*]. In 2001, I was in a psychiatric hospital for the first time. Because I was leaving everything, like the job at the storage. … There was this psychiatrist at the shelter and once she came and asked if I wouldn't get treatment. I was afraid of everything then. Didn't feel like doing anything. I was only smoking cigarettes. Even to this day I'm afraid of people, my hands just start shaking. Everything unnerved me, I was running away, stopping conversations. And on that basis it was diagnosed and doctors started to write it in my papers that I am … I don't remember … that I constantly feel sorry for myself and constantly have a grudge against someone. And that's how it was. …
> G. S.: What are the diagnoses? What disorders?
> p. M.: I can't quite figure it out, because part they describe it and part they just put down their own symbols. There was my homelessness, that I don't have my own family and never had one. And those symbols. And that bipolar recurrent depression is what I have. Here, too, I sit quietly in the corner over there, by where the psychologists are. I have earplugs. I can't focus on one thing. When I'm reading, I want to smoke; when I'm smoking, I don't like it and just want to walk around. Something drives me forward all the time. Mostly I just want to leave, walk out of the room. I can't talk, I have nothing to talk about. I have no contact with my family, my brothers have grandkids already, so I'm ashamed to go. Their children are adults, the conversation doesn't flow.[24]
> …
> I often think that I'm fifty-six already and haven't really achieved anything. All the time I have those thoughts in my head that I'm homeless, have no home, no place to go. … Back home [in Masuria], when Kotański [the Polish pioneer of activism for the rights of the homeless, people with addiction, and HIV/AIDS in the 1990s] opened a center, I ran away after two weeks, because the director wanted to make me a team leader. … I was afraid there would be pressure. … I got scared, took my things, and went to Warsaw.

P. Mieczysław has now been hospitalized seven times and the initial diagnosis of recurrent depressive disorder was now provisionally changed to bipolar. But his anxiety and his nerves had always been part of his nature, he says.

He had always been scared of responsibility, always "shaking." His bipolar diagnosis is an attempt to see if mood stabilizers might work better for him than antidepressants and help him stay away from the bottle. His "compliance" has been poor in the past—he would not continue to take his medication very long after leaving the hospital. But similarly to his earlier diagnosis of depression, his diagnosable conditions seem secondary to his overall life situation: his background and past of poverty and excessive drinking and his terrible loneliness—probably the effect of what psychologists would call anxious and avoidant personality, but no sustained psychotherapy is offered to him during his hospitalization.

Before our conversation, I had been present during p. Mieczysław's examination in one of the weekly general meetings by the clinic's much-revered head, Prof. Waldemar Szelenberger, referred to simply as *Profesor*. *Profesor* asked about his family and other relationships, about his life, and about his plans much more than about his symptoms. The replies painted a saddening picture of loneliness, meager existence, and a plan of securing a spot at a shelter for people with chronic conditions. "A most unfortunate man [*nieszczęsny człowiek*]," *Profesor* said after p. Mieczysław was asked to leave the room. "And he will likely stay like this." The treatment, if continued, would likely help make his experience of the burden easier, but effecting any measurable change on his situation seemed beyond the power of the well-intentioned physicians. The clinical diagnosis, formerly changed from recurrent depressive disorder to bipolar disorder, was not much discussed beyond the concern over his compliance and his commitment to continue to refill his prescription. The practically dominant factors in his life were distinct: poverty; homelessness; loneliness; a past of drinking; and personality traits that none of the ward psychologist would address.

Anthropological analyses of psychiatry have shown the ways various biases related to such social descriptors as race, class, and gender may inform clinical diagnosing. Most notably, Emily Martin has analyzed the ways in which race and class shape the distribution of diagnostic categories of different severity, leading to white, middle-class patients in the United States being more likely to receive the less debilitating diagnosis of bipolar disorder, whereas poorer patients of color would be at higher risk of being diagnosed with schizophrenia (Martin 2007). Jonathan Metzl has brilliantly shown the reinscription of gender norms in the clinical assessment and treatment of patients with mood disorders, from psychoanalysis to SSRIs, and traced the transformation of schizophrenia during the Civil Rights era from an affliction of middle-class white women to a psychosis characterized by aggression and diagnosed in African Americans (Metzl 2003, 2010).

Guided by these studies, my aim here is to suggest that depression as a clinical category and popular idiom of distress "loses" to alcoholism and "social factors"

in the perception and treatment of patients whose socioeconomic positions make access to existing treatments of depression difficult—and the prospects of success of such treatment poor. Alcoholism, homelessness, and impoverishment remained the idioms of distress that defined p. Mieczysław's and p. Henryk's clinical situations. Even though depression and bipolar disorder were recognized and formally diagnosed, they were questioned or marginalized and remained clinically and practically inconsequential. There was no sufficient social space or clinical ground for the idiom of depression to take hold. There was little in terms of actually available treatment.

As I have argued so far, depression began to emerge in Poland during the transformation period of the 1990s within a problem space occupied by other idioms, primarily alcoholism. It would only be with the formation of a new realm of problems that depression could rise to prominence and its emergence gained momentum later, in the 2000s. But the mere existence of cultural practices and experiences—such as pressures of work or unfulfilled aspirations—would not be sufficient to produce a new problematization.

What propelled depression into broad cultural awareness were three interrelated dynamics: the introduction of new antidepressants on the Polish pharmaceutical market; a new diagnostic manual linked with a reform of the health care system and its financing; and significant awareness raising efforts. The diagnostic and system reforms will be discussed in the following chapter. Below I sketch out the role of new drugs and social campaigns in bringing depression to the clinical and popular forefront.

Pharmaceuticals and real depression

The entry of new pharmaceuticals into Polish psychiatry was part of a global process and followed a largely similar path and timeline, if with some delay (Petryna et al. 2006). The main change it brought consisted in three things. First, from the clinical perspective, the new drugs appeared to have fewer side effects than the relatively more debilitating tricyclics. As such, they were more suitable for ambulatory use and wider consumption and could soon be prescribed not just by psychiatrists, but also by general practitioners. Second, therefore, the scale shifted. Over the course of about a decade, antidepressants—along with the trend concerning the condition they were supposed to treat—went from being highly specialized and rather marginal substances to becoming "primary need medicines" (Poławski and Buczek 2011). Third, they were now a consumer product—and a very profitable one at that. If a common issue in the past had been a lack of medication that could be used to treat less severe complaints in outpatient

settings (just as Dr. Bugajska described to me, still with some torment, when talking about the women in rural Poland to whom she had had nothing to offer back in the 1960s and '70s), then starting in the late '90s there would be many such drugs. What's more, they could now be prescribed by any doctor, not just by specialists, which would significantly drive up the number of prescriptions.[25]

The first SSRI to arrive in Poland was Prozac. Already famous in the United States, where it was introduced in 1987 and quickly became a "blockbuster drug," it arrived in the Polish pharmaceutical market in 1993. Although only 60,000 packages were sold in the first year, the sales went up quickly, in part thanks to the publicity that surrounded it from the start and in part due to aggressive marketing by the manufacturer and, more broadly, the transformation of the Polish pharmaceutical market after 1990. Poland was transitioning from its previous position as a large producer and exporter of pharmaceuticals in the former socialist bloc to the fervid consumer of new foreign drugs that it became within a decade. Between 1992 and 2001, Poland's antidepressants market alone grew from $2 million to $34 million (which equals a 1,600 percent growth). By 2010, it would almost triple to about $90 million, and more than double again by 2018 (Bliźniewska-Kowalska, Chęcińska, and Gałecki 2020).[26]

But the growing sales were, of course, also part of a shift in the global pharmaceutical market. The 1990s were a time when international drug companies were devising new and bold—and highly successful—marketing strategies which earned them the dark image of the powerful and cynical "Big Pharma," exerting, through their lobbyists, sales "reps," and academic ghost-writers various kinds of pressure on doctors and pharmacists as well as on law-makers and journalists, often in ethical and legal gray areas (Applbaum 2006; Healy 1997, 2006; Medawar and Hardon 2004; Angell 2004).[27]

The rapid increase in drug consumption also had to do with the nearly continuous changes to Poland's health care system post-1989, including regulations regarding reimbursement by the state of prescription drugs for the different categories of patients. When Prozac (fluoxetine)—to stay with the first commercially successful SSRI—first came on the market, its full price in pharmacies placed it far beyond the reach of most patients (costing about one-fourth of the average monthly income per packet), but, if prescribed for a chronic mental disorder, it was dispensed free of charge. Quite soon, generic forms of fluoxetine became available, too, and at a much lower cost. As the system of prescription drug reimbursement continued to change in the following years, the discount level would vary, but it remained high for eligible—chronic—patients (set at 70 percent in 1995 and then 50 percent in 1996). In effect, antidepressants—"third generation" drugs like fluoxetine, but also some older ones—became available at typically discounted, if highly variable prices (sometimes for a promotional

price of only one *grosz*—one penny), and in great quantities. By the end of the 1990s, twenty-one of about thirty antidepressants in use worldwide were approved for clinical use and marketed in Poland. A decade later, in 2009, 14.2 million[28] packets of antidepressants (one packet being, typically, a month's supply) were being sold in Poland's pharmacies annually (Heitzman 2010; Poławski and Buczek 2011). What the drugs made possible—or greatly facilitated—was bringing psychiatric care out of the clinic and into the daily lives of consumers of medicine on a scale never previously imagined.

One of the effects of these new drugs was that they shaped what depression came to mean and be, both in biomedical psychiatry as it was gaining global prominence as a diagnostic category (Applbaum 2006; Janes and Corbett 2009; Patel et al. 2008, 2011; cf. Watters 2010), and in Poland at a specific historical moment. Broadly speaking, "third generation antidepressants" further advanced a biological and neurochemical understanding of depression on the one hand, and on the other tied it to a cluster of symptoms that in and of themselves may not be signs of "pathology" but rather appropriate, if severe, responses to adverse circumstances—and therefore may not per se constitute proper causes for medical intervention (Horwitz and Wakefield 2007; Hirshbein 2009; Lewis 2011; for a a more in-depth discussion of the transformations of the depression diagnosis see Chapter Two below).

As such, the new drugs played an important role in making depression a new idiom of distress in Poland and in giving it specific meanings. They also helped create a new image of the sufferer, more in line with new styles of work and consumption. Newspaper articles from the mid- and late 1990s show it clearly. Talking of American wonder-drugs, primarily Prozac, with an inquisitive mixture of optimism and skepticism, journalists began to frame depression as a response to stressful life circumstances—the kinds of circumstances that were becoming increasingly common and that now may have become easier to manage with treatment. And that now may have a range of treatments to choose from.

The early patients—or users—of Prozac depicted in those stories did not have debilitating, "biological" psychiatric disorders, nor were they former state farm workers. They were: a young physician studying for professional exams; a mother with a sick child; a couple of businessmen with business problems. The new generation of antidepressants helped turn "being ill with life" and the increasingly common stresses of market transformation into a legitimate object of psychiatric treatment. Depression was becoming less of a pathology of the psyche or brain, and more a problem involving a person's way of relating to his or her circumstances, a relationship between the subject and "what is." Increasingly, too, the image of the person afflicted by this problem was not one of the maladapted *Homo sovieticus*, but of someone well integrated into

the new reality—inhabiting it on its terms and according to its parameters of a good life.

Raising awareness

The most significant concerted effort to make depression an object of public concern and popular knowledge in Poland was the extensive awareness raising campaign under the slogan "*Lecz depresję. Depresja jest chorobą*" ("Treat depression. Depression is an illness").[29] In Warsaw's mental health clinics almost a decade after the slogan's debut, I still heard it repeated to me by psychiatrists and patients alike. It invariably came up in conversations with psychiatrists about depression's emergence from a strictly clinical category to one that is at once "cultural" (that is, used by non-professionals) and much more common in clinical practice. They agreed the campaign had had a significant impact on the popular perception of depression, perhaps even pushing the pendulum too far in the other direction: from ignorance to overuse.

"*Lecz depresję*" launched in March 2001 as a month-long effort that comprised extensive media coverage and a depression hotline. The media coverage was impressive. Since major outlets, including public TV and radio and the largest daily, agreed to partner with the campaign, it included TV and radio ads that aired regularly, articles in newspapers and magazines, billboards in eight of Poland's largest cities, and a website. The hotline offered anonymous and free-of-charge conversations with mental health professionals and access to contact information to local mental health centers throughout Poland. On the whole, the Polish media space was flooded with content showing what depression is understood to be (something most people never previously thought of as a medical, psychiatric problem that could be treated with medications), how to recognize it, and what to do.

The campaign was officially endorsed by the national consultant on psychiatry—at the time, Prof. Stanisław Pużyński. It was also supported by pharmaceutical companies but, because of Pużyński's objection, no official sponsorship was approved (an initial print of billboard posters with the logo of an American pharmaceutical giant, Eli Lily, the maker of Prozac, had to be withdrawn).[30] The campaign would run annually for several years and gradually morph into a sustained effort—both the hotline and the website remain active today. It also led to the founding of a new NGO targeting depression awareness, the appointment of an advisory team on depression at the Ministry of Health, and the establishment of the annual Polish Depression Day (*Ogólnopolski Dzień Walki z Depresją*). Every year on February 23, events and conferences are held and the media coverage helps keep public attention on the disorder.

The original campaign was organized by Fundacja ITAKA, an NGO devoted to searching for missing persons, in partnership with a mental health NGO, Centrum Zdrowia Psychicznego. Itaka was well known in Poland in the 1990s. Its president, the journalist Wojciech Tochman, was the host of a popular show on national television that presented the cases of missing persons and sought information from the public. In many cases, it seemed that those who had disappeared had suffered from depression, but their problem was not recognized as such, or they had not sought professional help. The popularity of the show helped Tochman start the campaign, as did his position as an accomplished journalist at *Gazeta Wyborcza*, at the time the country's most influential newspaper.

The message of the campaign was the following: a lot of people suffer from depression without realizing they have it. They are often perceived as "lazy" and told to "get themselves together," but what they have is an illness, not a character flaw. Further, as the slogan explicitly spells out, depression is an illness and it can and must be treated—especially now that new medications are available. The goal was also to break the taboo around mental anguish: a psychiatric problem is a disease like any other—like the flu, or diabetes—and there is no shame in seeing a psychiatrist.[31] Thus, the campaign was part of a broader modernizing mission to transform Poland—the modernization the country was undergoing on its way from the collapsing Soviet Bloc to the European Union and in the shift from politics and the economy to individual and intimate life. Organized by nongovernmental organizations and volunteers, the campaign was also an example of civil society-building with the involvement of organizations committed to furthering democracy in Eastern Europe. (The "*Lecz depresję*" website was funded by a grant from the Polish branch of the Soros Foundation.)

In other words, the campaign was an informational and didactic effort to teach Poles how to live in a market democracy, with its new regimes of work and consumption and new mechanics of the neoliberal state, and how to be liberal subjects approaching problems in responsible, rational, and professional ways. But in that way, it also helped depression to become an idiom of distress of those new subjects—not the maladapted *Homo sovieticus*, but those who worked and consumed, took socially appropriate risks (mortgage or business loans) and sought new skills to brave the competitive and demanding new reality around them.

Critical conditions

A decade after this influential campaign, a standard narrative of depression offered rather different images.[32] "Ever more young go-getters turn to antidepressants,"

announced an article in a 2012 issue of the leading weekly, *Polityka*. "Some because their success is crushing them. Others—to succeed even more. They're not afraid of taking them; they treat them like another dietary supplement. They're afraid to get *off* them" (Ćwieluch 2012). It's suggestively titled "Depresanci"[33] and the subtitle adds: "A generation on antidepressants."

The article tells the stories of four people. Krzysiek is an ambitious and successful lawyer in his mid-thirties, climbing the career ladder of his Warsaw-based law firm. After noticing that his efficiency was dropping, he made up for it by working longer hours and extra days. That, in turn, created more problems at home, where his wife wouldn't understand the demands his job put on him. With promotions came more responsibilities and fear that he couldn't show up for them. After another stressful period at work, he ended up in the emergency room, believing his heart was failing. Medical tests showed he was fine; the problem, he was told, was in his head. He declined medication until, after losing an important case, he finally had his PCP write a prescription for antidepressants. They helped. He lost his job, though, and his marriage was still falling apart.

Ola, when the married man who got her pregnant left her with the sickly baby daughter, moved in with her mother. The company she worked for was publicly traded and happy to reduce their workforce, "which apparently increases shareholder confidence." Caught in between the fear of losing her job and the guilt of being a bad mother, she became more and more tired and irritable. She went on antidepressants. They made her feel much better.

Edyta, a successful journalist, invested everything in her career in Warsaw. Ambitious and a perfectionist, she left her previous life and husband behind in another town, but it was antidepressants that helped her make that difficult passage.

Janek, too, went on meds just to get through a rough patch. They helped him sleep better, work better, feel better. When he once tried to get off the drugs, he got worse again and decided it wasn't the right time. The doctor suggested supportive psychotherapy. But for now, it's still just antidepressants.

These images of the young and successful are representative of the way depression sufferers are portrayed in Poland today. They're no longer "Soviet persons," inhabiting the spaces of postsocialist economic collapse, but examples of *Homo economicus*, focused on their careers and dealing with the stresses not of failing to take part in the new reality but rather of engaging in it too fully—too, one might say, uncritically—not setting their boundaries, as popular psychology (which has indeed become popular in Poland since the 1990s [Jacyno 2007; Rose 1996]) would have it.

Depression has changed, too. It appears not as a psychiatric pathology with roots in the biology or even the deep psychology of the person, but rather as

an effect of the demands of life in a competitive market economy, with inescapable conditions of overwork and stress. "Stress is a state of tension that keeps us alive," a psychiatrist is quoted as saying. "[I]t is life's developmental engine [*motor rozwojowy*]. Problems start when it turns into anxiety. Anxiety is a level of stress a person can't handle. One feels one has reached the wall and is about to crash into it." "This," the author of the article states, "pleases economists, but places psychiatrists on alert." "It is the order of the day to assign to employees more tasks impossible to do in the time they have for them," says another psychiatrist. "At the end of the week the manager comes with a long list of tasks you're only able to finish if you work during the weekend." The author states it clearly: this must produce frustration. If made a regular practice, it leads to deeper disorders. Under such pressure, it is hard to look into the future with optimism or to take pleasure in life. Of course, people will use drugs that improve their mood. Poland's economic success in recent years, this psychiatrist suggests, must in part be credited to antidepressants.

Stress, in this account, is a product of work rather than unemployment, the context in which depression had thrived in the early 1990s. The journalist and the psychiatrists he quotes portray antidepressants as effective but problematic, in that they allow for the unhealthy conditions of the depressives' lives to continue. The problem is in the demands which reality places on people, this time on the citizens at its core, not just the vagabonds of its margins.

This repositioning is captured emphatically in a feature story in another weekly magazine (Isakiewicz 2010). Mixing neuroscience, politics, and history, it portrays depression as an essentially healthy response to unhealthy conditions of the new reality. Here, too, the afflicted are not the dependent and helpless "Soviet" people, unable and unwilling to adjust to the fast-paced market-democratic life with its challenges, risks, and responsibilities, but rather those who have successfully adapted to it—the ambitious and hardworking, often working too hard. Depression is a way of one's brain telling one to stop:

> In doctor Michał Skalski's office … depression is at the fore. When he first began his practice in the 1980s, epidemiological research showed that endogenous depression (the heaviest in its course) made up no more than one percent of all cases, today every tenth Pole suffers from it. Doctors say: *depression is a defense against going crazy.* The brain resorts to a clever, but at the same time cruel, trick. In its gyri, a "leakage" of serotonin occurs—the neurotransmitter that makes us see the world in brighter tones. Physicians call it "serotonin reuptake." Only drugs can stop that process. But they don't work immediately. Treatment takes months, sometimes years. *As if the brain wanted to make sure the person really got the meaning of the suffering he or she had been dealt.*

> In other words, the statistics lead to a conclusion so politically incorrect it may be shocking: in the previous system, we were saner [*zdrowsi*]. (Isakiewicz 2010, emphasis added)

Against this growing insanity, depression figures literally as a defense system. Its symptoms may not even be signs of deficiency, much less abnormality, they may be a normal, healthy response to a reality that makes them sick.

It is as such that I understand depression as a "critical condition," an experience and an idiom that mark the limits of what is tolerable in the new reality; the limits of this reality's legitimacy. I would like to conclude this chapter with a short discussion of the critical potential of depression.

The economic and political reforms of the 1990s were a process of realification to the extent that they claimed legitimacy by reference to realness and truth. They sought to erase the fictions of state socialism in the economic sphere (see Introduction), in politics, and in everyday life. The discourses that dominated the public sphere and shaped the vision of what the new reality was to be were politically liberal and economically neoliberal; other positions were effectively marginalized and subjugated (Kochanowicz 1993; Ost 2005). Voices critical of the Balcerowicz "shock therapy" reforms that resulted in mass layoffs and impoverishment of workers of state enterprises—as well as the stabilization of Poland's collapsing economic indicators and then their dynamic growth—were dismissed as holding on to fictions that had to be eradicated or recognized only as sorrowful acknowledgment of the price to be paid for the return to normalcy, that is to say, for the construction of market democracy. But once it emerged as an idiom of distress of the new reality—the process I have traced in this chapter—depression came to demarcate a critical space in which both the new reality and one's relationship to it could be posed as a practical question.

My understanding of the very word "critique" here is informed by Michel Foucault's reading of Kant (Foucault 1997), and by Judith Butler's discussion of Foucault's essay (Butler 2002). For Foucault, critique was "a certain relationship to what exists," an attitude that simultaneously marks a limit. It centers on the question of "how not to be governed quite so much—not like that, not by them, not in the name of those principles." The primary task of critique, Butler adds, is to bring into relief the very framework of evaluation itself, to offer a perspective on the established and ordering ways of knowing which would not immediately be assimilated into that ordering function. It is not judgment, but a practice that suspends judgment in order to expose the constellations of power that structure the categories of that judgment. As such, resisting that assimilation, it is not simply a statement, but a practice, an art, a virtue, a relationship to what is, a matter of ethical self-formation.

I am not saying that depression *is* this vision of critique—it clearly falls short of soundly exposing the "framework of evaluation." But I am suggesting that in positing "healthy response" as a disorder, as a crisis, the relationship to reality is problematized in a way that marks out the limits of what is tolerable and poses the question of what to do. The assimilation of the problem back into an "ordering function" does, of course, occur. Giving a breakdown a medical diagnosis and prescribing a treatment is, one might argue, precisely that. But, as I have shown above, it doesn't entirely succeed. Both experienced and understood as a normal response to the conditions of reality, depression may also become a way of saying, "we do not want to—we *cannot*—be governed like that, in the name of those principles." It is not a call to arms; it is formulated within the order of the "new reality." But while not trying to denounce the terms of "what is" in the name of a different categorical framework, it does more than simply try to adjust. It brings out a limit where our brains tell us to stop, where something cannot be accepted, but still has to be somehow "worked through." It is a space and a moment where the ordering is suspended in not being able to go on.

Conclusion

Poland's "new reality," as I have argued so far, involved attempts to close the "reality gap" that had drained state socialism of legitimacy and made it an easy object of critique. In purely economic terms, the market reforms that promised to eradicate socialist "fictions" created a new problem space which included, as its most striking elements, the new phenomenon of unemployment, the impoverishment and abandonment of people who had depended on state enterprises for both work and other social provisions, and the challenges of adapting to market conditions. In public discourses, that space was typically represented and made sense of through the idioms of distress of the *Homo sovieticus*—primarily drinking, learned helplessness, and dependence, sometimes leading to suicide, but at bottom perceived as products of dysfunctionality of state socialism. In the late 1990s and early 2000s, thanks to the availability of new pharmaceuticals and new diagnostics as well as awareness raising campaigns, depression emerged as a new idiom of distress—distress not of those who failed to adapt to the new reality, but of those who inhabited it too fully, too "uncritically." The rise and transformation of depression was, on the one hand, a case of medicalization: it allowed a state of malaise to be perceived as a medically treatable illness. At the same time, this illness, the still ambiguous disorder, began to be understood not as a pathology but as a normal, even healthy, response to the pressures of life

after market reforms. In public discourse, it could therefore begin to appear as a "critical condition." In the lives of the men I met in Warsaw's clinics, it was experienced as such. It marked a limit of what was bearable.

In the following chapters, my examination of depression in today's Poland will unfold in two different directions. First, in Chapter Two, I will explore the ways in which depression continues to escape being subsumed under the "ordering function" of the new reality—how, even when formally diagnosed and treated, it is a messy and unstable assemblage lacking in what I call *realness*. In Part II—Therapeutics (Chapters Three and Four), I look at the ways persons suffering from depression seek to "work through what is" and to transform their relationship to reality and their own selves. In that way, I will continue to explore the social practices that coalesce around depression as a "critical condition."

Chapter Two

Affective disorder

In Polish diagnostic practice, depression seems at once omnipresent and strangely elusive, at once over- and under-diagnosed. Following it as an ethnographic object across different sites—from inpatient wards and outpatient centers and psychotherapy groups to self-help programs and archives of popular and professional publications over several decades—depression proved to be a moving target; a protean, unstable, and contested category. After several weeks of observing daily sessions of an intensive psychotherapy group designated for patients with depression, its lead physician, Dr. Antoni Orłowicz, told me that none of the patients actually had depression, although they thought they did. "It's mostly personality disorders, borderline. Maybe [one of the patients' name] has depression, but that's probably an organic case related to his somatic problems, his thyroid and other issues."

In the inpatient ward at the Nowowiejski Hospital, most of the depressions I saw over many months were *actually* or *also* something else and the diagnoses involved alcohol-related problems, personality disorders, neurotic disorders, bipolar disorder, organic depression (after a stroke), dementia, schizoaffective disorder, and schizophrenia. But there were also family conflicts, heartbreak, unemployment, impoverishment, debt. One of the "purest" cases of depression I was shown was a patient whose main complaints did not, in fact, include lowered mood, but primarily reversed sleep pattern and fatigue.

On the epidemiological level, despite the alarmist tone of reports speaking of ten to fifteen percent of the population suffering from depression, specific questions I put to physicians and public health experts quickly showed that no reliable knowledge actually existed. It appeared that Poland had seen a rapid growth in the prevalence of depression, as well as some other disorders, since 1990, but what the available data showed was only an increase in the number of *psychiatric*

services provided within the public health care system. Not only did this data exclude private practice (whose growth, especially in regard to depression, was assumed to be significant) but, more importantly, it said nothing about the proportion of the population who would meet the diagnostic criteria but were not seeking care. In other words, how many people were actually depressed (and therefore not living fully to their productive capacities, possibly receiving or seeking disability assistance, weighing down their families without contributing to GDP) was unknown. General estimates of the prevalence of depression in Poland were formulated only by transposing international data: global assessments published by the WHO or data from the Eurostat.

Indeed, the first ever large, international epidemiological study conducted in Poland, using the most precise tools developed by the WHO to assess the lifetime prevalence of mental disorders, only added to the confusion.[1] While this study (titled EZOP, acronym for *Epidemiologia Zaburzeń Psychicznych*, or Epidemiology of Psychiatric Disorders) revealed that the rates of alcohol-related disorders as well as suicide were, perhaps predictably, high in Poland, the rates of depression turned out to be unexpectedly low, in fact the lowest among all countries studied. Only three to four percent of the Polish population were shown to experience any form of depression during their lifetime, while the corresponding figures for other European countries were between ten and twenty percent (Kiejna et al. 2015; Moskalewicz, Kiejna, and Wojtyniak 2012).[2] These perplexing results have only been perfunctorily explained in terms of a variety of cultural factors that may have interfered in the recognition, expression, and communication of symptoms (for a classic study of such sociocultural mediation of symptoms, see Kleinman 1986).

I am citing these diverse figures and attempts to diagnose depression—whether in individuals or in populations—not to suggest that there is a truth to be unearthed there, but, on the contrary, to show how tricky an object of knowledge and concern depression really is. The EZOP study, because of its international prestige, laid bare depression's definitional and diagnostic malleability, raising the question of what constitutes "real depression." Many psychiatrists with whom I talked expressed clearly mixed feelings about this, as if unsure whether to welcome increased prevalence as a sign of progress, dismiss it as a recent fad, question it as still inadequate, or speak nostalgically about the "good old days," when diagnostics had a stronger hold on reality.

In this way, the term *affective disorder*—ostensibly a formal modifier assigning depression to the class of afflictions of mood—takes on quite another sense: It conveys the disorienting ethnographic reality of the seemingly orderly classification. What many psychiatrists saw as the outcome of the apparently straightforward diagnostic categories was indeed quite a mess. And it is here

that the question of the realness of psychiatric reality and of depression specifically comes most urgently into view.

This chapter focuses on the "real" in "real depression," examining the changing ways in which the very realness of the disorder is produced—and challenged. I discuss new diagnostic categories introduced in Polish psychiatry (and in much of international psychiatry) since the 1990s, and new ways of operationalizing them in the context of postsocialist realification in health care. These diagnostic and organizational changes, seeking to bring Polish psychiatry to Western standards, were an attempt to "realify" psychiatry by scientific, economic, and political means. A more technical and formalized classification posited depression as a disorder that can be objectively identified and targeted and that afflicts a definable proportion of the population with specific treatment needs. The sweeping reform that sought to do away with the "fictions" of socialist health care followed a free-market-based notion of reality and the image of individual patients free to choose providers in a marketplace of medical services. I argue that, paradoxically, the diagnostic confusion surrounding depression in Poland, manifesting in a "deficit of realness" in the diagnostic category itself, is in part an effect of this *urealnienie* (realification). I analyze this process in terms of referentiality and clinical agency.

By the referentiality of diagnostics, I mean the ways in which the classification of disorders, while *denoting* discreet biological and behavioral phenomena, at the same time *connotes* organizational, financial, and ethical realities. On both counts, such referentiality reinforces a discrepancy between formal categories and the practice of clinical work, between what is proclaimed and what is experienced—the very gap it ostensibly seeks to close. I show how, in that discrepancy, the point of reference and measure of reality continue to be permeated by figures of "the West," the E.U., and "Europe." An implicit juxtaposition between the way things are and used to be "here" and the way things are "there" not only remains central to Polish political and historical imagination, but also permeates the psychiatric imagination and clinical practice.

As regards clinical agency, I argue that the deficit of realness I observed in diagnostic practice is connected with the psychiatrists' diminished control over the clinical process. What used to be part of treatment and was largely under the power of the physician is now an interface between standardized clinical work, administration, financing, and the realm of patients' freedom and responsibility. In these ways, I argue, diagnostic and clinical operations are actively and intimately bound up with the realness of the "new reality" at large: with the broader ongoing processes of economic, political, and scientific realification. Those, however, remain unfulfilled; the changes that have been transforming Polish psychiatry over the last two decades have not simply

produced a "tighter," more binding, stable, and controllable reality, as was the claim and promise, but also new "fictions" that have to be navigated and managed—sometimes crisis-managed. In other words, the "reality gap" didn't quite close; it shifted.

I start by discussing in detail the nature of the diagnostic transformation that occurred with the introduction of the new WHO classification of diseases, the ICD-10, in the late 1990s. I focus on this transformation's pursuit of a technical and formal realness in biopsychiatry. In the way it intersected with the health care reform that changed the organization and financing of Polish psychiatry and the role of diagnostics within it, it limited the discretionary and pastoral powers of physicians—which I discuss in terms of clinical agency. I then turn to the referentiality of diagnostics to show how clinical categories, including depression, remain bound up with a referential reality that has a hold over psychiatrists' daily experience and practice in a ward. I conclude by showing some of the ways in which diagnostic and clinical practice are informed by the processes I've analyzed.[3]

Diagnostic transformation

The new diagnostic classification—the tenth edition of the International Classification of Diseases, ICD-10—came into clinical use in Poland in 1997, four years after its launch by the WHO and around the same time as in most European countries.[4] It was intended to be more "stable and flexible" (ICD-10: International Statistical Classification of Diseases and Related Health Problems 2011: 173) and thus more suitable for a highly technical and formalized environment. In Poland, the new diagnostic categories would come to play a new and different role, since the 1999 reform of the health care system placed ICD codes at the very center of the organization, financing, and audit of mental health care.[5]

The new revision constituted a move away from etiological (and therefore speculative) classification and toward empirical-descriptive classification; from broad disease categories to functionally understood disorders, from qualitative to quantitative. In other words, and in contrast to the general philosophy of earlier revisions, categories of disorders were now based less on their assumed underlying causes (etiology) than on their symptomatic manifestations (symptomatology) (Faravelli, Ravaldi, and Truglia 2005).[6] In this regard, the changes reflected in the ICD-10 were in step with the changes in the American classification, the Diagnostic and Statistical Manual of Mental Disorders, or the DSM, since 1980,[7] and with the increasingly bioscientific and "a-theoretical" approach to mental illness. Indeed, the goal was realification: an operationally tighter (or more objective,

stable, commensurable) relationship between classification categories and the entities they described. As a consequence, the new diagnostic definitions came to rely almost exclusively on observable symptoms, largely eschewing questions of etiology, context, and meaning.

With respect to depression in particular, the new international classification, just like the DSM-III (and IIIR and IV) before it, deeply changed the way it was understood, bringing it into alignment with the new biological and neurochemical view of mood disorders (Ehrenberg 2010; Greenberg 2010; Horwitz and Wakefield 2007; Jackson 1990; Kitanaka 2012; Kleinman and Good 1985; Lawlor 2012; Lewis 2011; Metzl 2003). Earlier revisions of the ICD generally distinguished between two kinds of the disorder: *endogenous depression* on the one hand and *reactive*, or *psychogenic depression* on the other. Endogenous depression ("originating from within") implied underlying biological causes and was an "affective illness." Serious and debilitating, often cyclical, it would warrant pharmaceutical treatment with one of the relatively invasive older generation tricyclic drugs (like chlorpromazine or imipramine) and often hospitalization. Psychogenic depression—a disproportionate reaction to adverse life events or the effect of neurosis—was typically referred to as "neurotic depression," "depressive neurosis," or "anxiety depression." Here, the treatment of choice was psychotherapy, which was not widely practiced in Poland until the 1990s, and if so was usually conducted in inpatient and group settings. Falling outside this bifurcated diagnostic realm were all reactions to adverse life events that could be deemed appropriate, even if severe and exhibiting the central characteristics of depression, such as deep sadness, loss of pleasure, sleeplessness, and weight loss in the wake of a significant loss—reactions that until recently had not been effectively medicalized.

This distinction between two kinds of depression mapped onto the fundamental divide between psychoses and neuroses reflected in ICD-9. Endogenous or "major" depression was listed under the general class of *Psychoses*. Psychogenic depression was included under *Neurotic disorders, personality disorders, and other nonpsychotic mental disorders* as "Depressive reaction" or simply "Depression." In the new diagnostic criteria, however, that fundamental divide was annulled. The category of depression became largely voided of its etiological underpinnings. Regardless of what might have "caused it," with the wide availability of drugs targeting the alleged neuronal mechanisms of depressive symptoms, the preferred course of treatment involved primarily or exclusively antidepressant drugs.

Where there had been a strong and etiologically grounded divide between psychotherapy and medication, now both were to be combined in treatment, although the emphasis was on medication. Tying the diagnosis more tightly to symptoms, such as lower mood and energy, disturbed sleep and appetite, feelings of worthlessness or helplessness, anhedonia (the inability to feel pleasure),

but also somatic complaints, led to depression being ever more broadly diagnosed. In the new classification, the two broad categories of endogenous and neurotic depression, fundamental to diagnostic practice in the past, were translated into at least fourteen subcategories under the general codes F32, F33, F34 in the *Mood (affective) disorders* block ("Depressive episode," "Recurrent depressive disorder," and "Dysthymia," which subsumed much of what used to be called depressive neurosis), as well as at least two broad subcategories from the next block, *Neurotic, stress-related, and somatoform disorders* (F41.2 "Mixed anxiety and depression episode" and F43.2 "Adjustment disorders"). Another block, *Disorders of adult personality and behavior* (F60), includes other entities, which, as I learned, are closely related to lowered mood, such as dependent, anxious, anankastic (emotionally unstable), or "immature" personality disorders. Following "depression" ethnographically led me to all these different diagnoses and to various forms and sites of treatment, but nowhere was it a stable and clearly defined object.

On the whole, the ICD-10 sought greater realness by establishing more scientific, objective, and formal criteria of evaluation. The classification offered apparent technical precision of largely symptom-based categories. Informed by advances in bioscience, it attempted to "carve nature at its joints" with its newly sharpened conceptual and pharmacological tools.[8] However, just like in other realms in Poland, from economy to politics, realification in psychiatry involved not simply a tightening of the relationship between categories and their objects or a confrontation with hard and unquestionable "facts"; rather, it involved a different distribution of "realness" and "fiction," of soft and hard facets of reality, of negotiable and nonnegotiable aspects of practice.

As I mentioned above, shifting from one to the next version of the ICD also involved a new way of using the diagnostic system in the organization and financing of health care. The fundamental reform of Poland's health care system, initiated in 1999, introduced insurance-based financing and placed diagnostics at its very center. What used to be predominantly a clinical matter—a way of naming the patient's illness and devising an appropriate course of treatment, largely at the discretion of the psychiatrist involved—became a highly standardized procedure central to the financing, organization, and audit of health care, thus susceptible to other kinds of pressure.

In this way, both the health care reform and the adoption of the ICD-10 constituted an organizational and financial realification of Polish psychiatry in the spirit of neoliberal governance (Rose 1996; Collier 2005a, 2011) and the "global mental health" paradigm (Béhague and MacLeish 2020; Bemme and Kirmayer 2020; Patel et al. 2008, 2011). However, in clinical practice, the old divide between endogenous and psychogenic depression remained in use and the formally obliging codes were approached with some distance as administrative instruments,

and sometimes, as I show below, treated with scorn as products of a Western formalism that is out of touch with local reality.

This "affective disorder" in diagnostic practice and epidemiological imagination poses the question of the realness of depression itself. Ostensibly, that question is: what is *real* depression? However, it inevitably leads to a different problem: how is that realness produced and how is it challenged?

A deficit of realness

Dr. Hanna Bugajska hosts me in her elegant pre-war apartment in one of Warsaw's "better" neighborhoods —a typical *inteligencja* home, I note, with plenty of books, tasteful art, and antique furniture. Later I will learn that she has only lived there for a few years and had spent most of her life in a small and anything-but-luxurious apartment in a typical "communist-style" project *blok*. The move was a sign of her improved economic status after private practice in the new reality became much easier and more profitable. A senior psychiatrist with about fifty years of experience, Dr. Bugajska has retired, but at the time of our conversations over the summer of 2009, she still works part-time at a public outpatient clinic and at another private one, where patients pay per visit and out of pocket.

Dr. Bugajska is a generous interlocutor, with clear and strong opinions but also an open mind and a philosophical sensibility. A self-identified conservative (when it comes to psychiatry, at least—but also in her abhorrence of the politically correct), she doesn't mince words but also challenges and tests her own opinions. Her language is vivid and figurative, with references to literature and a French word or two thrown in with precisely aimed irony. She makes humorous remarks referring to her age—which she does not disclose, and I would not have the bad manners to ask—but is full of energy and *au courant* with developments in contemporary psychiatry.

I wanted to know about Dr. Bugajska's experience with the changing diagnostic definitions and practices of depression over the years. The tendency to diagnose depression broadly, which she, too, has observed over the last decade or so, is our starting point. Psychiatrists do it, primary care physicians do it, and people themselves more readily see themselves as suffering from depression and seek help. The new ICD has been a major part of it. "It was as if the meaning of words was changed," she says emphatically. "It's as if you said 'good morning' but now it meant something else! … The concept of psychosis is gone, mental illness is gone—[there are] only disorders." And depression? Dr. Bugajska explains it in terms of isolating a symptom from what used to be an illness category and assigning the label to the symptom itself:

> [D]epression as a complex of symptoms, so a disease, is one thing; but in the Polish [psychiatric] language, "depression" has also always meant *one of those symptoms*, the lowered mood. You see? So there are two meanings. And usually the over-diagnosis of depression means that disorders in which one finds lowered mood as a symptom—although the other symptoms used to exclude depression, but now do not exclude it—become part of it. … That's what there is more of: more people seeking help and a wider tendency towards covering by the word "depression" the disorders that up until ten or twenty years ago would never be counted as depression.

Depression has become a symptom, often episodic, rather than an etiological entity. In other words, rather than perceiving the symptom as a sign that points to an underlying problem, the symptom itself became the problem now understood increasingly in terms of neurotransmitter action susceptible to modulation. A pathological entity has been translated into a functional disorder, a quantitative rather than a qualitative matter. At the same time, in a move from what may be called romantic realism to technical nominalism, a depth has been flattened. Not only in the sense of a psychological depth having been "reduced" to the neurochemical plan,[9] but also in terms of a biological depth, where an ontological entity is transposed to a plan of variable functions and intensities, in other words, of quantity. Where there used to be a disease manifested in symptoms, now there seemed to be only symptoms, which *were themselves* the disorder (cf. Mol 2002). Breaking down the fundamental divide between reactive and endogenous depression, the new diagnostics lost grip of the *real* illness, the depression the "realness" of which was pinned on the autonomously biological referent and on symptoms' signifying quality (Žižek 2008).[10]

Dr. Bugajska's discontent with the current diagnostic of depression is in line with established critiques that see it as a "psychiatrization of normalcy"—an expansion of psychiatry into the realm of "normal" problems and experiences (Horwitz and Wakefield 2007; Kokanovic, Bendelow, and Philip 2013; Witeska-Młynarczyk 2019; Wróblewski 2018; cf. Rose 2006a). However, she seems equally concerned about the apparent overall inadequacy of the new, supposedly precise diagnostics. In her view, depression seems to have grown in both directions to include states of normal sadness, or at least those not previously considered an illness (neurotic and otherwise psychological problems, adjustment reactions), as well as some of what used to be more serious mental pathologies: psychotic syndromes, in so far as they are accompanied by depressive symptoms. "There is a tendency to pretend," she says. "I mean, when the patient is clearly delusional, then, reluctantly, one will concede that it is something more than just a depressive disorder." Otherwise, there is a tendency to avoid any strong formulations or "hard facts."

Despite the scientific methodology of the current classification, Dr. Bugajska finds it lacking in realness. In the past, the relationship between diagnostic categories and the reality they described—the reality of mental illness that, as she assures me, one learns to see after many years of clinical practice—seemed firmer. The ICD-10, in her description, is highly technical, formalistic, and rigid, far less interpretive than it used to be. With the slight scorn of an experienced practitioner, she talks about the way depression as a cluster of symptoms is approached today:

> They classify some [symptoms] as more important and weighing so and so many points, and others as less important for less points, and one has to know how many of the more important ones have to be present to give a diagnosis, and how many of the less important in addition … it's a real nightmare [and] … it is completely unnecessary, to be honest with you, because anyone who has worked for a little while sees how it is.

The problem with the current diagnostic practice lies not only in what she perceives as the inadequacy of the allegedly precise categories, but also in its pervasive and constraining technical nature. Before the health care reform and under previous classificatory regimes, diagnosing was primarily in the service of treatment and more of an open, interpretive act over which physicians had full control. Psychiatrists' theoretical views and clinical practices were informed by a variety of approaches and classifications—the ICD, the DSM, theoretical orientations of their mentors in the past and their workplaces at present—which, in effect, would give different clinics their own, quite distinct diagnostic cultures.[11] In many ways, that is still the case today: academic programs in psychiatry teach the ICD as well as the DSM and other theories and systems developed by international and Polish researchers.

In effect, psychiatrists often continue to use categories that are at odds with the current official classification—such as reactive and endogenous depression or understanding dysthymia alternatively as an affective (biological) or "neurotic" disorder.[12] However, the final translation of the interpretation into a diagnostic category seems now at once more reductive and more consequential in organizational and financial terms. It is taken at once less and more seriously. Bugajska's account conveys an image of clinical practice in the past with less standardization, less external control, and less emphasis on classification, all of which left more power in the hands of the medical staff. In contrast, the "Anglo-American approach is constricted exclusively to the classification," she says. It "loses spirit."

G. S.: You mean because the description isn't more, say, poetic?

> H. B.: It's not a matter of poetics but of … [pauses to search for the right word] *realness* [*Nie chodzi o poetyckość, chodzi o … realność*]. Because the previous divisions [*podziały*] … were much less detailed. They were rather gross separations between groups of [conditions] that were easy for anyone to understand. Within those groups there were, of course, some petty distinctions [*różne tam jakieś podzialiki*], but some believed this, others that, one would say "according to [Kurt] Schneider it is this" or "according to [Eugen] Bleuler it is that." … You know, it wasn't all that *rigid* [*sztywne*, stiff]. Because behind those divisions, neither then nor now, was there ever any actual theoretical knowledge. Because, as you know, in psychiatry we still don't know anything, and it is a [philosophical] question whether we're ever going to really know. So anyway, on such sand they have built this incredibly precise bureaucratic division. I completely do not understand the point of it.

Since the reality behind the diagnostics—a reality whose positive ontological status she never doubts, but whose knowability she questions—isn't precisely determined, making the system more specific only removes it even farther from "what is." The specificity and technicality of classificatory distinctions seems to refer to something other than the biological-behavioral reality it purportedly describes.

There are several things going on here. On the one hand, the ICD-10 is shown to be a realification in the sense of what Roland Barthes called "reality effect," or the way in which realist literature achieves its realism. Barthes (1989a) saw it as brought about by the use of "seemingly superfluous details" that add little content to the account, but whose referent is "the category of the real" itself (see Introduction). Similarly, psychiatric diagnostics draw their realness from the technical objectivity and allure of precision and authority of scientific biomedicine (cf. Clarke et al. 2003; Pickstone 2001). One of the charges Dr. Bugajska brings against the ICD-10 is exactly its technicality and rigidity.

But the problem goes far beyond excess of detail. Barthes connected "reality effect" in literature with conventions of verisimilitude in modern historiography and academic discourse more broadly.[13] A central such convention is objectivity: the "pure and simple 'representation' of the 'real,' the naked relation to 'what is' [which] appears as a resistance to meaning" (1989a: 146). The ICD and the DSM, having moved away from the more interpretative, meaning-heavy definitions towards a categorization that is scientific and symptom-centered, claim their realism and objectivity in exactly those ways. And they do that although the things they classify and objectify may not be amenable to such precise description (Hacking 2002b; Mol 2002).

It would seem, then, that the problem of the realness of depression is simply a consequence of the shift in the diagnostic philosophy behind the ICD-10: the

blurring of the fundamental divide between "real," that is, severe, endogenous, biologically grounded disease, and disorders that merely take similar form, but are, at bottom, reactions to current circumstances, including "normal sadness," or the product of a "difficult childhood." With that distinction blurred, the same categories (primarily that of "depressive episode") apply to what used to be quite different conditions.

This is a reflection of the divide between the normal and the pathological, fundamental to medicine (Canguilhem 1991; Margree 2002), being progressively blurred in psychiatry, including in the psychiatry of depression (Horwitz and Wakefield 2007). But this accounts for only a part of the deficit of realness. As I show below, in the Polish context that deficit has to do with two other processes. One has to do with the referential nature of diagnostics entangled in the political and economic as well as the symbolic and cultural aspects of Poland's postsocialist *urealnienie*. The other is the relative loss of physicians' clinical agency—their control over the process of provision of medical care, a consequence of the neoliberal reform of the Polish health care system.

Referentiality of diagnostics

In proposing this notion of referentiality, I draw on Barthes' distinction between denotation (roughly, the "literal" meaning of a word, association of sign and signified) and connotation (association of denotative signs with other signifieds, lateral as it operates "sideways"), two closely connected modes of signification (Potter 1996).[14] Just like the "superfluous details" of literary realism did not simply or even primarily refer to any "objects in the world" but rather "signified the real itself," diagnostics do more than just define and denote psychiatric disorders. They also invoke the power of modern bioscience and the images of advanced, Western medical services. They *connote* or represent—make present—a referential reality that seems at odds with what is directly experienced and yet remains a binding and corrective force. It is here that we can see how the realness of diagnostics is bound up with that of the broader "new reality."

In clinical practice, diagnostic categories don't precisely map onto what physicians may see as the "reality" of the patient's condition because while defining disorders of brain function and behavior, they also implicitly reference an apparatus of medical and social care designed to best address them. That apparatus, however, in many psychiatrists' experience, remains in part unavailable to Polish patients. This discrepancy drains realness from diagnostics. But it similarly undermines the realness of what is experienced, the "what is" of overcrowded and dirty hospitals. The referential reality of elsewhere, indexed

by the ICD-10 and by aspired-to standards of the more affluent countries of the E.U., maintains a corrective, normative hold over the experiential reality of here. It is not simply a fiction to be dismissed in the face of "what is." Rather, it exposes a persistent preoccupation with *how things should be,* or *how things are going to be, but still aren't*.

That underlying referentiality of diagnostics is suggested by the distinctions that organize Bugajska's account. Having drawn on a temporal opposition between "now" and "then," "before" and "after" the introduction of the current classification, she now weaves in a new opposition: between "us" and "them," "here" and "there."[15] In Bugajska's narrative, "*u nas*" generally means "in Poland" ("in this country"—indeed, that is one of the term's primary meanings) and is paired with the corresponding "*oni*," "*u nich*" (they, at theirs), generally meaning "in the West" (*na Zachodzie*). Thus, the ICD-10 was created by "them," it was "they" who designed the categories according to how things are *there*, "at theirs," "*u nich*," where psychiatric care reaches eleven percent of the population.

Separating the self from the Other is a fundamental categorical distinction of identity. But an Other who is not present, or at least who is not faced directly in an ethical relationship (which is how *they* differs from *thou*), is referenced in the term "they," which may be called one of the keywords of Polish cultural history over the last centuries and especially over the last decades (cf. Sowa 2011; Janion 2006).

It was used to refer to "the authorities" and invoke at once estrangement, opposition, and a refusal of identification. It was central to the symbolic organization of the political imagination under socialism and has lingered, sometimes used in reference to the government or "the West." "They" was also the imagined locus of control in socialist paternalism.[16] Today, it still often refers to "the government"—but also to the E.U., "the government in Brussels."

"This system makes no sense," Dr. Bugajska seemed to be saying, "it does not capture the reality of mental illness and it does not capture *our reality*, the way things are *u nas*." The other reality is that of medical organization and standards of care devised by the WHO. In other words, a social reality—at once medical, economic, and cultural—that is both "real" and at the same time remains at a remove, foreign, instituted by "them" for "their" needs, purposes, and abilities, according to how things are "there" rather than how they work "here." In that way, it is *referential* rather than *experiential*, but still real and binding enough not to be dismissed.

What forms of care, devised by "them" elsewhere, might these be? What kept coming up in my conversations with psychiatrists were images of a developed infrastructure of community psychiatry, with social workers, nurses, and formal support and supervision for patients in their daily lives after leaving the hospital

or returning from a sick leave. Dr. Bugajska talks about psychotherapy that should be available within public care for patients who don't actually need hospitalization and won't benefit significantly from exclusively pharmaceutical treatment. References are made to other countries, such as Sweden, or the U.K., the Netherlands, Germany, but also the United States. Senior physicians recall their experiences of the past, when community care, while insufficient, was in some places better developed than today and, more importantly, when physicians had more time and liberty to supervise their patients, as there were fewer formal restrictions and more informal practices mobilized in the everyday work of care. Some psychiatrists have their own experiences from abroad.

Dr. Marcin Walaszek, a resident at the Nowowiejski Hospital, told me about completing his residency program, which included an internship at a day ward. You consult patients, he said, hand out prescriptions, decide if a patient needs to be admitted to full-time care. But there is little to help those patients make the transition back to "normal life." As we talk about the lack of community psychiatry, he immediately makes a comparison to a hospital in the U.K. where he completed a clinical internship.

> They had this thing that each physician in the ward had a day, they called it colloquially "social Thursday" or "Tuesday," or whatever. For my supervisor it was Thursdays when he would go to a day center in the city and spend a couple of hours with patients who would come and talk about their problems with things like looking for work for the second month or something, and whether the center could help with negotiating with the employer, for example. … There was also a timetable for home visits in community housing. … The doctor would go and ask politely if he could look inside the fridge. If the patient said no, then they wouldn't open it. You wouldn't call anyone, but it was a sign something might not be going well. … You would see if it's clean or a total mess, if the patient washed him/herself. They [the British] did have it pretty well-developed. Plus, within the ward structure, for like a forty-bed ward, they had I think six or seven social assistants, like social workers, who would also have to supervise what was happening with the patients after discharge. They were not only [caring] for what was happening … during hospitalization. And here [at Nowowiejski], we have two social assistants for the entire hospital of 240 beds. [Later it turns out there are three.]

The contrast with the images of how it is done in "the West" is striking. It conveys an image that is at once aspirational and normative—this is how things should be—and one that is coded into the very laws and regulations of Polish psychiatry. Dr. Walaszek emphasized the respect physicians had for their patients, for example asking if it's okay that they open the fridge. In a similar way, other psychiatrists

with experience from clinical internships abroad talked about the difference in personal rapport with patients.[17] It was clear that establishing personal rapport was part of the way things should be and that the legal and organizational changes protecting patients' rights and choice had the goal of creating that kind of dynamic—but that it wasn't part of the reality on the ward.

During my time working in the hospital, I felt the way patients were treated didn't reflect their status or heed their dignity. The often subtly infantilizing treatment aside, the constant insufficiency of clinical resources in the understaffed and overcrowded hospital—from the time and attention of the medical personnel, to physical space on the ward, where patients' beds were routinely placed in the hallways, to the food that some patients understandably felt was substandard, bordering on offensive.[18] Outside the physicians' office in the ward there was invariably a line of patients knocking and waiting for a chance to ask their doctor a question—patients largely ignored, since trying to address their requests (some of which were interpreted as symptoms of their conditions) was considered impossible given the insufficiency of staff. Inside the office, the phone was constantly ringing—in part because much of the time, no one would volunteer to pick it up.

The medical staff, starting their day early, at seven or eight o'clock, would generally be gone around lunchtime to attend to their other jobs—typically private practice or, this being a university clinic, academic duties. But the morning hours, while the ward was in full operation, were quite chaotic, including for the psychiatrists themselves. They often complained about unreasonable overallotment of patients (Dr. Walaszek, a resident, was at one point the supervising physician of as many as eighteen patients), and about a constant need to attend to issues they didn't see as their responsibilities but that no one else would do (from dealing with red tape to trying to arrange post-hospital care for patients). Shaking of heads and audible sighing were frequent, as they talked of constant provisionality (*prowizorka*) and "guerilla work" (*partyzantka*). Granted that most of the time I worked on the ward fell during a period of greater-than-usual overcrowding (another ward was closed for renovation and modernization, and patients were distributed across the hospital), and the number of patients remained in the forties, though technically there was only enough room for thirty-seven, this provisionality of solutions seemed a broader problem.

When explicit, the presence of "the West" and the E.U., as both spectral and concrete referential realities, wasn't only positive or necessarily associated with clinical, organizational, or cultural improvement. The increasing level of bureaucracy since the reform and E.U. membership, which went hand in hand with the technical formalization of care and with new and strict audit standards,

was often bemoaned by physicians. After receiving a patient who had suffered a breakdown in London (where she had been working a service job as one of the numerous labor migrants from "new Europe," and from where she had returned to Warsaw), the ward staff discussed with horror the several-inches-thick file documenting her admission at a London ER. Already experiencing unprecedented formal requirements regarding documentation, they saw the copious documents and forms as a clear indication of what their own work would inevitably look like in the not-so-distant future. For the referential reality of Europe also translates into a temporality with a clearly defined *telos*—a temporality of development, modernization, and "catching up" that has permeated both public life and private aspirations in postsocialist Poland—that takes very concrete shapes in clinical standards and protocols.

This comparative style of reasoning was made explicit to me by Professor Matej. When I brought up the apparently increasing rates of mood disorders in a conversation with him, he agreed, but immediately added: "Yes, but compared to Europe we still have three times less. *We still have a long way to go* …" and then quoted from an official report on his computer: "'In 2006, Polish psychiatric establishments provided assistance to four percent of the population. In Europe in the same period, [the number was] eleven percent.'"

> So something has started to move, but *[we're still far] behind the standards*. … I think that in Warsaw things may be more or less the way they are in Europe, but the rest of Poland is dragging it down. … Assuming that our culture today is not much different from the culture of Western Europe … we can also say that we're still … operating within the lesser part of the people who need help. … At least half of the people are not seeking any kind of help at all. … If in the West it's eleven percent, and we have four percent who use mental health care, [then] seven percent still haven't turned up.

Comparability, that is, the transposability and commensurability of data—the "liquidity" produced by the convention of the diagnosis (Lakoff 2005: 21)—is in fact the primary purpose of diagnostic classification.[19] As a member of the E.U. Poland is brought into the same "space of measurement" (to use Lakoff's words again) with Western Europe—a space that's at once comparative, aspirational (as achieving the level of development of Western European, "core" countries is a widely recognized ambition, goal, and measure of Poland's development), and corrective (as it continues to reveal a yawning gap between those aspirations on the one hand and actuality on the other, or between the referential reality derived from foreign data and the experiential reality registered at home).

Clinical agency

The diagnostic transformation described above is still better captured by Georg Lukács' (1964) critique of objectification or "reification" ("thingification," *Verdinglichung*) and his distinction between realism and naturalism. The technical, non-etiological, and detailed definitions of new diagnostics might be seen to amount to little more than naturalist accumulation of details, "hollow bravado" (Steiner 1964: 13), only undermining the realness of the entities they define. But for Lukács, the reification of life was fundamentally an effect of alienation that cuts a person off from the world she inhabits, imbuing relations between humans with a thing-like quality, a "phantom objectivity."[20] What I mean to suggest is that, similarly, the technical diagnostic definitions both signal and effectuate particular forms of alienation experienced by Polish psychiatrists in public health care settings. This is an alienation that is more concrete and specific than a general domination of the scientific worldview: a diminishment of their clinical agency.

In Dr. Bugajska's narrative, clinical agency is signaled by recurring remarks about the "softness" and "hardness" of things and about diagnostic rigidity and looseness. Such remarks—sometimes explicit, other times less obvious—appear regularly in her account and are quite common in other psychiatrists' narratives. And they articulate an apparent contradiction: the new system is described as "rigid" or "stiff," but also as "softening," "blurring," or "diluting" categories (*łagodzi*, *rozmywa*). The way the ICD-10 is used in clinical practice appears alternatively inflexible and, contradictorily, loose, with a tendency to "round off edges" and shy away from "hard facts." While the purported precision of diagnostic definitions evokes the sharpness of surgical instruments, they are repeatedly described as "mild," "one milder than the other," they lead to "pretending," when serious illnesses are called mere "disorders," "making it murky for the patient" (*zaciemnia się pacjentowi*). This perceived rearrangement of hard and soft facets of reality speaks, in fact, to an actual rearrangement of clinical power dynamics and testifies to a degree of alienation of physicians from the clinical process itself. Put otherwise: it speaks to a "reality gap" between proclamation and actuality within the clinical process.

The juxtaposition of the "nightmare" of the highly formalized current classification system and the praise of the more interpretive diagnostic style in the past suggests that "rigidity" is a matter of limiting of the physicians' liberty in interpreting symptoms, naming conditions, and devising the parameters and course of treatment—in other words, a matter of limiting their control over the diagnostic and therapeutic process. The greater generality and malleability of diagnostic practice in the past (broader categories and less external control and scrutiny, since the role of diagnoses in organization and financing was minimal)

meant more power in the hands of the medical staff, especially those in higher positions in clinical hierarchies. The unknowability of the mechanisms apparently at work behind symptoms left more of the interpretation and decision making to physicians. This fit with the hierarchical, pastoral power of the doctor, characteristic of modern medical professions and institutions and deeply entrenched in state socialist medical services (Rivkin-Fish 2005).

With the increased formalization and symptomatization, some of that power has been absorbed into the diagnostic system and the organizational structure behind it. With the democratization and marketization of health care (a turn towards patients' rights as well as their responsibilities), another portion of it has been rerouted to the patients.[21] What from the ICD authors' perspective is an increased "flexibility and stability" of the classification (ICD-10 2011)—such as its a-theoretical and non-etiological approach and its ability to expand to contain more decimal codes and subcategories—translates into greater pervasiveness and the ability to penetrate and standardize diagnostic narratives, subjecting them to rigid scrutiny as units of financial accounting.

As I show below, in the medical care system-physicians-patients triad, the redistribution of power effected by neoliberal reforms since the 1990s has generally meant a relative outflow of power away from physicians (especially in public health care) and towards, on the one hand, the "system" (in the form of objective formalization) and, on the other hand, patients/citizens (in the form of responsibilization and patients' rights and choice). The reform and formalization rearranged flexibilities and rigidities among different groups of actors and actants (Callon 1984; Latour 1993b: 159–160, 2007: 54–55).

First, on the "system" side, as I mentioned earlier, following the health care reform, diagnostics came to play a wholly new role in the medical system. The reform, an effort to finally dismantle the state-socialist model and shift to a Western European one,[22] radically changed the way health services were financed and opened the way for their privatization. Touted as fulfilling the goals of the systemic transformation a decade after its high point, it consisted in the transition from state budget to insurance-based financing of medical services; the transition from the distributive logic of state-paternalist care to the calculative logic of competition and supply and demand of the market. Still in the service of fulfilling the biopolitical goal of the state, the reform's goal was to provide all citizens with universal and equal access to a health care system (Collier 2005a).

Under state socialism, the main operational categories were substantive: hospitals, wards, and outpatient clinics that were workplaces for employees and provided care to patients. Just like in other realms of the command economy, the financial organization of health care was characterized by "soft budget constraints" (Kornai 1992: 142–146; Verdery 1996: 21, 42), and funding was

allotted primarily according to size and substantive measures (the number of beds and staff) rather than actual clinical "output" (the number of patients treated or specific services provided). A larger clinic with more employees was thus better funded, regardless of how many patients were actually being served, and exactly how the money was then spent was largely up to the director of the given entity. There was little in terms of ongoing audits and controls (*kontrole*); these, too, were "substantive" and sporadic. Important statistics concerned the provisioning (for example, again, number of beds) rather than prevalence (for instance, use)—and diagnostics were largely a therapeutic and clinical tool. The system on the whole, however, was insufficient and failing in its fundamental function of providing free health care to all citizens. As an extensive article in *Gazeta Wyborcza*, summarizing the problems with health care in Poland in 1990, put it, "the universally accessible and free medical care is a fiction" (Cichocka 1990: 6).

During the 1990s, financing was rationalized and limited, "soft" budgeting was replaced by "hard budgeting," putting many hospitals and clinics in severe financial hardship and leading to cuts in both service and employment. The financing model, however, didn't change. That only happened with the reform, which, between 1999 and 2003, introduced a single-payer, universal insurance model and changed the main operational category to "service rendered." Premiums were collected from individual income taxes (7.75 percent, and then nine percent of individual income) and deposited in the newly established National Health Fund (*Narodowy Fundusz Zdrowia*, NFZ).[23]

Health care providers—public or private—would now tender for contracts with the NFZ for a specific number of services planned for the year, each service designated by the appropriate ICD-10 code, precisely standardized and priced in the NFZ catalog.[24] The NFZ would also increase audits and quality control, regulating in much greater detail the care offered to patients and the work of physicians and staff.[25] It would develop lists of drugs to which specific levels of reimbursement applied if prescribed for specific ICD-10 conditions. At the same time, social insurance benefits, such as sick leaves and disability pensions, came under unprecedented scrutiny.

In other words, the realification of mental health care was experienced by physicians as diminishing their clinical power opposite a formal diagnostic system. Whereas institutional organization under real socialism left a significant amount of informal wiggle room that generated a particular space of agency—space for the use of personal "connections" (Dunn 2004, 2005; Ledeneva 1998; Verdery 1996), a socialist "gap" between how things were officially devised and actually done—postsocialist, neoliberal forms of governance limited that space by becoming increasingly formalized, standardized, finance-oriented, and controlled

(Rottenburg 1994). The scheme was supposed to be autonomous and transparent. Where there once was jockeying for resources and a pecking order among party and local officials, there now was a complex algorithm devised by the Ministry of Health. The distribution of flexibilities and rigidities had changed—and had done so in a patterned fashion. The "locus of control" was shifting.

But clinical agency was not only limited by the new diagnostic, financial, and organizational arrangements brought about by the health care reform. The legal changes that instituted norms of liberal democracy in the public and medical realms also significantly limited doctors' power over their patients and their ability to control treatment, while granting guarantees of rights protection and self-determination to patient-citizens, along with corresponding responsibilities.

One of the most frequent observations psychiatrists have regarding clinical practice in the "new reality" concerns the level of their involvement in the care of and control over their patients. Calling a patient at home or paying a home visit, or even having them committed without consent (but often at the request of the family), used to be common and considered an element of care—paternalistic, sometimes authoritarian, but seen as necessary for achieving best outcomes.[26] Continuity of doctor-patient relationships was supported by the districtization model. Generally, patients could only regularly use health care facilities in the district where they were registered as residents.

In this way, although community psychiatry was never very well-developed in Poland (indeed, it has been a proclaimed direction of necessary changes for several decades, as archives of both popular and professional publications clearly show), some of the social work of outpatient supervision and securing continuity of care used to be provided by physicians themselves within the previous model of health care.[27] It was often done semi-formally, as part of the doctor-patient relationship and within the more lax system of physician supervision.

One of the explicit goals of the 1999 reform was *flexibility* and giving patients a consumer choice by lifting "districtization." At the same time, the doctors' ability to control their patients (for example, sending them summons to report back for check-ups) was greatly limited by the expansion of citizenship rights brought with democratization in the 1990s: the 1994 Psychiatry Act introduced a number of formal restrictions on hospital committal bringing Polish law to a par with Western European standards; the 1997 Personal Data Protection Act limited the distribution of personal information, and so on. Remarkably, these changes placed much of the *responsibility* for psychiatric care on the patient him- or herself, extending the notion of the liberal, self-governing subject onto the very figure traditionally marking the limits of rationality and sovereignty (Davis 2012a, 2013; Foucault 1965, 2008a).[28] The lack of continuity of care, even in the case of patients whose rationality and individual capacity for self-determination

is unquestioned, has contributed to draining the depression diagnosis of its realness in one more way. Choosing and changing doctors in a flexible system means fewer lasting clinical relationships and more first-time patients coming in already with a diagnosis. But, as many psychiatrists told me, "a diagnosis of depression could mean anything."

The diminished sense of clinical agency—and the frustrating realization that after years of working to get rid of the fictions of the old system, the new one had not only created new fictions, but had also made the informal practices necessary to navigate them much harder—was made explicit to me by Dr. Zbigniew Komorowski (name changed) at the Institute of Psychiatry and Neurology clinic in Warsaw. Talking about the increased control of physicians' labor, he made repeated references to the past. Since physicians in the public health care system remain heavily underpaid in Poland (relative to pay in the private sector), most of the medical staff keep one or more jobs on the side to make their profession profitable. But the practice of leaving the ward midday (around two o'clock here, somewhat earlier at the Nowowiejski Hospital), long a part of the work culture, was now coming under scrutiny and a plan of installing a formal clocking-out procedure had been put forth by the clinic's administration. At the same time, the state agencies regulating prescription and social security entitlements (NFZ and ZUS) no longer allowed doctors while at one workplace to issue prescriptions to patients they were officially seeing at other locations. Prescriptions were now assigned to the institutional service provider rather than the doctor as a person. In these and many other ways, psychiatrists' agency had been restricted:

> We used to feel freer [before the implementation of the reform]. I mean, a lot was in our power [*dużo zależało od nas*]. And now we are as though in the fetters of the NFZ [*jesteśmy w takich okowach NFZ-u*]. They've really tied us down [*bardzo nas skrępowali*] in a lot of ways.

That day, Dr. Komorowski, the head of the affective disorders ward at the Institute of Psychiatry and Neurology's psychiatric clinic, had to address a situation that epitomized some of the practical issues of clinical agency in the specific context of Warsaw and Polish mental health care. A woman in her early forties, pani Magdalena, who had recently been admitted to the ward and was now supposed to be discharged—she was diagnosed with a personality disorder and the ward didn't have the contract to keep her—was not getting reimbursed for the costs of her stay. She had sought help from a public psychiatric outpatient clinic (*poradnia zdrowia psychicznego*) but was told that the first available opening was in November (it was late June). The young physician in charge of her

treatment was going to discharge her but had not prepared any path forward—any continuing care.

Technically, she should have access to an outpatient clinic or a "mental health center" (*centrum zdrowia psychicznego*), a form of care linking hospitals and community psychiatry devised by the National Mental Health Protection Program (*Narodowy Program Ochrony Zdrowia Psychicznego*, NPOZP), a policy document approved by the Polish parliament (after years of delay) in 2010 and technically in force but practically left without the funds for implementation required by law.[29] "The centers exist—on paper. In reality, they don't," Komorowski told me with a mixture of frustration and irony. "What we have instead is guerilla action [*partyzantka*]"—clinical and institutional bricolage in an effort to avoid discharging people "into the void." Leaving it to the patients themselves to "responsibly" arrange care for themselves, even if it were more readily available, was, in Komorowski's view, unreasonable. "Our patients are very helpless, very un-self-reliant. They will precisely *not* take care of it—and end up left with nothing."

A path forward would at least include arranged access to another clinic, where p. Magdalena could renew her prescriptions, not to mention any form of psychotherapy. None of the doctors could or would prescribe her drugs for five months (if only for risk of suicide) and the patient objected to going home because she "couldn't stand it" and would "decompensate." She preferred to stay in the hospital. Since she could afford private care, the easiest option was to change her diagnosis to fit the contracted specialization of the ward.[30] "If we stretch it a bit," Komorowski said, "it will become a depressive episode." The problem is, this would effectively misguide the next psychiatrist on p. Magdalena's "path forward."

Komorowski also doubted that staying in their ward would actually be good for her. The second option was to try and find a place for her elsewhere—and that's eventually what happened. Although the Institute of Psychiatry and Neurology neuroses clinic was formally full and the waitlist was long, Komorowski arranged for things to be "moved around," procuring a spot for the patient. As the head of the affective ward and of the psychiatric clinic, he held considerable cache on the informal market of connections, favors, and "pull" in Warsaw and beyond. "I have hospital access and that's valuable to many. So if someone's nice to me, I can be nice to them—and there is a long line to see me as well, so I have something to sell. But this system is about as sick as that of ration cards for meat," he said, referring to the rationing system used in Poland throughout the late 1970s and all of the '80s. "It's nonsensical. I suspect it's a Polish specialty and the Anglo-Saxons (*Anglosasi*, a term commonly used in Polish to refer to the English-speaking countries) wouldn't understand what I'm talking about."

This belief that the organizational disorder he was describing would not be found in the Western—specifically "Anglo-Saxon" world—was a characteristic effect of the referential reality of the West continuing its hold on the Polish imagination and the persistence of the "reality gap." Poland, "here," was still falling short of the standards and ideas of how things would be in the "new reality."

When, sometime later, Komorowski was telling me about the importance of a sense of agency to a person's mental health (he explained it in terms of the Israeli psychiatrist Aaron Antonovsky's concept of *salutogenesis* and "sense of coherence"), we discussed "agency" in a broader, explicitly historical and political context. When I mentioned that a change in "the sense of agency" was, at least ideologically, a part of the transition[31] from communism to capitalism, his answer was telling:

> But to a large extent that change has not happened. … We don't have capitalism in Poland, I don't think. I strongly doubt that. We … in reality, very little has changed. … People still think that some "they" have done something to us.
> G. S.: Well, but you know, … it was like that with socialism, too. We never had socialism either. … [I]t was always the road to socialism—"real socialism" ["*realny socjalizm*"].
> Z. K.: We didn't have socialism, and now we don't have capitalism.
> G. S.: Now, the question is whether it's capitalism's nature that it doesn't really exist … I mean … We thought that socialism was evidently all baloney [*że socjalizm to ewidentnie wszystko bujda*] … because it was imposed from above so it was evident that "they" were commanding it, while capitalism is supposed to be happening on its own [*a kapitalizm niby dzieje się sam*], but that "happening" is very illusive.
> Z. K.: Well, yes, but it's still "they" that command—only a different "they."

Diagnosing purchasing power

The broad diagnostic realm of depression, from its "endogenous" to its "reactive" end and to the area where depression blends with "adjustment," "neurotic," and "personality" disorders is very much shaped by pragmatic considerations of the kind described above. What kind of treatment the patient is offered—whether it is primarily pharmaceutical treatment or a recommendation of psychotherapy, outpatient or inpatient, etc.—as well as what diagnosis they receive depends to a large extent on the psychiatrist's assessment of factors that extend beyond the clinical realm.

Diagnosing a patient with depressive symptoms, one wants to know, first, if it's not a matter of personality (crucial in this respect is a detailed personal history of the patient's life, with family relations, childhood events, and a record of relationships and careers along a culturally normal path of achievement stages). If personality is considered to be at issue, a recommendation of psychotherapy will be made. If an endogenous, or "biological" condition is likely, drugs will be discussed. In both cases, one has to assess the patient's financial capacity to pay for therapy or drugs beyond reimbursement limits. "A diagnosis of the wallet," as I've heard this procedure called.

While this pragmatic dimension of diagnostics has been critically explored by medical anthropologists (Farmer 2005; Jutel and Nettleton 2011; Martin 2007; Leibing and Cohen 2006; Risør and Nissen 2018), my analysis focuses on the ways in which economic assessments of and negotiations with the patient figure within broader modes of producing realness in the contexts of depression's mutability, the realification of Polish health care, and Poland's "new reality" more broadly.

In "socialist" health care, medicines were free to inpatients and distributed to outpatients at minimal charge. Similarly minimal, however, was the availability of new, Western-produced pharmaceuticals, and the overall supply of drugs was prone to shortages, just as was the case with most consumer goods. After the reforms of the 1990s, discounts on medications became available only to patients within specific diagnostic groups. For example, a chronic condition entitles a patient to purchase the drug for a greatly reduced fee. Psychiatrists are, of course, acutely aware of this; matching a disorder category with the patient's financial capacities is a major factor in formal diagnosing—especially in inpatient settings. Typically, a more severe and more stigmatizing diagnosis carries greater entitlements.

At the Nowowiejski Hospital, the doctors' practical concerns regarding patient compliance and continuity of treatment—in other words, whether the patient would continue to take the drug after being discharged (the hospital's own very limited supply of medications aside[32])—suggested "diagnosing up" in order to lower treatment costs for the patient. At the same time, the overall diagnostic policy of the hospital was to avoid stigmatizing diagnoses—if faced with ambiguity, better to "diagnose down." This commitment was guarded by the hospital's head doctor and defining figure over several decades, the deeply revered Professor Waldemar Szelenberger (referred to by his subordinates as *Profesor* with such reverence the capital "P" was almost audible). His clinical work was deeply informed by a concern with the stigmatizing power of diagnostic categories dating back to the antipsychiatric 1960s and '70s. The tension generated by these two opposing forces—diagnosing up and diagnosing down—would come up regularly during my time at the hospital. Diagnosis was not simply

a matter of identifying patients' illnesses but rather a point of articulation of clinical, cultural, economic, and bureaucratic factors.

What I witnessed in most cases was a problem of limited purchasing power, as in the case of pani Hanna, whom I first saw during her diagnostic interview with Dr. Walaszek. P. Hanna was a woman in her sixties with a history of depression. She had been hospitalized once before, five years earlier, with a depressive episode. Her current diagnosis was also depressive episode, possibly in the course of bipolar disorder; it was hard to tell, however, whether she had actually ever been manic or hypomanic. Following a line of questioning I recognized as fine-tuned to detect a possible history of (hypo)manic episodes ("Any periods of increased activity or agitation? Any significant purchases? What about credit card use?") (Martin 2007), the only abnormality she reported—indeed the main reason she was admitting herself to the hospital—was her inability to read.

"I couldn't read. I just couldn't," she said, sitting across from Dr. Walaszek's desk. "Not because I didn't feel like it or wasn't interested, or was tired. I just couldn't read at any length, I had to put it down after a few sentences." It was a curious trait and her diagnosis remained provisional. Indeed, about a month later p. Hanna "turned psychotic" ("*upsychotyczniła się*") and her case was discussed at length during the weekly general meeting with *Profesor*. She had been put on brand-name olanzapine, a neuroleptic that would be quite expensive for her to buy once she left the hospital. From there, the focus of the entire meeting became the correct "setting up of meds" (*ustawianie leków*) with respect to their market prices. The ward director (*ordynator*), Dr. Krystyna Kaczmarek, addressed the room:

> Seriously, you really need to think about how much those meds cost. A patient without [the right] diagnosis cannot have atypical neuroleptics prescribed. Who's able to pay several hundred złotys per month for meds? [Here she listed several brand names of drugs.] We are talking 300, even 400 złotys [at the time, $100–135] per month. At least you have to ask![33]

Shortly after the meeting, Dr. Walaszek and his colleague, a more senior resident, Dr. Stefan Rataj, talked to p. Hanna in the physicians' office: "Do you think you are able to spend 300 złotys per month on the medication?" they asked. "Of course not! Where would I get that from? [*Ależ skąd! Skąd ja wezmę*?]" Dr. Rataj and Dr. Walaszek paused and looked at each other in silence for a moment. "Great," the patient said. "Now we're going to start getting off this one and experimenting with other drugs." "How much would you be able to pay per month?" the doctors asked. She took a moment to think. "Well … 150 at most. I do take other meds, you know."

Dr. Rataj eventually decided to put her on the minimal dose of 10 mg, or even 7.5 mg, of the Polish-made generic brand of olanzapine to fit into that expense window. He matched the treatment up to the patient's symptoms, her responses to drugs—and her wallet. Now a matching diagnosis had to be made, too.

As medical anthropologists have long argued, the effectiveness of treatments depends not primarily on the chemical effectiveness of medications, or even patients' compliance, but on their *ability to comply*—which, to a high degree, depends on their ability to pay the necessary fees (Das and Das 2006; Farmer 2005; Petryna, Lakoff, and Kleinman 2006). Physical tolerance of the drug is crucial, too, as is the physician's perception of the patient as a person—his or her social support, needs, and aspirations.

Another patient, a high-school English teacher in his late thirties previously diagnosed with schizoaffective disorder (which carries no reimbursement for treatment), had been re-admitted after he stopped taking his medication. He was the patient of Dr. Byczewska. "When you're paying full price, taking yourself off meds comes much easier," she told me. This time, they diagnosed schizophrenia. It did not come easy; this is a diagnosis that weighs heavily on one's future. But so do the invasive medications one may be left to taking without it:

> Schizoaffective disorder is like 50 percent schizophrenia and 50 percent affective disorder. What we do is we diagnose schizophrenia with depressive symptoms and that's how the patients are discharged. That's how [the teacher] was discharged too. How could I have put a young man on haloperidol [the cheap alternative—an old and relatively invasive antipsychotic drug still in wide use in the Nowowiejski Hospital during my fieldwork] and get him totally whacked out [*żeby był kompletnie skuty*] and could do nothing more in his life? In this way, he's getting his meds for free—atypical neuroleptics, which work much better, because olanzapine is much softer, it doesn't wreck you as "halo" would in the long run. But some families just don't want the schizophrenia diagnosis. So they get F25 instead of F20. That's an omission in the system. Or a straight-up mistake.

Giving the patient a "lighter" diagnosis—whether in recognition of the family's wishes or out of concern for the patient's "dignity"—may also be problematic. Since the category of depressive disorder—a less damning diagnosis—sometimes plays that role, this contributes to draining its realness. And it brings us back to the problem of responsibility, care, and the specific situation of Poland, where growing socioeconomic inequality has coincided with the institution of liberal standards of citizens' and patients' rights. Dr. Bugajska put it explicitly in terms of a political and ethical problem:

> I don't want to put it all on doctors, so let's say: of society, which has the duty to care for sick people. The less sick they are, the less duties we have. We're signing a contract with the patient. We agree the [National Health] Fund will pay for six weeks for a patient, who needs to be given three months, six months, nine months—because one has to try a number of different regimens and we know that the patient will not continue the treatment at home, because [s/he] is alone, because [her] husband is a drunk, because [s/he] has five kids someone has to take care of, and so on. And [s/he] will not continue the treatment alone, because here [*u nas*, in Poland] it is not like in Sweden, where a nurse will come every day and take care of everything and even take you out for a walk arm in arm. *So we pretend it is like in the West. But, here in this country* [u nas] *we need those paternalistic elements. Because only that offers any kind of care.* … So there are two downsides of this very *loose* [*luźnej*] attitude [that is, impact on life decisions and poorer treatment outcomes], and here I'm sure I'm right. But my being right doesn't change anything, because they don't have money, so they can't keep the patient, they have to discharge, and in order to discharge, they have to classify him appropriately, that is, write down "discharged in improved condition." So it's both culture and reality [*realia*] I have told you about. Which [i.e., reality] I think also plays a role for them [i.e., in the West] because, after all, they understand all of this better … after all, we are still only learning this accounting [*rachunkowość*] while they have been using it for a long time. (Emphasis added).

By bringing it to a question of financial accounting, Dr. Bugajska makes clear that diagnostic codes today are not only categories of illness but also markers of value in the financial accounting of health care institutions. But they also translate into health and social insurance entitlements and access to medication. All of which have come to figure far more centrally in the diagnostic process in the new system, where uneven access is closely tied to individual purchasing power. In effect, the reality of inequality—the hard truth of patients' often limited financial resources—forces doctors to respond by manipulating diagnoses and treatment protocols, balancing what a patient may need with the calculus of what they can claim for a given diagnostic code and what may be available to them. This kind of technical performativity under conditions of otherwise constrained clinical agency undermines the realness that has been the explicit goal of Poland's health care reform—and, by extension, the broader outcomes of Poland's economic and political realification. Again, the "reality gap" has not closed, but shifted.

Conclusion

In the Polish psychiatric practice, the ICD-10 diagnostic category of depression—symptom based and intended to be objective and precise, thus claiming scientific and technical realness—is surrounded by confusion, distance, and distrust; in other words, it is depleted of realness. As I have argued, this "affective disorder" consists in several processes, especially pertinent to public health care settings. On the one hand, because of the shifts in the philosophy that underlies the current ICD classification itself, depression seems not quite "real" because it's not an "illness" but a cluster of symptoms bridging pathology and normalcy. On the other hand, the realness of depression is weakened because of the ways the diagnostic system operates in Polish settings specifically, in the context of the broader postsocialist, neoliberal realification, especially the 1999–2003 health care reform. The diagnostic category doesn't simply denote the alleged biological and psychological malfunction, but concomitantly serves as a unit of financing and organization, and at the same time connotes a referential reality of capitalist modernity, "the West," and the European Union, made concrete in its standards and regulations.

Depression's realness is further diminished because the category aligns itself with a liberal biopolitical form in which patients are regarded as autonomous subjects, are granted rights (to privacy and choice), and are given responsibilities at the expense of care.[34] Patients in need of psychiatric care—precisely those who in one view are struggling with their grip on reality or with reality's grip on them—are put in charge of themselves and of their functioning on this new, highly technical (and therefore paradoxically abstract), bureaucratized, and discontinuous terrain.

Through its role in the new system of the financing and organization of health care, psychiatric diagnostics has also been connected to the palpable limitation of clinical agency that physicians, and particularly psychiatrists in public clinics, have experienced in the last years in Poland: diagnostics mediate the absorption into the formalized and controlled health care system of some of the medical power that used to be at doctors' discretion. The attempts to reconstruct clinical agency, as I have described above, involve the creation of new diagnostic approximations, guerilla practices, and provisional "soft" responses to "rigid" rules that only maintain and reproduce the affective disorder surrounding depression in the new and orderly classificatory, organizational, and financial system.

PART 2

Therapeutics

Chapter Three

The psychopolitics of incapacity and care

The complex of three buildings at 42 Dolna Street in Warsaw's southern district of Mokotów is separated from the main street by a chain-link fence, a wall of green, a small yard, and parking lot. A dilapidated, gray, three-story construction houses three off-site wards of the Nowowiejski Hospital: a general inpatient unit; a similar psychogeriatric unit for elderly patients (about sixty inpatients in total); and a day unit that also offers group therapies in day care settings. Behind it on the right, in sharp contrast, is a recently built single floor unit painted in bright white with a red roof; it is *Centrum Psychoterapii* (henceforth CP), a public Psychotherapy Center catering to inpatients as well as outpatients. The third building, right across the small yard, is a large, old villa in rather decrepit condition, now rented out, and serving, somewhat oddly, as a commercial hostel to visitors unaware they are staying on the premises of a psychiatric unit. During the warm months, the benches in the yard and on the nearby lawn serve as a resting or smoking area for those able and permitted to go outside, who are often elderly, often appearing to be in a poor mental and physical state, their pajamas or bathrobes signifying their inpatient status. For the day-care patients coming in in the morning for their daily sessions, the presence of inpatients often served as a reminder of their own status and the challenge it posed to their self-perception as normal, healthy, or sane—a challenge reflected in recurring jokes about being, after all, in a madhouse (*w domu wariatów*).

Both outpatient clinical units offer group therapies that follow a similar format: daily meetings in day care settings—five hours five days a week, lunch included—over a three-month period, each group consisting of ten to fifteen patients and two-three therapists (plus, possibly, interns), with the additional support of a psychiatrist physician in charge of medical and pharmaceutical supervision. This format is the most popular form of psychotherapy available

free of charge in the public health care system in Poland; around 300 locations offer this kind of treatment and reach around 8,000 patients each year (Suszek et al. 2015). "Most popular" does not, however, mean widely accessible. 300 locations in a country of 38 million people is drastically insufficient and wait lists to join a group may be up to a year long.[1] On the whole, access to any psychotherapy in free-of-charge settings in Poland is very limited. Individual therapy is rare, and groups, like the ones discussed here, are located in large cities and are very few. For most persons with symptoms of depression who actively seek help but want to avoid paying out of pocket, the first contact will be the primary care physician, who may prescribe antidepressants or—which has been a problem—benzodiazepines (highly addictive anxiety medications not indented to be used to treat depression, but, according to the psychiatrists I talked to, commonly prescribed by primary care doctors). Alternatively, patients can seek help directly from a psychiatrist or a psychologist at a public psychiatric outpatient center (*Poradnia Zdrowia Psychicznego*), since psychiatrists are among the few medical specialists one can visit without a primary physician's referral. The typical treatment will also be pharmaceutical, with monthly or bi-monthly checkups. In some places, however, appointments, especially for a first visit, may be already booked for weeks or months in advance (depending on the place and time of the year—later in the year a clinic may already have run out of contracted hours). It is therefore often faster to see a psychiatrist in private practice or a private health center, where a first visit would typically also last longer, not to mention be in a more upscale setting, but the cost of roughly 100–150 złotys ($35–50 in Warsaw, 2010) per visit is prohibitive to many—unless one holds an insurance plan with a private provider, which some employers offer.[2] Often, an ongoing negotiation that pitches financial capacity against a perceived quality of medical services (public or private; out-of-pocket or public-insurance-covered) and that hierarchizes personal medical priorities is a central part of the process of seeking care. Assuming a standard of one session per week (common in cognitive-behavioral therapy, see below), it is still cheaper to pay for a supply of antidepressants and even a private visit to a psychiatrist. Regardless of the place of visit, if the psychiatrist observes symptoms or cues in the patient's life history that suggest a diagnosis of neurotic or personality disorder might be applicable, he or she may recommend psychotherapy as the preferred treatment—typically in addition to, rather than instead of, drugs. The patient is then back on the path of looking for available care.

But access to adequate public health care is only part of the story. Admission to a group means not only luck in finding free-of-charge treatment in a public facility, but also entitlement to a number of social security benefits. Most of the outpatients I came to know over the course of several months observing at Dolna

Street were indeed receiving one or another form of social security, generally with the exception of those who, as the therapists put it, had difficulties "entering adulthood" and were still between school and work, often living with their parents (as is common in Poland until the mid-twenties). All the patients I met who were employed at the time of therapy (or registered as unemployed) were on sick leave for at least the three months of the group's duration, and this leave could last up to six months and paid 80 percent of the person's usual salary.[3] Some were applying for, receiving, or seeking to extend other forms of benefits. If partial incapacity to work (i.e., significant loss of capacity to work in line with professional qualifications) was confirmed by the Social Insurance Institution (*Zakład Ubezpieczeń Społecznych*, or ZUS) or by a certifying physician (*lekarz orzecznik*), patients could receive a very humble disability pension (*renta*) for a year or more, with the possibility of renewal.[4] An alternative form of pension was the rehabilitation benefit (*świadczenie rehabilitacyjne*), given as an extension of sick leave for up to one additional year, also at around 80 percent of last income level.[5] The rehabilitation payment was therefore relatively higher; by definition, however, it has the purpose of restoring one's capacity for work—it is a part of the ZUS's prevention policy.

The diagnosis and the discharge documents patients received at the end of the therapy served as basis for benefits applications and, as the therapists saw it, some patients were more interested in that than in any other potential outcomes of the treatment. The humorous and yet at least subtly or unsubtly dismissive pun I often heard used by the clinic staff was "*przewlekła rentoza*" "chronic *rent*osis"—pathological dependence on benefits. As Dr. Krzysztof Zientarski, the director of the CP, explained to me:

> Some patients come from the start with the intention that they need another paper for the ZUS, to prove to the ZUS that they are unfit for work and life … They're offered therapy, but they don't have therapy in mind but rather that they will be in treatment and eventually they'll receive a certificate that they're untreatable (*nieuleczalni*). They will endure therapy to get that paper … You can see it clearly in that they boycott, they reject any possibility to see their own potential … exactly in order to escalate their sense of inability (*poczucie niemożności*).

Against some of the patients' claims to incapacity, Dr. Zientarski saw the CP as a place of activation, not protection. He explicitly contrasted its spirit with the remaining institutions of social care catering to people who hold little promise of improvement towards fully productive lives. His goal was to enable and support real change in the patients so that they might adequately recognize

and mobilize their own potential and resources in life. This is *treatment*, not *care*, he told me. Once, as we discussed links between therapy and the broader political and economic and ideological changes in Poland, he stated, again contrasting the CP with institutions of passive care, such as large psychiatric hospitals of the past, where patients could live for years: "We act in the pro-freedom, pro-democratic, and pro-capitalist direction."

This chapter addresses the psychotherapeutic *urealnienie* (realification) of depressive patients within the public health care and social insurance system as a key dimension of the biopolitical relationship between the citizens and the state. With the gradual demise of the 20th-century welfare state model, the medicalization of both political and ethical claims to protection and care, and the rise of new biotechnological security regimes, much debate and research in anthropology and social and political theory more broadly over the last two decades has centered on Foucault's concept of biopower (Biehl 2005; Collier 2005a; Foucault 1980a, 2008b; Petryna 2002; Rabinow and Rose 2006; Rose 2006b, 2007; Ticktin 2006, 2011; see also Agamben 1998). Here, however, I want to address a much narrower and more specific biopolitical aspect of psychotherapeutic treatments of depression in Poland's postsocialist reality, shaped by the contradictions of what I call "real neoliberalism," or "actually existing" neoliberalism in Poland.

"Real neoliberalism" signals the uneven implementations of neoliberal policies in specific local circumstances and the ways those implementations often require an active engagement of government in apparent contradiction to neoliberalism's proclaimed laissez-faire character (Brenner and Theodore 2002; Cahill 2010; Collier 2005b; Ryan 2015). As an analogy to "real socialism," it draws attention to the continuing "reality gap" at its center and to the elusive and illusive nature of realification. In this context, the term *rentoza* is at once humorous and poignant, as it points to a concrete link between the apparently dependent "positions" and personalities of the patients at Dolna Street (unrealistic; unrealified) and the position of the Polish society, or body politic, relative to the promises and deficiencies (fictions) of postsocialist governance.

From care to assistance

During the transformation period, the state's existing disability pension system served, along with the newly established unemployment benefits, as a part of a buffer mechanism, "absorbing" those who could not find a viable place in the new economy but whose mass and complete abandonment could produce high political costs. During the mass restructuring of the economy in the early 1990s, unemployment climbed from nominally zero to sixteen percent in just four years,

1990–1993,[6] reaching the level of nearly three million adults. The number of people receiving disability benefits, always large as part of state socialism's "hidden unemployment," also climbed from around two million in 1990 to 2.7 million, where it stayed in the mid- and late 1990s, when a disability pension was the main source of income in about one in ten Polish households (Warunki życia ludności 1998).

Going on disability (*przejść na rentę*) and early retirement were ways to withdraw from the workforce for those whose chances of finding employment in the "new reality" were negligible. Such *renty* were considered socially legitimate even though, in strictly medical terms, their legitimacy and "realness" were often blurry. As a part of the social contract of the transformation period, disability pensions were easy to obtain (up to 300,000 new ones were issued per year in the 1990s), but, as a downside, paid very little money—their value often barely supported an existence near the social minimum (*minimum socjalne*), leaving the recipients continuously dependent not just on institutions, but also on their families and social networks, and leaving the state with a heavy burden of providing financial benefits, however small, to a significant portion of the population who remained, at least on paper, "unproductive."

Since 1999, the Polish government's efforts to drastically limit the number of *renta* pensioners (*renciści*)—and thus to withdraw from its part of the unwritten contract of the 1990s—was a marker of the end of the transformation period. Effectively, over the last seventeen years, the number of *renciści* has gone down by 1.7 million (in a total productive age population of 25 million).[7] At the same time, a new type of temporary pension, the rehabilitation benefit, was introduced as part of an effort to both prevent more serious absenteeism and "activate" the ailing citizens, rather than allowing them to permanently drop out of the labor market, becoming passive and dependent.

Indeed, since 1999, the number of citizens receiving rehabilitation benefits has gone up nearly fourfold—from 21,000 to 78,000 in 2015 (Kostrzewski 2015). However, it amounts to only a fraction of the 1.7 million decrease in the number of disability pensions disbursed, further emphasizing the shift from a socialist, or welfare, state to a neoliberal one. The legal basis for *renta*, previously formulated in substantive terms of *inwalidztwo* (status of an invalid), was in 1996 replaced by formal and productivity-related terminology of incapacity to work (*niezdolność do pracy*), which may be temporary, lasting, partial, or (rarely) complete. Similarly, the names of social security institutions and programs in Poland changed from referencing care (*opieka,* as in *opieka społeczna,* social care) to *pomoc*, assistance or aid (*pomoc społeczna*).

Depression and neurotic disorders have been a large, although largely obscure, part of this story.[8] Throughout the 1990s, between ten and fifteen percent

of disability pension entitlements were issued on the basis of depression or neurosis—indeed, *nerwica* (neurosis[9]) had been considered one of the easiest diagnoses for which to obtain *renta* (next to such conditions as back pain) (Zyss 2005). Often, those diagnostic and disability qualifications could more accurately be described as "social cases" (i.e., offered care in light of their socioeconomic rather than strictly medical situation, see Friedman 2009).[10] On the other hand, persons with adjustment and neurotic disorders decompensating in a difficult situation may just as well have been diagnosed with somatic problems (such as back pain), whether for cultural reasons (such as stigmatization, still prevalent in the 1990s, especially outside of urban centers) or because the symptomatic manifestation of their distress was indeed primarily somatic, as continues to be common today.[11] In addition, as Polish medical jurisdiction literature states, cases of depression, neurotic and stress-related, and personality disorders are particularly difficult in disability assessment: neurosis can be successfully treated and does not constitute a lasting incapacity on the one hand, but on the other it may interfere with work and overall functioning to the extent that adjudicating partial incapacity to work may be justified (Trzebiatowska 2010). A diagnosis of depression may signal a neurotic or personality disorder, and the latter diagnosis is not generally considered a justification for incapacity to earn an income.[12] In effect, particularly as it concerns patients with "milder" psychiatric disorders, the role of the state as a provider of care (now, assistance) remains ambiguous.

When I asked Dr. Zientarski and Dr. Magdalena Werner, a psychiatrist and psychotherapist at the CP, about the state's putative withdrawal from the provision of care—the popular image of neoliberal statehood—they immediately corrected me:

> K. Z.: No. The state is just tangled up in a system from which it can't disentangle itself.
> M. W.: In this sense: it's not clear what its obligations [*zobowiązań*] are. … Because some of these people … well, there are two groups: there are those who don't feel like doing anything [working] and they follow the hard line of the old way [reference to state socialism] that they simply deserve, they have a demanding attitude (*roszczeniową*). But I think there is also another group who actually don't really have a way out. Meaning, those people who may be of such age and such professional skill level that [they really don't]. Say, people who have worked at the same workplace for thirty years. Stamping some papers, right? Sometimes it's nice with such people when it turns out that they may not believe they have any, say, adaptive abilities left in them, but in fact they do. And it's not so psychopathic on their part that they are just negative (*na nie*) from the start, but [it's] more

based on a belief that one can actually change. This group is probably larger in the country, because in Warsaw it's easier to find work. And some just don't want to work, they're lazy …
G.S.: Lazy? Maybe they have depression? …
K. Z.: Yes, a *veeery* long depression.
M. W.: These are unfortunate effects of the press campaign about depression years ago [that laziness is in fact depression].[13]

Just as the diagnostic divisions are in practice blurry, so is the attribution of incapacity to the "person" as isolated from her circumstances an exercise in indefiniteness. Whether the patients will turn out to be suffering from *rentoza* or a "legitimate" condition is a matter of not only diagnosis but treatment and medical certification, in a situation where forms of assistance are at once badly needed and claimed to be psychologically detrimental (dependence-producing), offered and retracted, tempting and insufficient. In patients' accounts, seeking public assistance occurs in the same affective registers as their more personal and existential challenges—and it "provokes" the same subjective positions that therapists target in the treatment. In effect, the new definitions, regulations, and practices concerning disability pensions have placed patients in a new position of negotiation with the state—a negotiation, practical and affective, of financial benefits and the assessment of incapacity to work (extending to the ability to find and keep a job in the specific socioeconomic and personal circumstances), where the moral and substantive claims of entitlement to care in the face of a difficult reality have been replaced with a procedural and formal framework surrounding the claims' legitimacy and rehabilitative efficacy.

This shift of individual relationships to the state from substantive to formal—from a passive one of need and care to an active one of diminished capacity and assistance—maps onto the work the patients do in psychotherapeutic groups.[14] Through the architecture of general rights and specific entitlements to medical care (NFZ-funded) and social insurance assistance (from the ZUS), the therapeutic process focuses very concretely on the subjective dispositions at the heart of individuals' relationships to the state as a precarious provider—even though the state as such is rarely referred to explicitly in treatment. The intention is indeed for the patients to achieve greater independence and "maturity."

As I show below, the therapeutic work seeks to support patients in leaving behind what is thought of as spaces, periods, and "positions" of protectedness and entitlement (infantile demands impossible to fulfill and generating frustration) by learning to experience their emotions and understand their thought patterns in order to advance to a more "mature" place in life. Although these are processes and techniques that seek to therapize the psyche, I consider them here as ways

of engaging—through participation in publicly funded three-months-long therapy and through public assistance—in a relationship with the state, whose provisions are inconsistent, ever present in patients' lives, but always precarious. On a broader scale, this engagement and reshaping of the psychic dimension of citizenship—a psychopolitical relationship to the state[15]—addresses one of the main ways in which Poland's political and economic *urealnienie* didn't simply bring the reality gap of state socialism to a closure but instead produced a new one, harder to articulate.

Discussing aspects of the same dynamic I explore throughout this book under the concept of *urealnienie*, sociologists Arista Maria Cirtautas and Edmund Mokrzycki have examined what they called a gap between the *articulation* and *institutionalization* of liberal democracy in Poland during the postsocialist transformation. They convincingly argued that the initial articulation of what the democratic state would be—an articulation that resonated strongly with most of Polish society since beginning of the Solidarity movement in 1980–1981—rejected state socialism in the name not of (neo)liberal democracy but of a system of self-governance where broad distribution of resources and employment (and provision of care) would continue but would be controlled by the collectivity rather than the corrupt party hierarchy (Cirtautas and Mokrzycki 1993). In other words, this articulation was centered on a *substantive* and *collective* (rather than individual and formal, or procedural) interpretation of rights and, drawing on powerful cultural forces such as the tradition of national independence movements and Catholic notions of dignity, it united intellectuals and workers with a strong support of the Catholic Church.[16]

This articulation, however, was never realized: the post-1989 market democratic reforms paved the way for an institutionalization of a capitalist and neoliberal kind, at odds with the original social formulation, alienating the very social groups (primarily the workers) who had supported it and embedding in the body politic a contradiction that remains unresolved (for a discussion of the "defeat of Solidarity" and its affective and sociological aspects, see Ost 2005).[17] This largely unrealized articulation is central to the fiction of Poland's particular version of "real" or actually existing neoliberalism, and it haunts the psychotherapeutic work that targets the dependent, immature, and adjustment-disorder-plagued patients who continue to rely on—and feel let down by—contemporary state forms of care and assistance.

Just as it was crucial to the articulation of democracy in Poland in the 1980s, another presence that haunts or informs patients' therapeutic process is that of the Catholic Church as a cultural institution and Catholicism as an ethic and religious practice. Rarely made explicit in the sessions themselves, popular, cultural Catholicism continues to shape, in ways both palpable and subtle, not only

the patients' lives and ethics, in a Weberian sense, but their relationship with the state and thus the "psychic life of power" (Butler 1997) in today's Poland.

This chapter brings us into the intimate space of group psychotherapy and addresses the ways in which patients' psychological dispositions, those most important to their psychopolitical relationship to the state, are understood and targeted in the therapeutic process. I focus on three dispositions that were essential to the *urealnienie* the therapists sought to bring forth in their patients. One was the attainment of and working through the *depressive position*. Originally coined by the British psychoanalyst Melanie Klein in her writings on infant development (Klein 1952, 1975a), the depressive position was regularly brought up by the Warsaw therapists (especially the psychodynamically informed ones). Its implications refer to the second central theme, that of *maturity*. The depressive position is a necessary and natural mark of maturity, or adulthood, and represents an adequate and functional approach to reality. The third theme is that of *emotionality* and emotional experience (*przeżywanie*), understood in a behavioral fashion and posited as crucial to being in touch with reality, adequately responding to it, and "taking care of oneself."

Efforts to cultivate these dispositions are also ways in which group psychotherapy constitutes a technique of realness. The therapists understand most of these patients' depressive symptoms as related to "problems with reality," to not accepting that reality will not yield to their expectations or provide for their needs, and it is this relationship that is the main target of therapeutic intervention in the three-months long intensive group setting.[18] The alleviation of symptoms and, more broadly, a functional—livable—life, are in this view only possible if reality is perceived maturely and adequately (maturity, *urealnienie*), experienced emotionally (emotionality), and accepted for what it is (depressive position).

I argue that these dispositions—*maturity*, *depressive position,* and *emotionality*—are realifications that are key to the practical and affective reworking of the bio- and psychopolitical relationship with the state; a relationship that, in this context, centers on pension entitlements posed against an institutionalization that has veered from the early articulation of Polish democracy as distributive, substantive, and collectivist. Furthermore, though I argue that these therapeutic techniques aim to shape dispositions in line with those of formal, neoliberal subjectivity, my observations were that patients in fact could and often did draw upon quite distinct notions of care—ones embedded in a more collectivist and substantive ethos. That ethos, shaped by the specific social realities of Poland's sociopolitical past (Leder 2014; Sowa 2011), supported by its particular forms of social personhood (Dunn 2004, 2005), Catholic ethics (Tischner 1984, 1987; Tischner and Życiński 1994), and in line with the substantive and collectivist articulation

of democracy spelled out by Cirtautas and Mokrzycki (1993), continues to inform patients' "working-through" of their resistances and color their insights about their "positions" in therapy. It emerges in patients' attempts to become materially and emotionally independent of care and protection, in their weighing their social relationships to others against their therapeutically inculcated commitments to themselves, and in their focused and intimate search for an understanding of what their emotions are telling them and of what accepting "what is" might mean.

Before exploring a few examples of this work of psychotherapeutic *urealnienie*, one caveat is important to make. While I am addressing here a bio- or psychopolitical relationship, the state as such is frequently at least one degree removed from my ethnographic account. Although claims for leave, rehabilitation, and *renta* entitlements are a point at which this relationship becomes overt, its "seat" is in the patient's particular set of dispositions as they are worked upon in the therapeutic group, in the kind of subjectivity they are assuming (Butler 1997; Foucault 1977, 1980b). The relationship to the state, although central to my argument, is therefore rarely explicit in therapeutic encounters and discourses and it is the goal of my analysis to draw out, fill in, and bridge the apparent "distance" between the psyche and the state.[19]

In what follows, I start by showing how the experience of *rent*osis might look as it emerges at the intersection of psychological need and social insurance regulations against a backdrop of the provision of care and support by a Church organization. I then discuss in more detail the way in which Warsaw therapists and psychiatrists understood *urealnienie* in the treatment of their patients and the ways in which notions of maturity, the depressive position, and emotionality were invoked during treatment. The stories of two patients in particular provide examples of the kind of individual *urealnienie* that occurs in therapy, involving the patients'—successful or not—process of repositioning vis-à-vis expectations and desires. I conclude by placing the presented material more explicitly in the context of Poland's ongoing political transformations.

"Chronic *rent*osis"

Pani Anna was a thirty-eight-year-old patient in the cognitive-behavioral therapy group at the CP who suffered from anxiety, depression, and obsessive-compulsive disorder, and who had also repeatedly sought disability benefits. A special education teacher, she had spent over two of the previous four years on either sick leave or rehabilitation pension.[20] She was pursuing her case with the ZUS and her workplace and was currently seeking an extension of her rehabilitation pension. She was also relying on forms of care she could find through

the Church; this allowed her to avoid public mental health services, which (in part based on experience) she thought to be of poor quality. The CP had a good reputation and she had been lucky to skip the long wait period when someone she knew had given up a place.

She started seeking mental health care at twenty-four, while struggling with "entering adulthood." She started to work as a teacher of children from "pathological families"[21]—a job her father had "hooked her up with" (*załatwił jej*)—but found it to be very stressful and poorly paid. For a long time, she couldn't afford to leave her family home and her relations with parents involved "emotional and psychic violence." P. Anna's neurotic problems seemed significant. Besides symptoms of depression and anxiety, which she readily recited (sleep disturbances, panic attacks, low mood, suicidal thoughts, loss of appetite), her OCD made her life even more difficult (once, after a fire in the basement of her apartment building, she had started bringing her iron and stove burners with her to work out of worry she'd forget to turn them off). Her relations at work were turbulent, likely in part because of her personality, but she spoke affectionately about the members of her prayer group.

During the crisis (*kryzys*) in her twenties, a friend invited her to join the Light-Life Movement (Ruch Światło-Życie), a Polish movement of Catholic renewal. Besides the friendly people and the sense of belonging she felt there (she doesn't bring up any details about her spiritual experience but speaks a lot about the Church as a resource), it offered personal confession and it was her priest who, "his cassock wet from her tears," suggested she see a psychologist or a psychiatrist. She had had a bad experience with a public clinic psychologist in high school, but a nun in her prayer circle referred her to a psychologist with a diploma from Warsaw's Catholic University and a vision impairment that prevented her from taking a full-time job and who therefore offered consulting on a sliding scale through the parish. The twenty-five złotys ($8) p. Anna paid per session was a quarter of the market rate in Warsaw at the time and the only sliding-scale offer I heard about during my research in Poland. P. Anna did also see a psychiatrist at a public outpatient center, but only to renew her prescription for Polish generic sertraline (the original, Zoloft, she claimed, was "purer" and had fewer side effects, but she couldn't afford it). During her year-long sick leave, p. Anna had entered a program in library science, planning a career change, as work with children was, as she had now found out, not what she was cut out for after all. When her sick leave ran out, she still had a semester of school left to finish. Sessions were held every other weekend—but she wouldn't be able to come back to work. She had a library internship and still wasn't feeling well. Her life during those months sounds idle and empty—a lot of sleep and listening to music, learning to swim twice a week, the psychologist once a week, a walk,

a mass, more sleep—but the sick leave was necessary, she says. "Something terrible, an act of violence really would have happened if I couldn't take that time off."

Determined to not go back to work at this time but to finish her program, she decided to request a rehabilitation pension.

> The lady in the ZUS chastised me up and down, brought me to tears—everyone leaving her office was in tears, women in their fifties, she was a real nightmare. The man I talk to now is like an angel, but she really treated me like someone trying to swindle money from the state, a liar pretending to have symptoms. But then she saw I was crying—*really* crying—because I felt treated unfairly and … she eventually gave me six months of pension.

After that time was up, however, p. Anna got another sick leave from her psychiatrist. "I had a relapse of depression and sat at home. This psychiatrist, she's known me for years and I think she has pity on me (*lituje się nade mną*)." Still employed at the school, p. Anna feared going back to the children and the colleagues who, she felt, disliked and mobbed her. "I could have gone back to work after three months, but I knew I'd just mess something up. So why even bother?" She was now on another four-month rehabilitation pension, for the period of her therapy at the CP and all of summer. "I could try and extend it [seek a *renta*], but I think I'd like to go back to work. I feel a little better now. And the therapists are sending signals that if I sit at home, I'm going to waste this therapy." Her lengthy pension, though a difficult time spent mostly in depression, had been important and helpful. It gave her something she needed:

> I felt taken care of [*otoczona opieką*, literally: surrounded with care]. The psychiatrist really understood me, she'd spend forty minutes with me every two months, the psychologist too, from half an hour to even two hours, that priest I had was also good to me. Every three weeks he'd tell me: "don't sit at home, go to therapy, look for work, discipline yourself—or it won't end well. Don't end up on *renta*, it'll be the end of you."

Quoting her priest, p. Anna articulates the dynamic of care and dependence playing out at the very center of her life and setting the coordinates of both her existential and political position. In her articulation, the need for safety and attention that she expressed so often seemed not only to permeate her personal relationships, but also to extend through the therapy room, the ZUS office, and the priest's confessional towards both the state and the Church.

The affective intensity of the application process at the ZUS also loomed large in the experience of other patients,[22] as well as in the view of doctor

Katarzyna Markowska,, a psychiatrist and certifying physician at one of the ZUS's Warsaw offices. "Almost every woman starts to cry almost as she comes in. It's too much," she told me complaining about her increasing emotional exhaustion from work. Recently, most of the applications she was processing were for rehabilitation benefits—and most were not for what she would call "real illness" but for depressive, adjustment, and personality disorders. "There is a lot of psychiatric requests now—but it's the effect of unemployment," she stated in a tone of obviousness. "There are a lot of layoffs now, especially from places like banks. The [financial] crisis is really hitting now. … It's truly terrible," she added, referring, in part to the distress caused by unemployment and in part to the flood of entitlement claims she saw as illegitimate and had to reject despite the pleading and the tears.

> If you're thirty-five, worked at a bank, you've been healthy so far … and the bank lays off 300 people this year, what kind of doctor do you go to for a leave? It just suggests itself. That's the mentality here [in this country], I'm sorry to say. … If you lose your job and have a stress reaction [adjustment disorder], well, okay, you may take a moment to adjust, but that's for a few months. But it becomes six months of basic [sick leave], then up to a year of [rehabilitation] benefits and then? In reality, they're not sick. They keep asking for more and this entitled attitude builds up (*roszczeniowość narasta*). And they think they'll get *renta*. … It's this "give, give, give!" attitude. … The way things are in Poland, it would never end if the ZUS didn't cut it short. The point is to get a job, but we are waiting—and there's no job.

Although she questions the legitimacy of the majority of such claims, Dr. Markowska admits that for some people, the stress is unmanageable. In so far as she's able in the at most forty-five-minutes she has per case, with the often slim medical documentation for persons without significant psychiatric history, she does her best to consider the person's overall functioning and to take into account their situation in the labor market as well, primarily in regard to age: "If someone over fifty loses their job, especially a woman, their chances of finding work are slim, right? That's a huge stress, I get it. I consider many factors in certification, so as not to harm people." Her considerations of applicants' personal struggles are, however, increasingly limited by the ZUS tightening audit policies (see Chapter Two). As a certifying physician, she identifies with her duty on behalf of the ZUS to cut short individual claims and protect state resources from abuse, but, in her both emotional and expert labor at the office, as she puts a medical, psychiatric lens to "incapacity for work," she also seeks to balance *care* against *harm*.

The inherent unreliability of the diagnoses of adjustment and personality disorders (considered as a common basis of depressive symptoms) in the context of benefits entitlement places them at the blurry point of intersection between patients' individual circumstances and psychological dispositions and shifting policies of what I call the "real-neoliberal" state in Poland.

Urealnienie: maturity, emotionality, and the depressive position

Centrum Psychoterapii, the yellow building across the yard from the imposing concrete "madhouse," ran five or six different group therapies and offered individual visits with psychologists, sexologists, and psychiatrists.[23] The groups were both psychodynamic and cognitive-behavioral and targeted specific clusters of disorders—personality, neurotic, or behavioral, in line with the contracts the CP had with the National Health Fund (ICD-10 codes F40 to F69)—with slightly different therapeutic approaches.[24] Even though many of the patients came with symptoms or prior diagnoses of depression, they received new diagnostic codes in accordance with the CP's formal certification and financing and the staff's psychological orientation. CP therapists and doctors generally saw depression as primarily symptomatic and sought to address what they saw as the underlying neurotic and personality disorders. Once at the CP, many of the patients were initially diagnosed with "mixed anxiety and depressive disorder" (F41.2), which the therapists agreed was a convenient diagnosis in ambiguous cases and allowed admission to a group; later diagnoses, based on extensive interviews and observations in the group, would typically go in the direction of neurotic, stress-related, or personality disorders.

The CP's director, Dr. Krzysztof Zientarski, an accomplished psychotherapist, psychiatrist, and sexologist in his forties with expertise in multiple modalities of therapeutic work, tended to combine cognitive-behavioral therapy (CBT) with elements of existential therapy.[25] The group I observed in the CP, run by Dr. Zientarski and p. Tomasz, was comprised of patients with predominantly depressive symptoms, but not suffering from an illness—in other words, the patient population by which the psychiatric realm in Poland has expanded the most since the early 1990s.[26] The therapists made use of a different and wider variety of activities than the psychodynamic group in the day unit. It involved guided relaxation sessions, greatly enjoyed by the patients, in which p. Tomasz would narratively take the group (as they, their eyes closed and in a quasi-hypnotic state, sunk deeply into their chairs) to calm and beautiful imaginary places. Film therapy took place on a weekly basis—patients and therapists would watch a movie together, the main rule being that anyone could raise their hand at any moment

to talk about a feeling or association that accompanied a given scene. Sometimes watching a ninety-minute movie would take more than a day, but both the patients and Dr. Zientarski, who came up with the method and the list of titles, found it very effective.[27] They would also use music therapy and, like the day unit group, psychoeducation, psychodrama, and drawing. The main mode of work, however, was therapeutic group conversation.

One afternoon, after the group session for the day was over, I stayed at the CP to talk with the interns—two young female psychologists who supported Dr. Zientarski—and with Tomasz Karwan, one of the cognitive-behavioral therapists in the group for persons with neurotic and personality disorders. I was curious about the phrase "to enter reality" or "into realness" (*wejść w realność*) that I had heard come up regularly in therapists' conversations over the previous months. I framed my question in the context of the standard sociological theory that mental distress and eventually suicide may be related to a gap between socially sanctioned aspirations and the means available to fulfill them—Robert Merton's take on Durkheim's notion of anomie (Durkheim 1997; Merton 1938, 1968).[28] Is the way to help the patient, I wondered, to support them in the fulfillment of their aspirations, or, on the contrary, is it to reduce those aspirations to make them more feasible to fulfill? And does that understanding of the problem make sense?

> Intern 2: You know, it depends on how the patient looks at it, if it's more reality-based or less reality-based [*zależy, jak człowiek patrzy, czy bardziej realnie, czy mniej realnie*]. Sometimes people have different ideas pretty removed from reality [*odrealnione różne pomysły*], yes? And then it makes sense to bring [the patient] down to earth and tell him. Because the world won't adapt to him, it is he who must come to feel better in the world, right? … But what you said, that discrepancy [between expectations and reality], one can clearly feel it in some cases, like narcissistic cases.
>
> Intern 1: When it comes to those expectations, it also depends on the patient, because some of them really do have expectations, like, they come to therapy for the therapist to show them how best to manipulate their surroundings.
>
> Intern 2: Right, like the world has to bend to suit them—so, how to make that happen?
>
> Intern 1: Yes, exactly. Usually the therapist is supposed to strengthen the ego, so, in a way, [for the patient] to be able to integrate his desires and thoughts with the demands of reality. But sometimes it is so that one must [strengthen] the negative side, so point out the limitations, because something may simply not be realistic. A goal the patient might have, or what he is doing may not be entirely realistic or beneficial. The world won't accept it. And other times one has to give them a push, right? In those patients who are really beating themselves up, yes?

G. S.: But what would be a realistic story? Can you think of an example to illustrate that?

Intern 1: If a patient comes … and asks: can you tell me how I'm supposed to deal with my wife so that she's not such a pain? Right? Well, therapy won't guarantee that something will change in the wife. One can help the patient learn something, well, one can work on his contribution, his responsibility, and on what he can do, how he wants to behave, what he wants to do with the marriage, in this relationship, and possibly how best to communicate it. … But there is only one side here, the side that comes to see us and that's our field of action. So that's not a realistic goal, that's an example of an unrealistic goal. It must be realified [*to trzeba urealnić*]. We don't have a way to brainwash the wife so that she may change.

Here is a very straightforward understanding of *urealnienie*: the word "real" (*realne*, *realny*) is used interchangeably and almost-synonymously with "realistic" to mean "reality-based," carrying with it implications about the nature of reality (which "can't be changed") and the world (which "won't adjust" and "won't accept [unrealistic expectations]"). The example offered to illustrate it is as common and mundane as reality itself—feelings and wishes concerning marital conflicts. It is articulated by the young psychologists in a language of cognitive-behavioral therapy—focused on correcting cognitions regarding the world and finding optimal ways of behaving relative to attainable goals set in therapy rather than, as a more psychodynamic approach would have it, on unconscious conflicts rooted in early childhood and repeated in the transferential relationship with the therapist and the group. Still, captured even in this mundane example is the centrality of the notion of reality as a corrective and normative measure, an entity that confronts us with its unyielding demands in ways that ultimately cannot be avoided, or rather, whose avoidance produces symptoms of, quite often, depression.

But *urealnienie* is more than just bringing grandiose narcissists down to earth, as the interns' example might suggest, and "strengthening the ego" and "strengthening the negative side" are not mutually exclusive. Rather, patients must both recognize and accept their limitations, the unyielding realness of what is, and at the same time learn that something can still be done, and some things can still be had within those realified parameters.

In the course of the three-month program, the therapists employ different clinical modalities in order to achieve slightly different goals. In the depression group at 42 Dolna, the dominant psychodynamic modality was designed to allow the patients to experience, in the context of the group, their "immature" ways of relating to "what is" by way of frustration and then anger and then finally acceptance. The cognitive-behavioral and educational components of the

therapy program sought to expose for the patients the "cognitive distortions" and "behavioral patterns" they habitually deployed and thus help them deconstruct and "correct" their current perceptions of reality. The assertiveness training workshops were supposed to offer them behavioral tools to act in the reality they would now be able to enter on new terms. The medical supervision offered pharmaceutical support without positing drugs as "the answer" to the patients' problems. (A discussion below of Dr. Zientarski's cognitive-behavioral and existential group at the CP, where an even more explicit emphasis was placed on patients' ability to experience, understand, and express emotions, will home in on emotionality as a further technique of realness.)

A more detailed articulation of the problematic relationship to reality was offered to me by Dr. Werner. Asked to describe the center's "typical patient," or groups of patients, she paused to think and then offered an account of what, in her experience, constitutes the most common problems and how those are addressed:

> A quite typical group would be … persons with threshold problems. A life threshold, like entering adulthood, proves difficult to such an extent that it decompensates them, anxiety-depressively. … There are [also] "balance sheet" problems [*bilansowe problemy*, or problems with moments of taking stock of life]. That's a bit broader, because there you have a worry about the future and here you have problems related to recapitulating how things could have been. So, usually [these are] persons who [decompensate] during some sort of external situation—I don't know, losing a job, [going through] a breakup, problems in relations with one's children. … Perhaps this would be our typical patient: a person generally more-or-less functional, but with that external factor present for most of them. With those "life-starters," students, the mechanism is more that various deficits [surface] that one had so far been able to balance because *one was still in the kind of protected period, with support—because even those who work and support themselves financially during their studies, one is still a "student" … and doesn't really "have to."*

Dr. Werner's characterization of the CP's typical patient is informed by her psychoanalytic approach as well as her experience as a practicing therapist and psychiatrist. After describing the "life-starter," someone having a hard time crossing the threshold to adulthood, she broadens her scope to other transitional decompensations triggered by external events and involving "balance-sheet" moments of taking account of one's life. Both types represent the broad groups she and other staff at the CP generally referred to as "ours" (*nasi*)—"personality," "situational," or "adjustment" patients (*osobowościowi, sytuacyjni, adaptacyjni*). But in taking that broader view she addresses a larger political reality. The

distribution of "protected" periods and spaces on the one hand, and spaces and periods of confrontation with reality on the other, have changed dramatically in Poland over the last two decades.

As I described in Chapter One, the confrontational nature of reality has, on the whole, been a more pronounced part of social experience since Poland's transformation—itself often framed as a restorative, purifying, and confrontational "reality check." That shift, in many ways a consequence of the systemic transformation, was economic (a competitive market in products as well as jobs, greatly increased economic insecurity), political (liberal democratic arrangements replaced the generally authoritarian rule based almost entirely on a single-party controlled state apparatus), as well as cultural-imaginary, structuring people's aspirations and expectations (Appadurai 2004; Crapanzano 2003), and it followed different vectors and at different intensities; it meant the abolition of some and the establishment of other protections and an increase of confrontational engagements in some areas and their diminishment in others (see Introduction, Chapter One).

In this context, psychotherapeutic forms that focus on entering "reality" and that facilitate a transition out of "protected" periods and spaces gain a special salience and importance. Crucially, the historically loaded idea of leaving zones of protection—which were artificial, and therefore unsustainable, and which curtailed freedom and adult-like mastery and will—is brought to bear precisely on the changing relationship between pension-seeking patients and the real-neoliberal state.

In this ideal-typical conception of the patient, the method and goal of treatment is envisioned, as Dr. Werner explains, in terms of finding out what is holding the patient back and taking a close look at those mechanisms, which alone has a liberating effect. And what usually holds the patient back is,

> generally speaking, always a fixation on a stage. It is a little like, I don't know, when someone is unable to leave his parents, let's say he didn't get something from them and cannot reconcile himself to the fact that, well, that's how it goes in life, that sometimes we don't get something and although he's already big he's still sitting in their lap and demanding something—although he's too heavy and they are old and soon will die—he's still sitting there and the insistence and the compulsion to repeat … That's often the mechanism, something holding, an inability to let go, inability to accept, or—to use analytic language, to attain the "depressive position"—to accept that, well, that's how it is in life, that some things we have and others we don't, and that our parents are such that we may be grateful to them for some things and for other things we may hate them … and that's it.

The image Dr. Werner resorts to in order to explain the goals of therapy—a big child insisting on sitting in his parents' lap and demanding impossible gratification—makes explicit how the term "depressive position," originally a concept from Melanie Klein's developmental psychoanalysis, is inherently bound up with notions of maturity and immaturity, another key pair of terms that come up regularly in the context of depression.

For Klein, the depressive position was one of two crucial positions in a child's development, which could continue to be "worked through" later in life. The earlier, paranoid-schizoid position, was characterized by splitting and the projection of bad objects (such as the frustrating, bad breast that refuses gratification, along with the sadistic, hateful feelings towards it) and the introjection of the good object (the gratifying, feeding breast, and the love for it). The breast as both good and bad does not yet exist for the infant, much less the mother as a whole person. In the second quarter of the first year of life, however, this begins to change:

> The loved and hated aspects of the mother are no longer felt to be so widely separated, and the result is an increased fear of loss, states akin to mourning and a strong feeling of guilt, because the aggressive impulses are felt to be directed against the loved object. The depressive position has come to the fore. The very experience of depressive feelings in turn has the effect of further integrating the ego, because it makes for an increased understanding of psychic reality and better perception of the external world, as well as for a greater synthesis between inner and external situations. … The working through of the persecutory and depressive positions extends over the first few years of childhood and plays an essential part in the infantile neurosis. In the course of this process, anxieties lose in strength; objects become both less idealized and less terrifying, and the ego becomes more unified. All this is interconnected with the growing perception of reality and adaptation to it. (Klein 1975a: 14)[29]

Referring, in broad and pragmatic strokes, to this Kleinian concept, the Warsaw therapists saw their adult patients as still needing to "work through" the depressive position; to have their both fearful and grandiose infantile fantasies, along with the frustration and repressed anger about wishes not being fulfilled, yield to a sober recognition of things being just what they are, both good and bad, constrained by limits one has to accept, but still allowing some room for action. This is a deeply developmental perspective that posits the patients as children stuck in a vicious circle of unconscious fantasies of gratification and frustration and harboring the expectation—paradigmatic of immaturity and infantility—that "reality adjust to their expectations."[30]

In this perspective, attaining and working through the depressive position—coping with the feelings of loss of the "good object," or an unfulfilled wish—is a mark of development towards adulthood. It corresponds to leaving behind the "protected period" and moving towards greater independence and "real" responsibilities, in Dr. Werner's words, but it also mirrors the imagined advancement of the Polish society from a socialist stage and early postsocialist stage, symbolized in the figure of the entitled and dysfunctional *Homo sovieticus*, dependent on the socialist state, into a mature and democratic capitalist. But, as this chapter argues, it is not only a matter of formal resonance between the language of psychotherapy and the discourse that structures the public imaginary of post-transformation Poland. It is also a matter of concrete efforts to transform patients' dispositions to be in line with liberal notions of independence.

The immaturity of pan Roman

The groups at Dolna Street tend to have either cognitive-behavioral or psychodynamic (psychoanalytic) profiles, but since they involve, in addition to sessions proper, a variety of other elements, from psychoeducation through assertiveness training to film and music therapy and guided relaxation, they are, in practice, eclectic. The day unit group I observed daily for the months of May and June, 2009[31] was the first one of this kind ever created at the Clinic: it was intended specifically for patients with depression, i.e., with a formal diagnosis of depression (ICD-10 codes F32 and F33); previous groups had catered to patients with neurotic disorders or patients in specific age categories and this one was a response to the increasing number of patients with initial diagnoses of depression. It was led by Dr. Antoni Orłowicz, a clinical psychologist of psychoanalytic orientation, and it had a primarily psychodynamic profile—meaning that central to the treatment was the group process itself, in which patients are understood to transferentially act out their unconscious inner conflicts and experience them anew in the clinical setting.

The group met daily from 9 am to 2 pm with a free-of-charge lunch served by the in-house kitchen. The smell of "hospital food" would often permeate the first floor, where the therapy room was located. There were ten patients in the group—seven women and three men, ages twenty-three to fifty-five (older patients, if considered a good fit for group therapy, would be directed to age-specific "45+" groups).[32] Dr. Orłowicz, a large man in his mid-thirties in thick-framed glasses, was the lead therapist, and his psychodynamic approach dominated the profile of the treatment. If the psychodynamic sessions focused on helping patients accept "what is" by putting them squarely in the middle of it in order

to gradually "work through" their frustrations, the cognitive-behavioral therapy (CBT) sessions, led by pani Karolina, were aimed at correcting patients' distorted beliefs about themselves and reality.[33] Additionally, assertiveness training with pani Anna (like p. Karolina, a woman around thirty) sought to teach basic skills for a new way of acting in reality. The group was also medically supervised by a psychiatrist, Dr. Renata, who would visit from the main location of the Nowowiejski Hospital to dispense medications and do the group and individual weekly checkups.

The very format of the therapy group helps to set up a developmental context and serves the framing of the patients as immature, reliant in a not-quite-real-life on the care and protection of an Other, be it the parent or the state (See Introduction). Dr. Orłowicz talks about this in explicit terms when I ask him about how therapy groups work:

> One has one's own reflection in others and it gives the kind of social support and the possibility to work through things one didn't manage [to work through] in this reality [outside the group]. The group is, after all, a metaphor of a reconstruction of a child's development, a repetition of the consecutive stages, from [1] dependence to [2] a certain expectation from the therapist that he or she be like a parent and solve all the problems, through [3] frustration and realizing that it's not like that and then [4] idealization of the group—that it [can do it] all, that we can do it together on our own, like a peer group, like 16-year-olds, on our own, but that also serves one's own [individual] definition, up until [5] the depressive position, or realness [*pozycję depresyjną, czyli realność*], realizing that the group is not the ideal solution either and that in fact it is what it is, [and that] I have a somewhat adequate sense of what's going on with me and in accordance with that I can, in one way or another, make this life [for myself]. (Numeration added)

Inhabiting the depressive position, here defined as realness, rather than escaping it is what will relieve depression—at root, a problematic relationship to reality. The different stages of the therapeutic group relationship Orłowicz lists are indeed the terms in which the therapists talked among themselves. The reconstruction of the development process he describes was something they actively, if implicitly, tried to provoke in the patients during sessions and constantly create the right conditions for. As such, they put themselves in the position of all-knowing parents—and they frequently, if somewhat jokingly, narrated their experience of the sessions and the therapeutic process as a whole in terms of a children-parents dynamic. In the privacy of their shared office at the day ward, they would sometimes explicitly refer to the group as "children" and describe the patients' reactions in terms of adolescent resistance or infantile demands.

Even though they could see elements of progress in the group process over the three months—particularly different forms of more or less suppressed (and largely invisible to me) anger as the therapy was nearing its end and as the patients' unfulfilled expectations of improvement apparently produced increasing frustration—the therapists didn't count on any palpable achievements during the treatment period itself. Rather, in their view, support in "working through what is" would facilitate the patients' continuing progress towards the "depressive position" and help them, over time, to enter realness. The therapists saw their work as creating a space for experiences that would continue to "reverberate" in the patients in the future, and for opportunities to learn skills the effects of which would be similarly delayed.[34]

Each day of therapy consisted of two sessions and often included different activities; different modalities of therapy would typically fall on different days.[35] Weekly schedules varied somewhat, but Dr. Orłowicz and at least one of the other therapists were present at all times. Even on a day without distinct sessions reserved for psychodynamic therapy, the morning and afternoon rounds would typically have an analytic character and the tone set by Dr. Orłowicz's restrained psychoanalytic demeanor, just like this day: although it was the morning, the room was rather dark with curtains half drawn. The chairs[36] were arranged in a circle with all the patients, Dr. Orłowicz and p. Anna present—only my chair was withdrawn into a corner where I would sit outside of the circle at a desk, taking copious notes. There was little more in the room—a couple of low cabinets lined the opposite wall, a corkboard by the door with the weekly schedule, and an office easel with a large 3′ × 4′ block of paper that served as a drawing board. It was only later that I noticed a cross above the door.[37] Moments of silence were many—one could then hear the clock on the wall ticking—and speech tended to be soft. Dr. Orłowicz's attitude was somewhat removed and restrained, his responses sparse—bringing to mind a proverbial psychoanalytic style.

The sessions started with a round of updates about each patient's mood, frame of mind, and events of the last day or weekend. These rounds would typically generate topics to talk about during the session—and a round of summarizing comments would end each day. Now someone mentions feeling disillusioned with the therapy, someone else a conflict at work. When, during one such round, one of the patients, the youngest, twenty-three-year-old Maciek, spoke of his distress in the face of what he felt were life failures and broke into tears, one of the first reactions was from pan Roman, one of the group's oldest members. He addressed the question of the origin and inevitability of their illness: "I still ask myself 'why?' Is it personality? Is it biology? Why do some people get sick and others don't? Will any of the persons in our group be able to recover fully?"

His question did more than express the idea (not shared by the therapists) that they suffer from a disease; and it did more than pose the question of a psychological vs. biological basis of that disease (a question, arguably, pondered by generations of psychiatrists, only some of whom saw the alternatives as mutually exclusive). P. Roman, in the therapists' interpretation, expresses his demand that the therapy bring him relief, a frustrated expectation, an echo of the anger he feels inside but refuses to fully recognize.

A fifty-five-year-old man, fit, with hair buzzed close to the skin, even-tempered and friendly, p. Roman returned to the theme of the effectiveness of therapy on several occasions. Nearly halfway into the treatment, p. Roman said, he still couldn't quite feel any effects. In part, he was harboring a grievance against himself (*mam pretensję do siebie samego*) for probably not doing a good job, but in part his grievance was with "the therapy itself, in a way" (*częściowo jakby do terapii*) for not having improved his mood. His phrase was a bit awkward—grievance (*pretensja*) is something one can harbor against a person, not a process, and it was the therapists themselves that seemed to be implied. His recurring demands were noted and commented on in the therapists' room.

P. Roman's diagnosis established during the group meetings was personality disorders—immature and dependent personality. His history of related depressive episodes was deemed secondary (he had in the past received diagnoses of both depressive disorder and mixed depressive and anxiety disorder—a neurotic disorder). He was currently receiving a *renta* granted to him for one year and he was very interested in extending it—he was due for a checkup soon, but renewal was far from certain. He had practically not worked in well over a year and was supported by his wife, an elementary school teacher. Their income was small, but their needs were also humble (especially now that all of their four daughters had moved out of their little house not far from Warsaw), and the *renta*, although only around 800 złotys ($270), was a welcome addition to the household budget.

P. Roman sought not only monetary support but also medical treatment. Determined to find a cure for his depression (he had been in some or other form of treatment for the last seven years), he tried a number of antidepressants under the supervision of two different psychiatrists and spent several weeks in another day ward as well as time at several inpatient wards. He had even requested electroconvulsive therapy—a method of last resort shown to be effective in the treatment of "drug-resistant depression"—but was denied on the grounds that his condition did not warrant this extreme treatment. When he was turned away from the CP due to his age, his wife suggested he request a letter stating that services were unfairly denied—a letter he could include in his medical file—and was then informed about the depression group in the day ward.

Having little to do on most days, p. Roman had taken up amateur off-road cycling and was spending a lot of time training—currently preparing for a race and riding about fifty kilometers every evening. His wife was working; he was keeping himself busy with his therapy and his training… and questioning the meaning of it all.

P. Roman had studied engineering, but already in the mid-1980s he started his own one-person service firm cleaning carpets, a form of economic activity that was legal but not encouraged in late socialist Poland. The transformation period was difficult for them, he said. His wife was at home taking care of their four daughters, and his business, profitable at first, couldn't keep up with the competition in the 1990s. "I didn't respond to changes in the market, didn't develop," he told me, putting it on his lack of entrepreneurial talent. Raised Catholic but never deeply religious, p. Roman became involved in the Families of Nazareth Movement (FNM), a Marian movement within the Catholic Church founded in Warsaw in the early 1980s and centering on "entrustment," or "abandonment to the Blessed Virgin Mother" (The Families of Nazareth Movement: About Us n.d.).

P. Roman's spiritual awakening gave his life meaning and a sense of purpose in very concrete ways—he had individual spiritual guidance by a personal confessor, got involved in organizational work, then got a job managing a dorm at the boarding school run by the Movement. His whole family got involved in FNM. Over time, however, he started to feel that power relations at work were abusive and that employees' dependency was compounded by spiritual authority. Excessive demands and mobbing (an onslaught of responsibilities and demands, a frequent theme in many patients' accounts and a relatively new object of public discussion in Poland) remained unaddressed. The president of the school was a priest with great authority and "charismata" in the eyes of the fellowship, but p. Roman perceived him to be a cruel and tyrannical man. "The bringing in of God into these relations created a dissonance that was too much for me to bear," he explained to me.[38]

In 2000 and 2001, his symptoms started: problems getting up in the morning, back pain, a "tightness in the throat" (in retrospect he says it was anxiety, but back then he didn't know what it was or that one could have anxiety without a specific object), general mental discomfort, and feelings of failure and low self-worth. "My whole family suffered abuse," he told me. "This kind of stuff really gets to the inside of you." But p. Roman would remain in the movement until 2005 and at his job (although with a new leadership) until 2008. In 2002, in a waiting room about to see a doctor about his back pain, he picked up a flyer about an antidepressant and realized that his symptoms matched. Over the following three years he tried several antidepressants, but without satisfying

results. In 2005, he spent a few weeks in a day ward for the first time but couldn't find a place with therapy. Finally, his condition worsening (he practically couldn't get out of bed before midday, had negative thoughts, stopped biking or any other activity), he left his job and stayed in an inpatient ward, and was able to receive *renta* for a year.

During the therapy at Dolna Street, he was feeling relatively better, but he was not free of his symptoms, and he still didn't know what he would do with himself after. If he could extend his *renta* for another five years (until the age of sixty), he would qualify for early retirement. But in the "new reality," where former care and responsibility, however minimal, for those currently unable to procure an income had been replaced with limited assistance in activation of capacities and a restrictive definition of "incapacity to work," his diagnoses of personality disorders did not bode well. Meanwhile, in the group, p. Roman talked about being drawn to "adrenaline" and a "life on the top" (*życia na topie*), that is, at the top of his form. But at the same time, he felt that that kind of life might not serve him—his psyche and his family—very well. He felt he wasn't meeting expectations. His mood was not improving. He knew he had to stay active, but he didn't quite know what to do, what he could want.

While p. Roman's condition could easily have been coded as "laziness" or *rent*osis, by another reading, in line with both psychotherapeutic theory and the parameters of action and grid of intelligibility set by the state, it was an effect of not taking care of himself, a form of mismanagement of himself as a resource. As Dr. Orłowicz put it:

> The biggest stereotype is that a person with depression should go to work in a quarry and the problem would resolve itself. It presumes that it's weak people who have depression. But it's the opposite. It is the fact that one has a strong character that causes one to keep going strong, with a smile on his face, not allowing the emotional experience to come through [*nie dopuszcza tych przeżyć*], [suppressing] everything that's happening with him, and eventually ends up with that bag of rocks, still laughing, until at some point—biologically, physically—his shape [*kondycja*], his daily rhythms and everything else, give in. His body physically refuses to carry that load. And he is then confronted in reality with what he's been running away from and what he doesn't want to admit or allow to surface.

In this reading, p. Roman was not attending to what was weighing him down, didn't understand the emotional signals his body was sending him, didn't even allow them to surface. This blockage of emotional experience was understood in cultural terms—both, taking after Freud's *Civilization and Its Discontents* (Freud 1989), as a broader modern and generally human problem, and as a specifically

Polish one, attributed to a lack of attention to emotions and individuality in a rigid upbringing and education focused on external rules and values, especially under state socialism. Learning to understand one's emotions rather than suppressing them and to take care of oneself was the explicit goal of the therapy, especially at the CP.

"They have a responsibility for their organisms, not just for realizing some idea," Dr. Zientarski told me. In this light, p. Roman's current *renta*—his reliance on care from the state and his wife—and his search for successful treatment appeared misguided. The therapists had little faith in his success. What was ailing him was not a disease or an actual *incapacity* to work, their comments outside the sessions suggested. Rather, it was his lack of purpose and his inability to find a purpose when it wasn't externally provided for him (within the structure of employment or a religious movement). Directing his energies towards a relentless pursuit of virility and fitness in biking, especially considering his age, seemed similarly wrongheaded. What he needed was to come to terms with the futility of his efforts.

One Monday, p. Roman arrived in a downcast mood. That weekend, he had had his first race. "Tough, a lot of struggle," he told everyone, "exertion, competition. … But then I checked my result: I was number 402 out of 1,000. And so my mood plummeted. I saw that I have a sick ambition." Addressing his and a few others' reports, p. Karolina, the cognitive-behavioral therapist, brought up the topic of sadness. "Sadness," she said, "is an emotion that is supposed to help us notice and think about a discrepancy of some kind in our life; a discrepancy between our ideal self and our actual (*realne*) self."

Her statement brought together two key aspects of the therapeutic processes unfolding at Dolna: efforts to expose and help close the discrepancy between the ideal and the real, between wish and actuality—a form of *urealnienie* best captured by the therapists' use of the term "depressive position"—and an attention to emotion understood in a particularly cognitive-behavioral way. Accordingly, p. Roman's gains from therapy (cognitive insights as well as unconscious "working through") were posited by the therapists in two ways: on the one hand, the space and duration of the group were for him to understand and experience that his wish to recover and "live on top" was not going to be fulfilled—it was unrealistic. On the other, he needed to learn to notice and experience his emotions as direct sources of information—his anger, frustration, and indeed depression were telling him that he was not accepting reality. These two facets—*depressive position* and *emotionality*—are also realifications that are key to the formal and affective reworking of the bio- and psychopolitical relationship with the real-neoliberal state (itself drained of realness insofar as its institutionalization veered from the early articulation of Polish democracy as distributive, substantive, and collectivist)

through the pursuit of pension entitlements. I discuss these facets in the remaining part of this chapter.

Emotionality

P. Karolina, upon hearing p. Roman's dejected report of his mediocre race performance, had immediately stressed the importance of connecting thoughts with emotions, and she made sure patients made that effort while "doing the round" at the start of each day. Learning to notice and then understand the mutual and multidimensional influences among one's thoughts, feelings, physiological reactions, and behaviors is key to CBT.

One of the goals of the CBT portion of the group therapy was to teach the patients to observe themselves and their behavioral schemas in action and thus begin to gain a critical perspective on the ways their schemas distort their perception of reality, governing their lives and their moods. One of the ways this was done was by constantly connecting thoughts and emotions to ongoing situations and behavioral reactions. When responding to a topic discussed in the session or when telling the group about their current state and significant events in their lives at the moment, patients were instructed to pay attention to and name their emotions and physiological reactions. Discussing situations from their daily lives, they tried to understand their behavior by also examining their emotional and physiological responses and the ways their schemas and "mediating beliefs" may have shaped them.

A patient would talk about a difficult interaction with a family member or their fear of an upcoming exam, or just their general mood during the morning round—and would be asked to try and name precisely the emotions that accompanied them and place them on a scale of intensity from 0 to 10. They were often instructed to specify and revise their initial statements, distinguishing better between physiological reactions (increased heart rate, sweating hands, tense muscles, tearfulness) and emotions (sadness, hopelessness, fear, calm, abandonment). A chart of basic feelings was hanging on the corkboard as a reference. "Emotions," Karolina explained to me in an extended conversation about her take on the therapy,

> are what bothers the patients who come to therapy. They come here because of an emotion, not thinking or behavior. The point is to understand what it is that determines what one feels—we divide that into behavior and thinking. Any situation is in itself neutral. What matters is how we interpret it, and that interpretation determines how we feel. And so in CBT the goal is to learn to influence one's emotions by changing thinking or behavior.

P. Karolina's approach placed an emphasis on experience, *przeżycie* or *przeżywanie*.[39] She instructs the patient: "take it in, accept it, don't do anything with it, look at it closely, spend some time with it," and, most importantly to her, "feel it, experience it (*poczuj to, przeżyj to*). … What is important here is *przeżycie* [living-through]." Trained in highly rationalistic, structured, and scripted CBT—"an American program," she stressed—with its specific guidelines, predesigned exercises, and questionnaire to activate patients, set specific goals, correct their distorted cognitions of reality, and measure the attained alleviation of symptoms, p. Karolina saw emotional *przeżycie* and human contact with the therapist as fundamental to treatment.[40]

The emphasis on both *przeżywanie* and on helping patients to achieve a particular form of emotionality were central goals of the therapy groups at the CP. Emotional experience was posited as the primary way of entering reality. Dr. Zientarski understood the patients' main problem as a "blockage of *przeżywanie*," or a blockage of emotional awareness and experiencing, especially of anger. Through cognitive (learning about emotions and thoughts), behavioral (observing one's own reactions and patterns, seeking to change the latter), and experiential (watching one's emotions and physiological reactions as they're happening, in a safe and supportive setting) techniques, the patients could gradually "unblock," stop suppressing what they were feeling, and their symptoms would diminish.

This understanding of emotionality is behavioral and activating, in strong contrast to Poland's romantic emotional culture, where feelings[41] are understood as belonging to the realm of the sublime. In this cultural emotional register, emotions are shared, social, often communal—and are mobilized in the service of social norms, culturally potent values, and political action.[42] In contrast, defined behaviorally as they are in group therapies at Dolna, emotions are of the body, of basic needs and reactions, and therefore set apart from the culturally sublimated, but also from Freudian psychic drives with their sinful associations—drives defined precisely in opposition to the sublimated. A behavioral understanding takes emotionality out of that cultural sublimation / psychic drive binary altogether. Emotionality is stripped of its shared and communal quality as well as its dark, subterranean associations; the relationship it valorizes is a "healthy relationship" to oneself as a body—the body as medicalized, viable, capable of activity and work. Emotions are presented as at once information and fundamental energies crucial to pursuing an independent, active life—especially important for patients with *rentoza* masquerading as depression. This understanding of emotionality thus supports and promotes the replacement of a substantive, communal ethics with a formal and individualist one. And it is here that the relationship to the state again emerges more overtly.

In the first full day of the group, in the psychoeducation session, Dr. Zientarski gave the patients—seven women and seven men—a powerful introduction to the goals of the therapy and its foundational ideas. And he spoke mainly of emotions and in distinctly behavioral terms.[43] Explaining that just like all flavors are a combination of the four basic flavors—sweet, bitter, salty, and sour—all feelings are made up of the four basic emotions: fear, anger, contentment, and sadness. Zientarski told the patients about emotional expression in different species, from dogs and cats to crocodiles and snails, until he stopped to draw on the whiteboard an oval shape: the paramecium, a single-celled organism. In a not-at-all metaphorical comparison, he explained:

> The paramecium has no consciousness, no will. … Chemical reactions determine the movement of its cilia to produce taxis towards or away from an object. A tiny crystal of sugar melting in the water near the paramecium will produce a taxi toward it; a crystal of phenol, a taxi away. Now, in higher order organisms, those taxis are emotions. A taxi away is fear and thus escape; a taxi toward is… What? Does anyone have any suggestions?

"Love?" someone from the room offered. "No," Dr. Zientarski replied emphatically. "It's anger! Anger—and thus aggression. If we didn't feel anger, we would starve to death!" He stressed these words, pausing and looking around the room, and then continued:

> Aggression is not what we usually think: that an aggressive person is bad and deplorable. Aggression is movement forward. A person who is not aggressive is not able to do or change anything in life. … Why, then, are we afraid of aggression and don't allow it in ourselves? Anger and aggression are penalized in childhood. A good child is one that is calm and easy. The word "no" in a child's mouth is not accepted—while it's crucial, because that's how a child discovers that it is an autonomous being. Anger means that I'm not happy with what's happening and I'm aware of it.

Going over fear—an "easier" emotion, since it provokes sympathy—and contentment, which is passive, Dr. Zientarski finally arrived at sadness:

> Sadness is a more complex emotion. An infant, left alone, will first cry, be angry, then anxious … It has learned so far that when it's angry, the mother comes. But not this time. So what happens now is internalization, suppression of that anger—and a feeling of helplessness. Such internalized, suppressed anger, turned inside, is sadness.

Having thus connected sadness with anger (which he valorized at the expense of "love"—not as such one of the four primary emotions), Zientarski turned to a Kleinian proposition:

> [Sadness] resembles happiness in that it's passive, but it's imposed, undesired. More than that, there's another redirection [*przekierowanie*] that may occur in the child: I was angry at mother and now she's gone—maybe my anger killed her. Guilt appears. We have helplessness, sadness, and guilt plus passivity. One can't do anything, because sadness leads to nothing. Sadness—and happiness—don't have a corresponding movement. It's not taxis but ataxis.

This direct relationship between the ability to experience, understand and follow emotions, developmentally anchored in both individual and species history, was also a direct reference to the patients' passivity and dependence, underlying and reproducing their *rentoza*.

> There are many definitions of neurosis [*nerwica*], but one of them is: a blockage of experiencing [*zablokowanie przeżywania*]—there is something we're not experiencing consciously. And when it's suppressed, it turns into a symptom. … In this therapy, we'll be giving a lot of importance to what we feel. We will look at what the role of emotions is and of their disturbance [or "disorder"—*zaburzenia*] and how to take care of them in order to be happy. … The point is to learn to recognize basic emotions and free yourselves from certain norms with which you have been raised—primarily, that to feel anger is bad.

Here, Dr. Zientarski offered a strong and clear definition of the patients' general problem: the inability to feel and understand their own emotions. That inability is what keeps them from a truth that is necessary for a healthy and happy life—a truth they are too often barred from by way of their upbringing, especially in Poland, where, as therapists and patients generally agree, psychologically conceived "emotional culture" is underdeveloped.

Towards the conclusion of Dr. Zientarski's talk, it became clearer how the therapeutic emotionality he is promoting may be called, in terms of my argument, a technique of realness. Emotions are the superior way of being in reality.

> For millions of years, no one on this planet was thinking and life evolved quite well. Feeling is older than thinking and does quite well on its own. Meanwhile, our thinking has developed to the extent that it allows us to remove ourselves from reality [*oderwać się od rzeczywistości*] and experience everything in fantasies. That's what schizoid fantasies are. We must treat thinking as something that specifies [*precyzuje*] emotions, not contradicts them.

Below, in a final ethnographic vignette, I show how a return to reality and the acceptance of it through a depressive position were reached by one of Dr. Zientarski's patients in the group. Pani Honorata came to accept her emotionally abusive husband and her own dependence on him—rather than on the social insurance benefits she was only partly successful in obtaining. However, as the example shows, in the transformation that she experienced, p. Honorata drew not only on psychotherapy but also on the ethical guidance and support of her religious renewal group. Hers is an exemplary account of how patients may cultivate new subjective dispositions in therapy but via routes and contents quite disparate from those scripted by therapists: in her case, ethical notions grounded in the substantive, collectivist values of Catholicism and the fellowship of the church. In this way, I suggest, patients are themselves engaged in an act of realification quite distinct from that which is intended by their therapists: in drawing upon the unfulfilled ethical dimensions of the envisioned Polish democracy—which fell by the wayside of its neoliberal articulation—they implicitly shine light on the "reality gap" of the "new reality."

Pani Honorata: incapacity, anger, and acceptance

What the depressive position and an ability to fully experience and understand one's emotions might mean for a patient whose illness and recovery were bound up with the state's shifting provisions of care and benefits and the Catholic ethic of entrustment was illustrated in p. Honorata's struggles. P. Honorata, a woman in her late forties, had started seeking medical help with her problems nearly a decade prior to joining Dr. Zientarski's group at Dolna in the spring of 2010. Initially, her complaint was twofold. One aspect was increasing pain: headaches, debilitating pain of the spine and face. But, at the same time, around 2001, she realized (or the awareness raising campaign I describe in Chapter One helped her realize[44]) that she had symptoms of depression: something had clearly changed in her, she was nervous, tense, her mood and sense of self-worth were low.

Her first visit to a psychiatrist helped her articulate what she already knew: the problem was her relationship with her husband. He was emotionally abusive, especially towards their son, and it was getting worse as their son was growing up. A military man, the husband wasn't communicating with her or changing his ways, and their marriage was fraught. The psychiatrist prescribed antidepressants (Seroxat, paroxetine) but those didn't help much and, in the long run, little changed. Looking back now, p. Honorata knows she was suppressing her emotions. She knew she was angry, she tells me, but felt helpless and didn't know

she could do anything about it—and for years she did nothing. The tension between her and her husband only continued to build, boiling over into occasional fights. One time, when she threatened that if the mistreatment of their son continued, she would "do something unpredictable," like file for divorce, her husband opened up to her about his own mental distress, and she convinced him to seek professional help.

He was diagnosed with anxiety depression, also put on Seroxat and later spent three months in a similar therapy group at the Institute of Psychiatry at Sobieskiego Street. But the therapy had little effect: "he still didn't talk about emotions," she told me, and it was still a change in him that she was seeking. Meanwhile, her own mental and physical state was getting worse. In 2006, their son fell ill with an autoaggressive condition, and p. Honorata felt she was reaching her limits. Finally, one day she woke up in terrible pain, paralyzed. What followed was half a year of paid sick leave (she had at the time been working for a large company as an interior designer), three months issued by a neurosurgeon for her spine (they had found hernias and degeneration of spine joints, but the exact cause of the pain was unclear) and another three by a psychiatrist because of depression.

When she had maxed out the sick leave, however, the ZUS refused her a rehabilitation pension. "They told me I was healthy and should go back to work," she tells me. "But I couldn't. And I didn't, for another year. And no one could help me." Her back may have gotten better, but her mental condition was poor and, their son now a teenager, her problems with her husband were only getting worse. She was again contemplating divorce, but, her health aside, she was practically dependent on him. Without an income or rehabilitation payment, she was also, through his entitlements, using military health care, and they lived in a military housing estate (*osiedle*).

For the next year, even though the basis of her condition, as she now saw it, was her repressed anger at her husband, she was entirely supported by him. It was in part that feeling of dependency that made her go back to work—but she felt poorly, was always tired, and couldn't wait to leave; she wasn't what she had previously known herself to be. Distressed about her son's health, she was praying and reading spiritual literature and found a fellowship of the Community in the Holy Spirit (*Wspólnota w Duchu Świętym*, also known as the Catholic Charismatic Renewal movement). "It was my faith that helped me get through all this," she tells me emphatically. After two years, she was again struck by pain and paralysis. "After nine days straight in bed unable to move, I came to the conclusion that it was given to me to be humble, to find peace inside. … I was helpless. But I put it all in God's hands and I said to myself: Lord Jesus, do with me as you please. … I trusted in God and knew nothing bad could happen to me."

She took another six months of sick leave, this time followed by three months of rehabilitation pension for her spine condition. Having now received a diagnosis of fibromyalgia, which explained the pain that could not be attributed to her spine, she also consulted another psychiatrist, who saw her physical ailments as "masked depression": "It was that I wasn't expressing my emotions. On the outside all is fine, but inside I was as though a grenade had gone off," she told me. The suggestion was psychotherapy, and she was referred to Dr. Zientarski's group. She waited a full year to get in. And now her own understanding of her problems had been transformed: the underlying cause of her ailments, both physical (including fibromyalgia) and mental, was caused by repressed anger; but the anger, in turn, was an effect of not accepting her husband. It was that lack of acceptance, rather than her husband's ways, that had to change.

"I came here with an assumption, a theory, that it's simply that I'm unhappy with my husband," she told me. "I didn't even know I didn't accept him. … I still had to come to that realization … I had to mature to it." But that meant no longer seeking a change in him:

> So what that my husband has such and such problems? That he has anxiety depression? Sure. But what can I do about that? I certainly can do nothing about that. But I can do something about myself, right? And that depends only on myself. Only. In other words, this therapy was able to [help me] accept reality as it is. Or my husband just as he is. Because I can't change him. But I can change myself and [it is in that way] that reality around me can be positive and not negative. And in this therapy I have achieved acceptance.

In many ways, p. Honorata's account is a classic story of the politically and economically disadvantaged feminine position translated into a psychomedicalized ailment (see, e.g., Capps and Ochs 1997; Metzl 2003; Showalter 1987), where the immediate conditions of dependence are tacitly or explicitly reproduced by the biopolitical structures of the state (Rivkin-Fish 2004, 2005; Gal and Kligman 2000b; Ticktin 2006, 2011). In what resonates with the therapeutic ethic (Illouz 2007, 2008), her newfound acceptance of her husband was made possible by embracing more individualistic practices of selfhood than had been proper to the ethic she had been raised with, where greater emphasis had been put on communal and mutual interdependencies and alignments than on individual freedom and setting one's own boundaries. She speaks about it directly, detailing the ways in which she now "sets boundaries," acts in a more "assertive" fashion, "puts herself first," and "takes care of herself"—ethical and behavioral norms alien to the more collectivist and substantive ethic. But her acceptance of reality, as much as it aligns with the self-knowledge acquired in therapy, is strongly

motivated by the Catholic personal ethic she practices in her fellowship of the Catholic Charismatic Renewal.[45]

> p. H.: If it wasn't for my faith, I may have never accepted my husband. I don't know. … If I didn't believe, then: this husband doesn't suit me, so I divorce him. But on the other hand, there is the question: what kind of relationship am I looking for? Well: a partnership [*związku partnerskiego*]. But who can give me a relationship like that? Who? It is totally *virtual*. Isn't it better to work with the relationship that exists, so that this family remains, and to act so that my behavior makes my husband's and my son's behavior change? … The fact that I didn't leave my husband, that is the love for your neighbor that faith teaches us about. … Maybe that's my cross to bear, maybe that's what I should be working on.

The religious interpretation of her vision allows p. Honorata, by her own account, to attach meaning to the experience—a sacrificial meaning that, on the one hand, seems at odds with much of what patients explicitly learn in therapy, where the culturally resonant image of sacrifice, especially by the mother, is often the target of deconstructive analysis fueled by calls to "take care of oneself" and "put oneself first," though it repeatedly comes up in the accounts of patients who turn to figures of sacrifice in order to valorize and endure their suffering. P. Honorata's account of her spiritual practice in the prayer circle as congruent with her work in therapy shows primarily that what she took away from it was a strengthening of her acceptance. She tells me that she came to understand that her pain and illness—her "decompensations"—had been an effect of ignoring her emotions—her anger and her dependence—but the appropriate way of acting on the realization was acceptance and religious entrustment, which to her strongly resonated with the depressive position.

Conclusion

When Dr. Zientarski says that therapy teaches patients to decode their bodily emotions as information in order to "take care of themselves," his phrase is telling: "We teach them to be in a[n emotional] conversation with themselves, [to have] respect for their body, for their emotions; [we teach them about] *taking responsibility for their actions—but also their organism*, rather than just the realization of some idea." This understanding of "taking care of oneself"—as p. Honorata enacted in recognizing the emotional basis of her ailments and as p. Roman failed to enact as he wouldn't give up a job that was straining him nor his futile pursuit of fitness and cure—differs from the usual interpretations of self-care by scholars of the American-influenced "culture of therapy."

That psychological "human technology of liberal democracy," as Nicolas Rose would have it, is thought to center on the "pursuit of happiness," on governance through freedom of the individuals who choose rationally and whose emotional self-knowledge helps them to recognize their desires and to navigate interpersonal relations in liberal societies (Rose 1996; Illouz 2007, 2008). In the Polish context of shifting access to public health services and social assistance (the care of the state), and in the gap between the culturally resonant and religiously rooted ethic of substantive communalism and the progressing institutionalization of a formal neoliberal political structure, "taking responsibility for one's actions and one's organism" is an explicit formulation of a form of citizenship.

This is a citizenship in which it is the subject herself who becomes the provider of her own care; where her relationship to the state's biopolitical provisions continues but with a minimal reliance that is actively limited by the subject's very psychological dispositions: on the one hand, independence and acceptance (*maturity* and *depressive position*), and on the other, a watchful, self-respecting emotional management that will modulate daily stress and strain, keeping those at a bearable level in order to preserve health and capacity to work (*emotionality*). This is a self that treats itself as a resource and that both participates in and protects itself from the excesses of the new reality.

In Katherine Verdery's formulation, under "socialist paternalism," the state, or the "Benevolent Party Father," "educated people to express needs it would then fill, and discouraged them from taking initiative that would enable them to fill those needs on their own" (1996a: 24–25). Furthermore, "subjects were presumed to be … grateful recipients—like small children in a family—of benefits their rulers decided upon them. The subject disposition this produced was dependency, rather than … agency" (1996a: 63).

In this chapter, I have argued that group psychotherapies in Warsaw, especially as they targeted depressed patients' immaturity and perceived *rentoza*, sought, through different techniques of *urealnienie*, to transform dependency into agency and *substantively* oriented dispositions into *formally* oriented dispositions. I have argued that the gap between substantive and formal entitlements—the gap at the very heart of Poland's "real neoliberalism"—is filled not only by patients' continuous efforts to make successful claims to social entitlements, but also by their pervasive reference point in the Catholic Church in its historically cemented role of a provider of different forms of care and support—from ethical and affective to substantive and material.[46]

Chapter Four

The ethic of powerlessness

Marek is a *depresant*. He is a member of Depressed Anonymous (*Anonimowi Depresanci*, or AD), a twelve-step fellowship based on the model of Alcoholics Anonymous. In AD, it is depression and agonizing worry (*depresja* and *zamartwianie się*) that stand in for alcohol or any other addictive substance or behavior. Marek is in his fifties, of unimposing build, middle-class appearance, and friendly demeanor. Although the mood of AD meetings tends to be more subdued and melancholy than the relatively jolly tone of AA culture, he is energetic, straightforward, and speaks with clarity and confidence. He is also, at the time of our first extended conversation, becoming a mental health activist. In May 2010, Marek, his partner Joasia (a slender, kind-mannered, middle-aged woman I also know from AD), and I were sitting in a coffee shop recently opened in one of Warsaw's up-and-coming residential neighborhoods.[1] The AD group I had been observing for about ten months met in a nearby parish house, and I'd come to know Marek as one of its most outspoken and knowledgeable members. Now, with Billie Holiday singing and the espresso machine hissing in the background, he was telling me about his depression, about the program, and how important it is to change the way people think about their lives and the way we all think about mental illness.

Marek's "fall into depression," the forms his suffering took, his search for effective treatment, and his life in recovery are all part of a larger story. This string of life events exemplifies the rise of self-help programs as one of the socially available responses to depression in Poland. Marek's story also offers a particular perspective from which to explore the relationship between Poland's post-1989 market-democratic transformations and new ways of understanding and dealing with the inability to "function" and lead a "normal" life.

From the beginning of the transformation period, Marek had been able to find his feet in the "new reality." An entrepreneur by nature, it seemed, he started

small and, by the late 1990s, he was the manager and owner of two quickly growing businesses. He had altogether eight men's apparel stores in shopping centers around the country and another on one of Warsaw's main commercial streets. He had a wife, children, a house, and "really didn't have to worry about money." Neither did his kids. "I wanted them to have a secure future, be able to buy whatever car they wanted, whatever apartment…" he tells me.

Doing business in 1990s Poland meant setting out into uncharted territories, with both the opportunities and the risks such undertakings involve, but without many of the institutional, financial, or cultural resources of more established market economies. Enterprising and starting from scratch were, however, very much in the spirit of the time, and building a new middle class—which would be crucial to the new system, yet which was lacking after two generations of socialism preceded by a devastating war—could feel almost like a historical mission. Although he had little education (only a vocational school diploma) and no experience in trade and sales, Marek's practical talent fit right in with the economic reforms of the transformation, which allowed for private enterprise and the explosion of trade in a market long starved of consumer goods. But despite his success, or perhaps because of it, Marek would at times feel anxious and overwhelmed by his constantly hurried and stressful life in the unpredictable economic environment. He now knows that he was pushing himself too hard and ignoring signs telling him to slow down. "That life was hurting me," he tells me, "but I didn't even know I could live differently." His experience was one of entering the new reality on its terms but bearing costs he now says he hadn't understood.

He managed as long as his businesses were going well. By 2002, however, his fortune had turned: first one of his firms went bankrupt, then the other (an effect of the financial crisis in Russia in 1998, a tough lesson for many Polish businesses with partners in the East). He closed the stores and went into default on his business liabilities. Talking to me almost a decade later, Marek still has the court officer at his back—any income would still be garnished against his debts. "I can't go to work like a normal person," he tells me, and I note the irony in the multiple ways his normalcy has been lost. "The collapse consumed everything. And it was the feeling of guilt that pushed me into depression." Guilt about failing and, as he felt, ruining his children's future. For three years following the closure of his businesses, he barely left the house. He drank; he attempted suicide more than once; his marriage fell apart. "I was just a *depresant*, a clinical one." He was on medication, but that, he says, didn't help. In 2003, an old business friend—himself on disability due to depression, and with a drinking problem but determined to quit alcohol—persuaded him to go into alcohol dependence therapy. What followed were two and a half years in different treatment programs,

where Marek began to see depression, not alcohol, as his main issue. In early 2005, he was directed to AD by an alcohol addiction therapist and recovering alcoholic. AD was still in its infancy and the therapist, himself a veteran of AA in Poland, was helping to get the program off the ground. Skeptical at first, Marek gradually came to realize that he had no choice but to give it a chance.

What helped him bring his life to a turning point and entrust it to a "higher power" (a key achievement in any twelve-step program), was the public agony of Pope John Paul II's widely televised suffering before his death in April 2005—arguably one of the most significant communal emotional experiences in Poland since 1989. The humility and heroism of the ailing Pope's suffering and the commemorations of his life that followed moved the hearts of many and cemented John Paul II's position as the nation's greatest moral authority and the object of respect, love, and pride.[2] In those days, when many were inspired to vow moral renewal, Marek's life also took a turn.

He became involved in organizing new groups, helping to arrange the translation of materials they had received in the "starter kit" from the American Depressed Anonymous in Kentucky, and developing the fellowship. Over the following four years, Marek completed the program, began sponsoring other recovering *depresants*, and running AD workshops (*warsztaty*) where others could "work the steps," moving, one by one, through all twelve stages of personal and spiritual renewal. The program helped him transform his relationship to himself: he learned to understand who he really was by listening to his emotions; he gradually discarded false beliefs about himself and life—"misconceptions about reality"—like the idea that one should live for others, always follow social and moral norms, or that love is about giving; and learned to "put himself first" and "care for himself." But most importantly, he tells me, he stopped trying to control everything but instead began to rely on his "higher power" and "use powerlessness" in his daily life.

All of these are elements of the fundamental skill of living (*umiejętność życia*)—elements that, he explains, had not been fostered under socialism but which one needs all the more in capitalism, following a dramatic socioeconomic transformation that has brought a loss of security, but in which ideals of individual success and material desires run high. "Look at what happened in this country," Marek said to me, putting our conversation about depression into a similar historical context to most of my interlocutors, whether psychiatrists, therapists, or twelve-steppers:

> All of a sudden, people lost their jobs, industrial centers disappeared, education stopped mattering the way it had before … now you're no longer an engineer for the rest of your life—you could become one, but the [pace of] change is such

> that in a moment you can throw that diploma in the dustbin and [have to] become something else. And all that could have gone smoothly if it had happened over a few generations, but we fell into [this] monstrous loss of security in just one generation. There are no more factories where the father worked, and the son thought he too would work in the same factory, find a girlfriend in that same housing estate.

"I don't know…" Joasia voiced her disagreement. "I think most people today think about how *not* to do the same as their father but have no perspectives of doing anything else." "Yes," Marek replied,

> But [in the past] he knew that he had a place he could stay. And suddenly he is left with nothing. Because the factory isn't there, the perspective isn't there, he has to take care of it alone and everything falls apart. … They just end up on [antidepressants] and often on a disability pension. Which only solidifies their depression.

Describing people unable to find work and seeking the meager social security available to them in the underfunded state system, rather than those coping with burnout or being fired from corporate jobs, Marek was clearly speaking from his experience working in self-help programs as a free-of-charge treatment option for persons with mental health problems. For having learned to "put himself first," Marek saw his life become more than ever about other people. Working the steps, he gradually developed his own understanding of the method.

No longer a business entrepreneur, but still a talented organizer, he had become a community activist. Unable to take up full-time employment, he began to volunteer at a local mental health NGO. By the time I reconnected with him in 2013, he was managing it and had started another organization, a foundation, in which he runs his own twelve-step-based program aiming at a "life free of dependency and depression." The workshops, held at a community center recently renovated with E.U. funds, were contracted by the city. While still offering support for recovery from depression and/or addiction, they also emphasize prevention and personal growth and cater to a more functional, less pathologized clientele than AD. Rather than intervention in illness, Marek's foundation aims at optimization of health. Running two local mental health non-profits, he and Joasia (who used to co-own a small farm but now supports herself, in part, by cleaning apartments) make a humble living, but the main struggle they want to talk about is not making ends meet; it is with creating a space for people to learn to live free from depression and dependence, including dependence on public assistance.

In Marek's case, the twelve-step program—a local deployment of a precisely scripted, American program of self-transformation that has achieved global reach over the last decades—acted as a conduit of a broader "therapeutic culture" promoting individualism in the name of emotional well-being, personal liberation, and empowerment; a crucial element of late capitalism and advanced liberalism (Illouz 2007, 2008; Jacyno 2007; Rose 1989). At the same time, however, because of the ways its ethic of powerlessness has resonated with the historical moment in Poland, it has afforded him and others struggling to "manage their lives" a form of self-work and cultural space wherein to "think through," or rather "work through," the "new reality." That "working through" is part of the broader cultural and affective work of coming to terms with the reality that the hopes and opportunities held out by the transformation and Poland's E.U. membership would, in so many ways, for so many, remain unfulfilled.

This chapter examines the ethic of powerlessness cultivated in twelve-step groups targeting depression.[3] I draw on my ethnographic work with the Warsaw *depresants* and look closely at the ways their practice seeks to reshape their relationships to themselves (which I refer to as ethics) and the world (which I discuss in terms of agency).[4] I show that AD proposes a particular mode of agency that doesn't map cleanly onto modern ideologies of selfhood (whether liberal or socialist)—a mode of agency oriented towards recognizing and constricting rather than transcending its own limits. Showing how members struggle to attain a different agentic position in their lives, I argue that, in the Polish context, their experience becomes a way of living with a broader public secret of the "new reality"—that the opportunities and promises of the postsocialist transformation have in many respects turned out to be new fictions. It is in this way that *depresants* learn to see and accept "reality for what it is." I argue that while AD, as a self-help program, promotes ideological notions of personal and civil empowerment, based in liberal models of the self and of agency, AD's practice of "powerlessness" is in fact an exercise in failing to fulfill these aspirations and in accepting the impossibility of willful change of one's conditions as a sound basis for ethical life.

It is the ethic of powerlessness, not the emulation of entrepreneurial ideal types, that AD offers as a template for subject formation and social organization consonant with Poland's new reality. This ethic, I argue, is grounded in a "pursuit of realness" in a number of ways: through the notion that "reality" is something that reveals itself in an unyielding "reality check"; through the notion that the *depresant* has so far lived in a "fiction" and must be brought to see and accept "what is" and his or her lack of control over it; and through the precisely scripted program for acting and being "in reality"—by abandoning misguided beliefs and aligning oneself to the demands of reality rather than setting oneself up against them.

I argue that the ethic of powerlessness must not be considered as incompatible with neoliberal forms of subjectivity, but rather that it is proper to it as part of a dialectical dynamic of powerlessness and empowerment in liberal capitalism. While the pursuit of individual success has been greatly valorized in contemporary Poland, the less theoretically explored ability to fail functionally is, I argue, central to Poland's neoliberal culture of selfhood. Functional failure, or falling dramatically short of fulfilling the cultural ideals of liberal capitalism while still remaining within its grid of intelligibility, is key to neoliberalism as a political technology (as opposed to capitalism as a "purely" economic form). It is also at the heart of the liberal understanding of mental health.

Coming to terms with the underside of market democracy—not just the often dramatic consequences of the 1990s economic reforms but also the sustained production of the "new reality" in the 2000s—has been a key cultural and affective dimension of Poland's historical present. The AD model, and twelve-step culture more broadly, resonates deeply with this cultural and affective labor precisely because its philosophy centers on the individual subject and turns on an apparent contradiction: a dialectic of powerlessness and empowerment, individualization and dispersion of agency. The notion of agency evoked here seems analytically enabling precisely because it skirts dichotomous oppositions between achievement and resignation, independence and dependence.

My argument concerns the ways in which AD constitutes a cultural space for the practice of forms of negative agency and failure. Therefore, I focus on the powerlessness side of the abovementioned dialectic. While I acknowledge that "empowerment" and individuation are crucial to subject formation in twelve-step programs, an in-depth analysis of these elements lies beyond the scope of this chapter. Suffice it to say that much of the "empowerment" I observed in AD appeared a clear example of the much-analyzed "culture of therapy."[5] In many ways, the program aims for individuation effected through undermining adherence to widespread social values and norms, particularly those concerning one's responsibility for others and others' power over oneself.

In AD, it is crucial to learn to "put oneself first" by following one's emotions as guides, rather than traditional and strongly gendered norms of altruism and forbearance and conventions regarding what are considered legitimate personal values or right and wrong life choices.[6] This "empowerment," however, is simultaneously paired with a strong emphasis on powerlessness, which I analyze in detail below. AD does not offer a single, consistent, and coherent ethical vision or moral model, but rather a practical ethic generative of an agentic position explored in this chapter.

As I also show, with respect to my broader exploration of the theme of realification in Poland, AD serves as a technique of realness in that it operates

on a dynamic of *urealnienie*—a confrontation of an apparent fiction (and a gap it inevitably produces between what is proclaimed or wished for and what is experienced) with what is posited as an unyielding reality one has no choice but to recognize and accept. It also offers new ways of producing realness: recognizing one's lack of control over one's life (limited agency and no control over outcomes of one's intentional actions) is supposed to offer a more correct epistemology and therefore help close the reality gap. So, too, does "listening to one's emotions" in order to make individual choices rather than following entrenched social norms and values that dictate one's relationships to others and to the world. At the same time, as I show, the rise of twelve-step programs and the techniques of realness they cultivate historically coincide with the postsocialist and neoliberal realification in Poland.

In what follows, I first examine twelve step self-help programs as a specific cultural form. I describe the tenets of the recovery philosophy and program they propose and the brief history of its formation and diffusion, accounting for its broader cultural and political aspects. I then consider the context in which twelve-step programs arrived in Poland in order to show their resonance with the ideology of "new reality." The subsequent sections go into ethnographic detail of the ways in which the ethic of powerlessness is practiced in Warsaw AD groups and how it lends itself to negotiating subject positions in a cultural space where personal failures coalesce with the unfulfilled promises of the "new reality." I conclude with a discussion of the specific forms of agency and subjectivity produced in AD.

The Twelve Steps

In contrast to expert psychological and psychiatric interventions, twelve-step programs targeting addiction, depression, and even "life itself" occupy an ambiguous position in the field of mental health in general, and in the Polish "psy-" landscape in particular.[7] They are similarly just as marginal a topic in anthropology and sociocultural analysis.[8] They are nonetheless both socially widespread and culturally influential. These non-professional "fellowships of men and women" combine elements of psychotherapy, group support, and spiritual practice, while clearly separating themselves from psychomedicine, social activism, and religion (Mäkelä 1996; Valverde 1998; Woronowicz 2009; Kaczmarczyk 2008). While not a proper psy-discipline, self-help programs involve technologies of the self[9] that seek to produce self-governing, autonomous agents assuming responsibility for their life, health, and well-being. They also seem to be positioned somewhere between forms of psychiatric and psychotherapeutic

interventions and psychological programs of personal and professional growth used in corporate employee training or life coaching (cf. Dunn 2004).

This raises questions regarding the role of the "psy-" disciplines in formerly socialist countries following their market-democratic transformations. While the rise of twelve-step programs in East Central Europe has remained largely unexplored from this perspective (although see: Zajdow 1998; Raikhel 2016), the existing literature on similar addiction treatment programs, and on psychotherapeutic techniques more broadly, has pointed out a degree of consonance between new neoliberal ideals of personhood and forms of subjectivity and changes in treatment methods (Zigon 2010; Skultans 2007; Matza 2009, 2012, 2018). For example, Jarrett Zigon, in his analysis of an Orthodox-church-run drug rehabilitation program in St. Petersburg that bears some resemblance to the Polish depression self-help groups I studied, notes that the program "provid[es] a space for cultivating rehabilitants into self-disciplined citizen-subjects who are better prepared for reentering [the] new neoliberal Russia" (2010: 327). His analysis resonates with literature that explicitly, if carefully, connects advanced capitalism and neoliberal forms of governance with a dialectic of addiction and recovery mediated by the twelve-step movement (Valverde 1998; Sedgwick 1993).

The Twelve Steps of Alcoholics Anonymous are a charter of twelve statements that declare the consecutive elements of the program of recovery from addiction, using the overarching framework of "spiritual renewal." Each step succinctly describes and pronounces the achievement of another essential tenet in a process of personal and "spiritual" transformation. The transformation starts with admitting that one is "powerless" over one's problem (alcohol, gambling, depression) and that only a "higher power" may help the sufferer to again manage his or her life. It is followed by what amounts to a gradual reconstruction of self-hood: first, an examination of past errors (a "moral inventory" made with the help of an experienced "sponsor"); then making amends to those harmed by those errors; then a reconstruction of one's daily life according to a new code; and finally continued work in the program—on oneself as well as by helping other alcoholics and sponsoring members. Indeed, this interpersonal aspect of the program is often described to be as important as the work on the self.[10]

The twelve steps are themselves rooted in Christianity, specifically the Oxford Group, a nondenominational Evangelical movement of spiritual renewal whose members surrendered their fates to God. AA was founded in 1935 when Bill W. (William Griffith Wilson), a New York stockbroker on a business trip in Akron, Ohio, reached out to another drunk, a local surgeon, Dr. Bob (Robert Holbrook Smith), to help him resist the urge to have a drink. The two helped each other to stay sober and went on to establish the fellowship and the twelve-step method.

Bill W. (whose drinking had started to get the better of him during his successful career on Wall Street in the 1920s, and then dragged him down completely after the 1929 crash) was by then already on his way to sobriety. The turning point of his life had occurred a year earlier: while hospitalized on a rehabilitation program for alcoholics that involved treatment with the deliriant belladonna, he had a vision of God (as a bright light accompanied by a sense of peace and divine presence), which he followed up on by reading William James's *Varieties of Religious Experience* (Brandes 2002: 28). Spiritually awakened, Bill W. met with a former drinking partner who had quit booze in the Oxford Group and now convinced Bill to join (Brandes 2002; Mäkelä 1996; Alcoholics Anonymous 1976).

It was the Oxford Group's rules that served as the basis for the twelve steps. After a few years, what was to become the AA fellowship separated from the Oxford Group and the rituals, language, and focus of AA groups became more secular, or at least ecumenical. References to God in the steps took the open form "God, as we understood Him" or, more simply, "a power greater than ourselves." However, the role of religion in the formation of the program was as fundamental as the group format and spirit of mutual support. "[H]elping, talking to, or otherwise maintaining contact with other drunkards and engaging in some kind of spiritual activity" were at the core of the new program (Mäkelä 1996: 19).

By 1939, AA had one hundred members and *Alcoholics Anonymous*, commonly known as the *Big Book*, was published, giving the movement its name. In the early 1940s, the membership in the U.S. began to grow rapidly. As the movement gained popularity, offshoot programs soon began to emerge, targeting dependence on substances, compulsive behaviors, and relationships (and replacing "alcohol" with "narcotics" or "overeating," or "other people"). Though they are based on the same charter of twelve steps, and though a problematization of free will is a condition of possibility they share, these different programs nevertheless differ in the particular issues they address, their philosophies of recovery, and their visions of personhood, often reflecting the prevailing concerns and values of the various historical contexts and political climates in which they formed.

The American AA of the 1930s, '40s, and '50s focused on breaking down the alcoholic's false sense of pride and power over their drinking and sought to help them conform to social norms. It became deeply embedded in the white middle-class and working-class culture in the United States and, especially after achieving a degree of institutionalization, served to reproduce its values. Over time, however, the offshoot programs with their different preoccupations came to modify elements of the recovery philosophy itself. In contrast to the original fellowship, programs like Adult Children of Alcoholics (ACoA) and especially Co-Dependents Anonymous (CoDA) in the 1970s and '80s struggled, in accordance

with the zeitgeist, with the pains of self-liberation from the yoke of social conventions. Effectively, the paths to recovery they envisioned were, in important aspects, opposite to those of the original AA program (Irvine 1999; Valverde 1998). Or, as is clear in the case of AD, they came to contain, through the different components of the program, a tension between individuation and a vision of dispersed agency or even, in certain ways, between individuation and the very idea of a self-contained selfhood.

By the 1990s, both the number and variety of different twelve-step-based programs in the U.S. was exploding, a frenzy that Eve Kosofsky Sedgwick has aptly called an "epidemic of addiction attribution" linked to a "propaganda of free will [i.e.] … the imperative that the concept of free will be propagated" (Sedgwick 1993: 133; cf. Valverde 1998). Though the twelve steps had begun to "travel" internationally in the 1950s, starting with the Anglo-Saxon and Protestant countries and following patterns of alcohol consumption (see, e.g., Brandes 2002; Borovoy 2001, 2005), their growth in the 1980s (Mäkelä 1996) and the intensification of their international diffusion in the 1990s coincided with a global reorientation towards free market economics (Harvey 2007; Ong 2006), an intensification of global flows of cultural forms (Appadurai 1996, 2013), and a shift in the biopolitical relationships between states and populations, increasingly shaped by citizen-responsibilization (Shamir 2008). These broad dynamics form the backdrop of twelve-step programs' growing popularity, along with related crises of welfarism and an explosive commercialization and pharmaceuticalization of mental health care (Petryna, Lakoff, and Kleinman 2006), sometimes accompanied by a rise or demise of religious movements (Hansen 2012).

The circumstances of these structural changes, enacted at a globally ambitious scale, undeniably shaped the historical context in which twelve-step programs emerged in Poland. But more specifically, as I show below, the project of realification undertaken by Poland's market-democratic reforms resonated deeply with twelve-step programs' conceptualization of addiction and recovery, and its emphasis on the need to face reality and abandon fictions. How the logics of transformation and the philosophies of twelve-step self-help programs aligned and interacted in the 1990s bears upon how *depresants* are, today, mobilizing notions of self and circumstance, fictions and hard truths, and skepticism of late liberal models of agency as a way of living with the realities of post-socialist Poland.

Crisis and reform

Twelve-step programs arrived in Poland in the 1980s and '90s in the context of the deepening crisis of state socialism and the introduction of market-democratic

reforms. Both of these circumstances were reflected in the forms, levels, and quality of medical, psychiatric, and social care provided by the state and in the state's tolerance of social organizations and associations outside its direct control. The landscape of Polish addiction treatment—the immediate context of the introduction and popularization of twelve-step programs—had been fundamentally shaped by state monopolization and centralization of abstinence movements (previously run by the Church) and alcoholism treatment after World War II.

While it was declared, as per the oft-quoted dictum attributed to Lenin, that alcoholism—like prostitution and other forms of "deviance"—was a "survival" of bourgeois capitalism and would disappear in the future communist society (not unlike the belief that the drunkenness of the *Homo sovieticus* would end with the fiction of "real socialism"), the ban on temperance movements was part of a broader dismantling of civic associations or any independent, voluntary, local activity by the communist state, whose fundamental principle was to no longer be the society's *superstructure*, but rather its very *infrastructure*.[11] It's not surprising, then, that the first attempts to introduce AA—following the 1956 "Thaw"[12]—were blocked by the authorities; the content of the steps themselves, with their frequent references to God, did not pass censorship.

While some elements of the AA method were used locally since the 1960s, the first AA group began to meet in the mid-1970s in Poznań, with support from treatment professionals. The rapid multiplication of self-help groups began in the 1980s with the gradual political liberalization of the public sphere under late socialism. The number of groups grew from four in 1980 to 300 in 1989. By early 2009, around 2,100 groups of AA alone were meeting regularly in Poland. Various offshoot programs had emerged as well, including Al-Anon and Alateen, which provide support to families and friends of alcoholics, ACoA, CoDA, Narcotics Anonymous (NA), and Gamblers Anonymous (GA), among others (Woronowicz 2009; Kaczmarczyk 2008).[13]

The successful establishment of the AA method and movement in Poland occurred on specific local conditions that gave it a particular framing. One such condition was the urgency surrounding alcoholism as a social problem and the apparent inefficacy and inadequacy of existing methods, which relied largely on compulsory treatment and disulfiram tablets (bearing some similarity to the late Soviet culture of addiction treatment, see Raikhel 2016). But, more broadly, the second half of the 1980s was also marked by a dramatic economic crisis and an acute sense of the inherent inefficiency of the socialist state apparatus, leading to a deepening sense of living in a "fiction" of a functioning economy. The Economic Reform (*Reforma Gospodarcza*) of 1987–1989[14]—an attempt to liberalize the failing planned economy—both provided a sense of possibility of change and

exposed, through its failure, the "irreformability of the system," before it finally gave way to full-blown market realification in 1989.

AA's arrival on the scene thus figured within a set of larger discursive and symbolic forms characteristic of the mid-1980s centered on *crisis*, *reform*, and *urealnienie*. Just as the collapse of the fiction of the socialist economy constituted an emergence of truth in the form of "natural law"-like free market principles, so was it, on an individual level, that only the realization and admission that one had a problem could end denial and failures to self-reform.

What made the twelve-step message successful was not just its presentation as efficacious, "modern," advanced, and American, but also the related ideas placed at the foundation of AA philosophy: ideas of freedom, free choice, personal dignity, and self-determination. It also gained traction through its pledge to realness as opposed to fictions and lies. "Hitting bottom"—the AA phrase used to describe the moment of downfall leading to transformative confrontation with reality—shared with economic realification the formal quality of a revelation of truth at the time of crisis. In the politically and socially turbulent period of the 1980s in Poland, this was a powerful call.

The appeal and transformative potential of "hitting bottom" can be seen in the publications of one of the most ardent advocates of the twelve-step method in Poland, Ewa Woydyłło, a U.S.-educated addiction psychologist, writer, and promoter of a Western-style "culture of therapy." Woydyłło argued not just against obligatory treatment but also against different forms of social care and legal protection (in courts) that applied to alcoholics. The care and overprotection provided by state institutions, she argued, only allowed them to avoid "hitting bottom" and to continue living in denial. "None of the sober, recovering alcoholics," Woydyłło writes in an article from 1989,

> turned to the program because they were persuaded or came to understand something, but because someone had closed the protective umbrella and treated them, for the first time, like normal people, which means: made them bear the consequences of their own actions. (Woydyłło 1989: 6)[15]

The associations among "closing the protective umbrella," treating people like adults, and a return to health and normalcy were very much alive in the public sentiments and discourses that drove the postsocialist reforms, drawing upon psychological language to legitimize an Enlightenment social imagination—famously articulated by Kant as man's emergence from "self-incurred immaturity"—and austerity economics.

An intellectual with a diploma in psychology from California and close ties to the circles of liberal dissidents about to assume political power, Woydyłło

formulated her argument in a way that mirrored the message of freedom, truth, reality, and independence. Her principal emphasis is on freedom or, specifically, freedom of choice and the consequent responsibility: it is only if the alcoholic freely chooses to undergo treatment that it can be successful. His or her free choice to enter the program is a necessary condition of recovery. However circumstantial it may sound, it is notable that in 1991, a full five years before the translation of Milton Friedman's *Free to Choose* into Polish, Woydyłło published her own book about alcoholism therapy and life according to the twelve steps: *I Choose Freedom* (Woydyłło 1991).[16]

The popularization of self-help was also, in certain ways, part of a broader project of civic education. An equally important agent of the importation of the twelve-steps to Poland—along with many mechanisms of market democracy—was Woydyłło's husband, Wiktor Osiatyński, a professor of sociology and law, an influential public figure, and Poland's best known recovering alcoholic. During his years at American universities in the 1980s, Osiatyński found sobriety in AA and went on to author several very popular books and numerous articles about AA (as well as advise in the drafting of the new constitution of the democratic Republic of Poland in the mid-1990s). It was he who convinced George Soros to support the development of twelve-step-based therapy initiatives in Poland and to sponsor the training of Polish addiction therapists in the U.S. Facilitated by the Polish charter of the Soros Foundation—an organization committed to building liberal democracy in postsocialist Europe—the twelve-step program was explicitly proposed as a way of building civil society. As one former participant in the program, the Warsaw psychiatrist Dr. Bogusław Habrat, told me:

> Soros' idea was to create a civil society, that is, to teach citizens that things are no longer to be based on the state, but that everyone is responsible for themselves. It related to matters of the economy, the position of women, democratic rights, etc. And Osiatyński told Soros: you know what, this model is best implemented in AA, where they say: yes, there are problems, and there is the higher power, but at the same time things are in your own hands and you are responsible for what you're going to do. … So the goal … was to spread the ideology of AA, that exact self-responsibility, which seemed to fit what Soros was promoting, that is: "Don't count on the government, count on yourself."

These efforts led to the predominance of the twelve-step-based Minnesota Model in standard addiction treatments in the 1990s in Poland.[17] They were part of a broader educational campaign designed to help Poles learn how to live in a market democracy and civil society—and rely on themselves.

From specific metaphors of "hitting bottom" and freedom from dependency to more nebulous circulations between discourses and across registers, the twelve-step conceptualization of addiction and recovery resonated deeply with the logic of postsocialist transformation. In the sphere of treatment, the AA method and format was explicitly premised on doing away with a "state-socialist fiction." It promised effectiveness where the state-run treatment system was failing. It played on discursive affinities between the self-help language of freedom, independence, and sincerity, on the one hand, and, on the other, on the notions of crisis, reform, and the free market as a site of veridiction that underlay the critiques of the socialist state, itself about to "hit bottom." The transformation of actual "recovering" subjects was envisioned as a part of the systemic transformation and the promise of *urealnienie*. In other words, self-help was introduced to Poland as a way of not just shaping certain kinds of subjects, but also building a certain kind of society. At the level of the addict, the state, and the society at large, it was posited as a method through which to abandon fictions and enter reality.

Anonimowi Depresanci

I first learned of the Depressed Anonymous (*Anonimowi Depresanci*) group from a flier I came across at the psychiatric day unit at Dolna Street, where I had been observing the daily meetings of the depression psychotherapy group. I found the leaflets among the materials therapists would offer for future reference to patients concluding their therapy. Though the infrastructure of care in the capital city is incomparably better developed than in most other locations nationally, Warsaw mental health care professionals often complained about the lack of a "path forward" that would be available to patients after treatment. Community psychiatry had for decades been recommended by Polish experts but was never actually well-developed, and since the 1999–2003 health care reform, the issue of post-hospitalization options for patients had been left either to NGOs or to other "health care market participants," which have so far hardly risen to the challenge.[18]

Therapists themselves knew little about AD, but their unfamiliarity seemed favorably neutral. "Even if it won't help, it won't do harm either," Dr. Orłowicz told me, adding that patients generally benefit from the support such groups can offer. While attitudes toward twelve-step programs among the Polish "psy-" experts range from praise to skepticism, the perception of twelve-step programs in Poland generally differs from its perception in the United States in at least one important respect: participation in meetings is not made obligatory by court

orders. Although Alcoholics Anonymous is a well-known organization and AA meetings are held in psychiatric hospitals, I had never heard of a twelve-step program targeting depression as such.[19] Now, leaflet in hand, after several months observing psychotherapeutic practice, I was going to visit my first twelve-step meeting.

The AD group that became "my" group met every Thursday night in a parish building in a formerly industrial neighborhood where the industry, by now mostly dead, was gradually giving way to new middle-class condominiums.[20] The parish premises were relatively large and the two-story concrete building—much less charming than the church itself—was situated at the back of the well-maintained park-like yard. It was home to a number of church groups, but at least once a week *Anonimowi Depresanci* meet here as well, paying only symbolic rent from what the members leave in the collection hat put in the middle of the table at each meeting. The local priest, I was told, was sympathetic to twelve-step groups, which wasn't the case in all churches. The organization, too, wanted to keep its distance and avoid association with the Catholic Church. That said, out of Warsaw's four AD groups at the time of my research, two met on ecclesiastical grounds; the other two at a community center (*klub osiedlowy*) and at the main AA club called "H2O" downtown.

Meetings are held on the building's lower level. The entrance door leads into a dark corridor where concrete floors, exposed heating pipes, and a coat of monotonously pale cream-colored paint give it a distinctive basement feel. On the first of several otherwise nondescript doors leading down the corridor, black sticker letters read: "AN. DEP."—a sign clear enough to help newcomers find the right room, but also enigmatic enough to protect the group's privacy (and which I always spontaneously read as meaning "Anthropology Department"). Behind the door is a kitchenette (where tea and coffee were prepared by service members, who would volunteer for this role once every year) and a spacious, fluorescent-light-lit room. A large, rectangular table in the middle can seat as many as twenty people and additional chairs line the walls, but it was only on special occasions, such as the Christmas meeting, that the room would come close to filling up. Centrally, on the end wall behind the table, hangs a large crucifix—part of the room's original furnishing—and next to it, on the side, a large banner carrying the blue-and-white logo of Alcoholics Anonymous: the two letters "AA" in a triangle surrounded by a circle and the words "*Jedność, Służba, Zdrowienie*": "Unity, Service, Recovery."

The meetings themselves struck me as strongly democratic and horizontal—a clear difference from the other social spaces constituted around the problem of depression I had seen, such as clinical wards or therapy groups, typically expert-led and strongly hierarchized. The non-professionalism of self-help groups

makes for an ambiguous relationship with experts, marked at least by distance. The only authority—based, still, on voluntary recognition—are the steps and traditions of AD (and AA), and the flatness of the structure is palpable.[21]

Meetings were socially heterogeneous in terms of gender (roughly as many men as women), age (from early adulthood to old age), and class or socioeconomic standing (as much as appearances and the stories shared could betray, signs of impoverishment, modest means, and personal neglect were more readily visible here than in psychotherapy groups). In this setting, participants could listen to and possibly take important lessons from people with whom they would otherwise never cross paths in any socially significant way.[22] The presence of men was striking not only in comparison to the hospital day ward group, but also in light of the oft-repeated but not uncontroversial "basic fact" of the psychiatry of depression that this particular affliction occurs twice as often in women than it does in men (Hirshbein 2009; Dunlop and Mletzko 2011; cf. Showalter 1987).[23]

What left an impression on me from the first evening I attended this group was not only the frankness of the narratives of everyday struggles with mood and attempts to stay healthy, refrain from worry, and rely on the higher power in the face of distressing personal events, but also another kind of intimacy unseen in psychotherapeutic groups: at the end of the meeting, while reciting the "serenity prayer"—a common closure ritual in twelve-step groups—everyone in the room held hands. While the handshake remains the standard gesture of greeting (especially among men, women often being offered other forms of salutation which may or may not involve direct physical contact), holding a stranger's hand for longer than that standard second is, particularly for men, a rare experience in Poland. It signals and establishes a shared intimacy that sets the social space of the meeting apart from the "normal" conduct of life.

The presence of men could, at least in part, be attributed to the link between AD and the highly masculinized AA. I would eventually learn that many (between one third and one half) of the members had come to AD through AA or another twelve-step program (like Antoni, a veteran of both AA and Gamblers Anonymous, a World War II orphan who spent his life as a ticket scalper in Warsaw and now lives as a single older man on the verge of homelessness but with a newfound Catholic devotion and a lingering weakness for televised horseracing; or Zbigniew, a musician and writer who'd come just short of having made a public name for himself in either area, but often talked about the mental toll of his successes and failures; or Agata, from a "good" home of Warsaw intellectuals and artists, whose young adulthood in the 1980s and '90s evolved around parties and a vision of a bright future in the "new" Poland, and whose depression had been, in her account, masked by her drinking).

Some of the members were currently seeing a psychiatrist but treated the meetings as a form of therapy, which they otherwise couldn't afford or didn't find sufficient (like Kasia, hospitalized after a suicide attempt a few years earlier, while in her early twenties, now unable to find long-term therapy that she can afford with what she makes working in retail; or Konrad, who had quit his medical studies after bouts of depression and was now, at thirty, under a psychiatrist's supervision, supported financially by his parents, and spending much of his time at home watching TV; or Wojciech, a fifty-year-old vegetable farmer from just outside of Warsaw whose primary care physician prescribed him antidepressants and referred him to a specialist). Others, however, were not under any professional care (Piotrek, in his late twenties and looking for a job, had never even sought that kind of help—AD was the first place he came to because of his depression, which he had not suffered from earlier in his life). Regardless, it seemed as though for many of the participants an important reason for coming to meetings was loneliness (as it was for Teresa, elderly and a retired office worker, living alone and traveling from the other side of town to make it to at least a couple of meetings a week; or Tomasz, skinny and quiet, in his fifties, who had spent over twenty years working in construction in one of the cities in the Northeastern U.S. and recently, after a divorce, returned to a lonely life in Warsaw, where he no longer felt at home).

AD meetings have a fixed and ritualized structure which is fairly uniform in twelve-step meetings around the world. They are led by a person elected for this function (or, as in the case I witnessed, the only one who volunteered) for a year at a time. After the candle on the table has been lit and cups of hot tea and coffee placed in the middle for everyone to help themselves, a meeting starts with the recitation of the preamble (a modified version of the AA preamble) by the chairing person: "Depressed Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from depression." It is followed by the AD credo: "We accept and believe that although today everything may seem hopeless, now is the right time to make the decision to recover. We are not helpless. Today we choose to feel better." Next, laminated sheets listing the Twelve Steps and Twelve Traditions (which regulate the functioning of the fellowship rather than its philosophy of recovery) are passed around and read aloud by volunteers. Finally, the person chairing the meeting asks if anyone in the room is new to AD. A newcomer would then be asked whether they are willing to "give up agonizing worry" or "mortifying sorrow" [*zrezygnować z zamartwiania się*]. That performative speech act is the only condition for becoming a member of the AD community and for being welcome at any meeting in the world. The newcomer can then say a few words about him- or herself.[24]

After the opening procedures, an excerpt is read from the by now extensive twelve-step (AA or AD) literature in Polish—either a brief chapter from the book of daily reflections or thoughts on a particular step. A meeting will typically proceed by passing around a piece of paper with a couple of questions further elaborating on the theme. Receiving this note in your turn is an invitation to speak to the questions or share any other thoughts, but speaking is not required; it's okay to pass. The rules are simple. Before speaking, one introduces oneself by giving one's first name and recovery identity, which may be multiple. "[My name is] X, [I am a] *depresant* and alcoholic" was not an uncommon self-description. Those new to the program may not yet use an identity label, but having one is by far the norm. One speaks only about oneself rather than commenting on what others have said or giving advice. Speaking concretely, as opposed to "abstract intellectualizing," is also encouraged. The topics of religion and politics should be avoided. A three-minute rule limiting the time one has to speak is stated, but, from my observations, rarely imposed, even when people go on at length. Incidentally, AD meetings, as I have often been told, tend to be less lively and voluble than those of AA and other groups. There is, if anything, a certain anxiety around silence and non-participation.

At the end of each meeting, which lasts for two hours and includes a ten- or fifteen-minute break during which many of those present go out to smoke and chat, the closing ritual consists of two things: first, someone will read the "Desiderata," the inspirational poem authored in 1927 by the American writer Max Ehrmann. Widely and wrongly believed to be an anonymous text found in a church in Baltimore and dating back to the 17th century, "Desiderata" is something of an anthem of abstinence and sobriety movements in Poland; the text was the theme-song of a popular 1980s TV program on alcoholism, *Wódko, pozwól żyć!* ["Vodka, let live!"]. Reading and listening to "Desiderata" tends to be contemplative, and the poem's tone helps end the meeting on a quietly optimistic note. The second and final element is the standing recitation, while holding hands, of the so-called Serenity Prayer, adapted by AA and other twelve step programs: "God, grant me the serenity to accept the things I cannot change / The courage to change the things I can / And wisdom to know the difference." This succinct formula expresses the central tenet of the twelve-step method: the ethic of powerlessness; a shift in the philosophy and practice of agency that transforms the relationship between the subject and what is posited as "reality." In what follows, I discuss in greater depth how powerlessness translates into forms of ethical and agentic practice that play into the broader cultural and affective work of coming to terms with the actualities of Poland's "new reality."

Powerlessness

Admitting powerlessness is the first and most fundamental of the twelve steps. Just like alcoholics admit their powerlessness over alcohol, Depressed Anonymous say: "We have admitted that we are powerless over depression—that our lives had become unmanageable." The phrase points to an apparent paradox: in order to regain relative control over one's life one has to admit one has lost it and can't even fully possess it—that there are only some things in our lives we have power over (Bateson 2000; Berenson 1991; Herndon 2001, see discussion below). The rest has to be left to a "power greater than ourselves" (step two and three) regardless of how one signifies that power—as God or destiny, or society, or the group.[25]

I had noticed references to powerlessness during the meetings I attended, but I only came to understand the importance of this concept when I started attending weekly workshops, *warsztaty*—separate meetings where a group of members "work the steps" more gradually, through talking, listening, and exercises, moving through the process of moral transformation that members suggest typically takes between one and a half and two years. There weren't many new members wanting to join the workshop, and even though some of the more tenured ones were interested in coming, the two-hour Friday evening sessions sometimes attracted only two or three members, an attendance, I was told, that was very different from some of the earlier editions run by experienced twelve-steppers. This time, they were led by Kasia—a woman in her late twenties who had been coming to AD for a couple of years and only recently finished working the steps herself.[26]

Powerlessness is at the core of the first step as the foundation that opens the way to recovery. It is supposed to break through the denial that AA understands to be central to the mechanism of addiction: it is admission that one has a problem—an illness—and that it is a problem that is beyond one's power to fix. In AD, the step that is taken is accepting that depression, or the tendency to get depressed, is among the many things in one's life one cannot control. In the words of the Serenity Prayer recited at each meeting, it is about recognizing the "things one cannot change." According to the twelve-step philosophy, this acceptance—indeed, a recognition and acceptance of "reality"—is a precondition of ultimately coming to manage one's life.

Yet the concept of powerlessness isn't immediately clear and, in the small group of AD adepts I saw "work" the first step, it took several weeks of workshops and meetings to begin to form one's own understanding of it. The *First Step* handout passed around in the workshop—a short essay introducing the new *depresant* into the fellowship—didn't explain the paradox of powerlessness any better than the following:

> Thanks to admitting that we have lost control we can remedy our depression. We learn that—paradoxically, counter to our understanding of depression—it is only when we give up control of our life, thinking, and action, that we can truly get it back. (*Krok Pierwszy* [*First Step*] n.a., n.d.: 1)

Rather than absorbed from such laconic written formulations, powerlessness would be contemplated, discussed, and tried over several weeks in workshops, meetings, and home assignments. It all starts with considering the meaning of words—examining, clarifying, and redefining one's understanding of the terms "powerlessness," "helplessness," and "to admit." What is meant by these twelve-step concepts will be shown to be different from what most of the participants associate with them.

Powerlessness, the group will be led to conclude, is not a crippling loss of control, but *the basic human condition in the face of reality*. We have little or no power over most of the things that constitute our world, especially depression (or, in most twelve-step programs, the drug of our addiction) when it takes hold over one. "Admittance" need not only be a concession to a weakness or fault but may serve as a source of strength and liberation. And even when powerless, there are still things one can do, things one can change: go to a meeting; work the steps; call a friend for support; find ways of addressing some aspects of a situation that is beyond one's control and adjusting one's own place in it. This is where the word "helplessness" [*bezradność*] becomes crucial. In contrast to powerlessness, helplessness signifies resignation despite the possibility of action. "Powerless, but not helpless," I often heard in meetings. The difference—again, one at the center of the twelve-step prayer—is key and, as I show below, difficult for many *depresants* to identify and keep. As Zbigniew, a returning member of AA and AD who is taking the steps workshops again after a few years, prompted by a recent episode of depression, says:

> Powerlessness is a lack of feeling of omnipotence in my life. … I am powerless over the fact of my depression coming and going. But I'm not helpless. I can keep doing things about it. I am powerless over my childhood, there is no way for me to fill that black hole. … I am powerless over my son, over others, over the driver who almost killed me. But I'm not helpless, I will not declare helplessness.

This refusal to declare helplessness was his rationale for returning to the program after several years of life free of "mortifying despondency."

Powerlessness is thus the recognition of the limits of one's agency in life—and of the very ways in which that agency may be exercised at all. It is, as each *depresant* puts it while reciting the Serenity Prayer, the ability to tell the difference

between what one can and cannot change—and to accept what one cannot. But that difference, as well as the acceptance, are difficult to identify. The boundary between powerlessness and passivity—the latter being at the core of *depresants*' problem itself—often seems blurry.

The difficulty of finding that balance was apparent in the *depresants'* attempts to learn to "*use* powerlessness," a task AD members were assigned in the workshops. It is one thing to talk about it and draw connections between one's life and broader economic and historical forces (which the program discourages one from doing), and quite another to actually use powerlessness as an ethical guide in one's life. Powerlessness is "important only when I can use it practically," "it's concrete and practical to the core," members say. It is not an intellectual notion but a practical attitude. It means more than "accepting [*uznanie*] that one will not fight something against which one cannot win." Discussing the results of their attempts to use it, the Warsaw *depresants* show the versatility and down-to-earthness of the method.

Konrad, around thirty and a seasoned AD member, talked about animals killing and eating each other—it upset him when he sat at home watching Animal Planet. But he used powerlessness, acknowledged that it must be this way, that someone had arranged it so, and he felt some relief. Before sharing this, he complained about his worsened condition and the return of suicidal thoughts. He had recently started a new antidepressant that hadn't yet kicked in and that very night he was supposed to attend a social gathering, for the first time in weeks, which was already getting him down. "They all have careers and families by now," he said. "I'm not looking forward to that confrontation." He was powerless over that fact, he said, as he was also powerless over his mood.

Piotrek, in his late twenties, used powerlessness in looking for a job. Often, in the mornings, he would plan to look through job announcements and to send out applications, but then a sense of powerlessness would overcome him; he had been trying for several months with no results, despite his college diploma. "One can't get a job through an ad, it's all arranged through connections. I'm powerless over that," he concluded. He didn't have such connections, and now his depression made it even harder for him to try out new ways of finding a job.

Other participants' attempts to "use powerlessness" involved not going to the gym because of the weather (indeed, often bad and depressing, especially during the long winter months), ceasing to try in vain to change other people's opinions, saying "no" to social commitments because of feeling depressed, quieting their rage at public transportation (delays, poor service), dealing with witnessing abuse at work, and coping with rudeness and aggression in daily interactions with strangers ("Poland is a country of frustrated people [*Polska jest krajem frustratów*]," they'd sometimes say).[27]

These examples of how participants were experimenting with powerlessness are easy to read as self-defeating rationalizations, a retreat from self-assertion—an ethic of stoicism, if not passivity—in the face of mistreatment or state or social failure. As I learned, these disconcerting first readings are not far off from what is, in fact, intended in an ethics of powerlessness, but only insofar as it is precisely the contents and ethical valence of a historical concept such as "self-assertion" that is under active questioning. It is such an ethic of self-assertion that is key to the explicit ideologies of selfhood, self-determination, and personal responsibility that have held so much salience since the transformation of the 1990s; an ethic that, in the twelve-step reading of depression, allows for the *depresants*' often muted but relentless insistence that things be otherwise. That insistence is what needs to be surrendered through powerlessness.

Two further accounts of how AD members work through and upon the idea of powerlessness better bring out that insistence and expose the effort to reshape, inherent in the ethic of powerlessness, the relationship between the self and the world.

Kasia told the story of finding a kestrel with a broken wing and bringing it to a bird asylum, skipping her own doctor's appointment to do so. When she got there, she learned that the veterinarian had already left and that the injured bird's care would have to wait until the next day. She was very upset but told herself that she had done everything she could and that she's now powerless over the outcome. As Kasia continued to tell this story to workshop participants, it became clear that there was something more to it: "My wonderful plan—that I would make a sacrifice and save the bird and they would heal it—collapsed," she said, and she had "used powerlessness" to counter what she now described as her own grandiosity. "Powerlessness" meant not only accepting that she could not control the course of events, but also giving up on the image of the idealized, heroic self. Or, to put it differently, powerlessness, as depicted in Kasia's story, is the recognition that selfhood and reality are intertwined in a way that makes the notion of the former controlling the latter through willful agency a misconception of their relationship. The realization of the subject's will through a control over reality is a harmful fiction. Admitting powerlessness is thus "seeing reality for what it is" as much as it is assuming a very different agentic position.

This point was made again at the conclusion of the workshop on "working" the first step. The group discussed the closing question: "Am I able to admit to myself that I'm not coping with the illness?" "What are my feelings about it?" Zbigniew put the question in somewhat different words: "Can I accept 'non-perfect recovery'?" he asked, and offered the following answer:

> I used to have a fantasy image of myself [*wyimaginowany obraz siebie*] but I didn't know it was fantasy-based. I sought perfection. And when I got to AD I also had

> this approach that now I'm going to recover and [in that way] I will execute my program of being perfect. I gave myself one year: that if I don't recover by next July, I'm going to kill myself. It was just an attempt to bring to life this perfect self-image that I had. The point was *not* to accept a "non-perfect recovery"—that is [one which is] gradual, with many defeats, but still a realization of that ideal self-image—but rather to "*recover towards imperfection*," that is, free myself from the perfect, idealized image of myself that had been holding me by the throat for years. To recover does not mean to get rid of the difficulties in achieving the ideal, fantasy image of oneself, but to get rid of that image and accept *oneself and reality just as it is*. (Emphasis added)

As Zbigniew explains, speaking from his by-now-extensive twelve-step experience,

> powerlessness is not having agency [*sprawczości*, the terms also used in the sociological sense of "agency"] in my life, in some aspect of it. So admitting powerlessness is a strength rather than a weakness. It removes the weight of guilt from my shoulders. It is admitting that solving the problem is not on me—and [it means] accepting my weakness.

The recurring slippage between agency and resignation, weakness and strength, powerlessness and helplessness, taking responsibility and disclaiming it, is precisely what I am focusing on. Rather than seeking a precise delineation between the terms, I take the frequent confusion—both conceptual and practical—experienced by *depresants* as a cue that this self-help philosophy and the subject positions it dictates come up against the ideologies of agency and the forms of subjectivity around which the market-democratic project of the "new reality" has been constructed. These are modern, Western (in the broad sense) forms, constituent of the active, rational, and will-driven agent, the "heroic, Promethean, hubristic" individual subject (Bateson 2000; Latour 2008: 3), the protagonist of liberalism; forms thought to have long been "blocked" by the "unnatural" fiction of communism (modern and hubristic as well, but centered on state control of activity rather than individualism and free enterprise). They are expected to reign supreme under market-democratic conditions with the release of the citizens' entrepreneurial energies and self-governing capacities. But what they are met with instead in AD is a cultural and affective "working through" of the failure to fulfill them.

However simplistic in their service of a tightly scripted recovery program, these discussions and struggles, as they were unfolding in a stuffy basement room of a parish building in Warsaw, show *urealnienie* in AD as an exercise in

accepting and inhabiting that failure through the ethic of powerlessness. This ethic does not insist on a perfect application of the program and a "perfect recovery" leading to a life free from mortifying worry and sorrow. Rather, the practice of powerlessness is itself fraught with failure—powerlessness is sometimes "understood incorrectly" or "used improperly"—but such denouncements are merely didactic and technical, for failure is precisely the point. Telling the difference, indefinite by nature, between what one can and cannot change invites constant slippage—for many *depresants* it is "erring" on the side of what they call "helplessness." This slippage, I suggest, is very much a part of the ethic of powerlessness and the realification it engenders: a contemplation and practice of falling short. Their problems will not be resolved here; the notion that delineating a more "realistic" horizon of agency will free up the energies to stay "free from depression" is, as I show below, as elusive as sorrow and worry are in comparison to the concreteness of drinking.

Rather, creating a more inhabitable space within "what is" and what conceivably won't change for the better is what the ethic of powerlessness may allow. The self-help philosophy that emerged in Poland as a technology of freedom and sovereignty is, in AD groups twenty years later, predominantly a technology of agentic reservation, if not resignation (Dumm 1999) – or, to follow Lauren Berlant's (2007) terms, a form of "lateral agency" in the face of "cruel optimism."[28]

Entrustment

The act of acknowledging powerlessness is connected with that of *entrustment* (*powierzenie*), which at once translates the phrase, in the third step, "*turn* our will and our lives *over* to the care of God, as we understood Him," and, in the Polish context, refers to the Catholic concept of personal dedication to the Virgin Mary and accepting one's suffering as a sacrifice to God. This act has a long tradition in Catholicism and a particular importance in Poland, where various forms of suffering, often explicitly political and specific to historical conditions of oppression and war throughout much of the 19th and 20th centuries, have been culturally elaborated in both the national-romantic literary and the peasant traditions and continue to deeply inform culturally available identity narratives (Janion 2006; Jakubowska 1990). Ideas about enduring one's suffering as an act of piety and about the strength one can gain from assigning religious meaning to mental anguish (for example, by contemplating the pain of both Christ and Mary) were recurrent in workshop discussions as well as in my conversations with patients in psychiatric wards. They are rather foreign to the Protestant and

positivist ethos of AA and, as I show below, often encounter resistance in meetings but are nevertheless prevalent. Just as the line between "powerlessness" and "helplessness" often turned out to be blurry in practice, so did the notion of entrustment pose a problem to many *depresants*—a problem of seeing it as a method of practical empowerment rather than finding mystical meaning in suffering.

Many—though not all—of the *depresants* with whom I worked were devout Catholics, sometimes having returned to faith under the influence of the program and its concept of a higher power. But many of the believers, in ways that surprised me, spoke critically of the Catholic Church and its power over the available forms of religiosity and about the traditional approach to Catholicism as an element of Polish national identity rather than as an individual experience and ethic. The way they talked about faith was strikingly personal. A few of them had personal confessors and spiritual directors, often Jesuits.[29] Although different twelve-step books of daily meditations were often cited in meetings, such as the AA *24 Hours a Day*, several *depresants* talked about regularly reading Thomas à Kempis' *De Imitatione Christi*, a 15th-century book of Christian devotional meditations, also used by Jesuits, which stresses withdrawal from the world, focus on inner life, submission to the will of God, and a dissolution of the self with its own will in the divine will.[30]

As discussed, studied, and practiced in twelve-step workshops and meetings, entrustment is a very mundane instrument. Just like powerlessness, it is something one uses as a tool (*użyć bezsilności*) in everyday situations. As Marek explained to me:

> [It] is not about being on my knees in the pit, but [about] purely, totally practical things. I can do it in any situation, at any moment: at an exam, at work, anything. … Entrustment is to say: nothing depends on me. I can enter any situation, any group, because neither am I all that important nor is there that much that depends on me. I can only be just what I am—the rest is up to God and reality, which I don't control. … When I'm going to do something, I'm just relaxed because I'm not controlling my surroundings, I'm not telling you what you should do, [or] how I should behave so that you feel this or that, so there is a certain freedom [*swoboda*] and energy left for other things. … Which doesn't mean I'll do everything perfectly, but I have the right to err—otherwise the blockage from action is huge.

But learning to understand one's own limited power and entrusting one's life to a higher power can be tricky, especially for a *depresant* who suffers from a sense of futility and tends towards helplessness. Agata, in her early forties, had

been in alcohol therapy and AA, but she turned to AD because, as she explained, alcoholics didn't understand her when she constantly talked about her depression. She felt more at home with other *depresants*. We were sitting in her cozy attic apartment in central Warsaw, where stylish antique furniture tastefully composed with modern décor told of an elite *inteligencja* background and of a past job (long lost) in TV and film production. With us was her best friend, Bożenka. They had met years ago in an inpatient ward of a neurosis clinic. I learned about her difficulty with the concept of powerlessness. Agata had stopped going to AD because she discovered that the meetings were making her feel worse.

> We took it to mean that now we must stop feeling negative emotions … and now we must give ourselves to God and wait for him to come up with something. And he'd make it so that we'll feel different. … "I am powerless [*bezsilna*] over depression" meant that I should stop forcing myself to do certain things, I should just let go, that's it. So I did let go and put myself to bed and said "I have no strength [or power, *nie mam siły*] to do anything—but I will pray!" And I'll ask God to grant me a job, or a guy who'd help me, because I have no strength. Or, better yet, to take away my depression. … When we got to the moral inventory and we were to write down the faults of our character, I broke down … My feeling of guilt came. [My friend] had the same.

Agata wasn't blaming the program but herself: while working the first steps, supposed to prepare you for further recovery and moral reconstruction, she wasn't very committed. She was coming to meetings mostly for social reasons. Now, it's different. After a few years of unemployment, she has gotten a job through a friend as a guide at a local museum. Before, she would have dismissed such work as menial, but having grown more humble, she took it. She says that she knows that her higher power will only help if she also tries to do all she can. She entrusts things to God. How?

> I read the [AA] book of meditations, *24 Hours*, every morning … And I pray every morning, and evening … Like: "I entrust to you this day, may everything go well, give me strength, courage, and power to rise to it [*żebym mu sprostała*] …" Yes. And, "I entrust to you my anxiety, my depression, my dependence …" And then I have this feeling that … someone is watching over me, you know? That nothing actually bad can happen to me. If it does, it was supposed to be. Meaning, you know … *If they fire me from this job, then perhaps, if I've done everything right, then maybe it makes sense. That I should be doing something else.* (Emphasis added)

Agata's practice of entrustment subtly but clearly differs in its inflection form Marek's more optimistic and generic account. His exposition, which he was at

the time actively developing in his ongoing adaptation of the twelve-step philosophy into a depression and dependence prevention and personal development program, foregrounded being "more relaxed," individuated and free, with freed-up energy and the "right to err." In Agata's account, entrustment invokes notions of care, humility, acceptance, and resignation.

The powerless subject

What mode of agency emerges in AD? And what can it tell us about the politics of subjectivity in Poland's "new reality" and ongoing formation of the social?

Powerlessness and entrustment seem enabling—both existentially and analytically—precisely because they complicate dichotomous oppositions between freedom and dependence, between being the subject *of* one's life and subject *to* one's lot. This, one could say, fundamentally human problem has been put in a new practical context by the postsocialist transformation of the 1990s, through which questions posed in terms of individual responsibility, independence, and freedom took on new significance. As I am arguing here, the answer that twelve-step programs offer to these questions reshape the very notion of selfhood and the relationship between the self and "what is." Rather than a self-contained entity in constant pursuit of its own interest (as a common image of modern, Western, capitalist selfhood would have it), the ethic of powerlessness posits the subject as an element of a greater, dynamic, uncontrollable whole—at once a lived psychological reality and a partial congealment of a broader constellation of elements.

In a 1971 essay based on his work with AA, in which he lays out a cybernetic theory of alcoholism and the self, Gregory Bateson offers an account of "powerlessness" I find very helpful to my analysis. "Philosophically viewed," he writes, "th[e] first step is not a surrender; it is simply a change in epistemology, a change in how to know about the personality-in-the-world. And, notably, the change is from an incorrect to a more correct epistemology" (Bateson 2000: 313). The sobriety of the alcoholic, which presumes that he can control drinking, is, in Bateson's view, an "unusually disastrous variant of the Cartesian dualism," in this case a dualism between "will" or "self" and the remainder of the personality-in-the-world (313). "The 'self,'" Bateson pointedly adds, "is a false reification of an improperly delimited part of this much larger field of interlocking processes" (331). The powerlessness of the self is then simply a recognition that "in no system which shows mental characteristics can any part have unilateral control over the whole."[31]

But there is more. Central to Bateson's argument—and to his anthropology more broadly—is his distinction between *symmetrical* and *complementary*

relationships. Symmetry occurs, as he puts it in his cybernetic terms, if "in a binary relationship the behaviors of A and B are regarded (by A and B) as *similar* and are linked so that more of the given behavior by A stimulates more of it in B." If, conversely, the behaviors are "*dissimilar* but mutually fit together (as, for example, spectatorship and exhibitionism)," and "more of A's behavior stimulates more of B's fitting behavior, then the relationship is 'complementary' in regard to these behaviors" (323). "Common examples of simple symmetrical relationship" Bateson continues, "are armament races, keeping up with the Joneses, athletic emulation, boxing matches, and the like. Common examples of complementary relationship are dominance-submission, sadism-masochism, nurturance-dependency, spectatorship-exhibitionism, and the like."[32]

In Bateson's reading, the alcoholic's relationship to the bottle is deeply symmetrical; alcohol is a challenge and the pride that the first step is supposed to break down—his belief that he can control his drinking—is "an obsessive acceptance of a challenge, a repudiation of the proposition 'I cannot'" (321). Accordingly, "the religious conversion of the alcoholic when saved by AA can be described as a dramatic shift from [his] symmetrical habit, or epistemology, to an almost purely complementary view of his relationship to others and to the universe or God" (326). Importantly, Bateson adds, "the single purpose of AA is directed outward and is aimed at a noncompetitive relationship to the larger world. The variable to be maximized is a complementarity and is of the nature of 'service' rather than dominance" (335). Occidental epistemology, in Bateson's terms, is one that leads us to believe that "our relation to the largest system which concerns us—the 'Power greater than self'—is symmetrical and emulative." But believing that, Bateson states, we're in error.

While in AA the shift from symmetrical to complementary epistemology, to stay with Bateson's terms, happens via a change in the relationship to alcohol, in AD the situation is more tricky—and this is where the broader issue of "entering reality" comes into view. Depression is not a substance one must abstain from. If the twelve-step philosophy sees the alcoholic's symmetrical relationship to the world congeal in his relationship to alcohol, for *depresants* the challenge would seem more directly distributed throughout life as such.

While alcoholics, according to the AA wisdom, are "cocksure" that they can control their drinking and lead themselves on to another binge, *depresants* tend rather to see the world as a challenge they already have lost or are about to lose—and fall on the side of helplessness.[33] Thus, where alcoholics need rigor in bringing up behavioral barriers between themselves and the bottle (say, by keeping away from the company of liquor-loving friends), a "binge" of mortifying sorrow in a *depresant* may be provoked by things inevitably a part of the larger world they live in, like competitive work culture.[34]

As they understand it, escaping life has been exactly their problem and trying to avoid the world—even with all its anxieties and inevitable disappointments—would risk falling back into depression. This, again, means a negotiation of "power" and "powerlessness," avoidance and engagement. To return to the recovering *depresants* who opened this chapter with their insights about the particularity of depression in Poland's postsocialist context, Marek and Joasia told me:

> Marek: We cannot, as they do in AA, categorically cut ourselves off from certain things. We have to enter into this world, which is globalizing, which has its conditions. But we have to see [those conditions], see that rush is unnecessary, that the rat race is destructive—but that doesn't mean we cannot take part in it. … Of course we do it, the young people do it, and they suffer, because it hurts. You can go in that direction, against your own humanity, but at some point you break—some sooner, others later, others yet spend their entire lives like that, never being happy.
> Joasia: It's ok to work in a corporation, most people get on with that, but it's good to have the awareness that it's a choice I'm making and what the cost may be. And maybe make that choice for a certain time, with a certain goal. But it's not a goal in itself.
> Marek: … So if I accept it, that I can enter this world, I can go work at a bank … —as long as it doesn't ache me. But once I am spiritually awakened, I am not going to do that. For the simple reason that I would realize that *I* feel bad with it. But that doesn't mean I should break that bank and run, but that I should slowly begin to look for a new job. To take care of myself in that way.

"Globalization," as was clear from the context, was a reference to the "new reality," with its arrival of Western-style work regimes, and to capitalism more broadly, where, as Marek put it, "the human being is subordinate to the corporation and has to adjust to the demands of the corporation."[35] "That's where the world is going and there is nothing we can do about it—but that's what we have powerlessness for," he added.[36] Talking about "entering the world" that is likely to hurt or "destroy" you, Marek addresses what, I argue, lies at the heart of AD and other twelve-step programs as a cultural space where one comes to terms with the contradictions, or the *reality*, of "new reality."

It is the problem of becoming the subject, the agent of one's life in the apparent conditions of freedom that still feel as though they place innumerable limitations on and challenges to one's power over one's life. Those limitations, however, are not as easily perceptible as they were under state socialism—they are not mediated by institutional control in the name of obvious "fictions," haunted by a vision of a referential "elsewhere" in the West, where things were imagined to be otherwise. Rather, they seem and are said to be limitations and

challenges inherent in reality as such. It is thus that "programs for life" offering ways of dealing with apparently general existential problems proper to the human condition "as such" take on a historically specific significance in post-transformation Poland.

What Marek is describing when he says that "sooner or later you'll break" is strikingly similar to what Polish professional psychiatrists and therapists talked about when, between seeing patients, they reflected on the broader context of their professional experience: the depressions of people who lose their jobs while heavily in debt; persons who "decompensate depressively" because today's reality more often confronts them with difficult situations; those who break down because they "failed to adapt" to the new reality; and those who do so because they entered it "uncritically." All of these are ways in which depression, as an experience, idiom, or incorrect relationship to "what is" has aligned itself with the "new reality."

Conclusion

In the mode of agency it engenders, the ethic of powerlessness, as it is practiced in AD, embeds a kind of selfhood that, rather than seeking to impose its will upon the world, contemplates and exercises the futility of efforts to control it. It narrows, rather than expands, the subject's agentic horizon, flying in the face of the positive ideals of capitalist and liberal selfhood and constantly reinstating a tension—inherent in twelve-step self-help—between sovereignty and dependence, empowerment and powerlessness. In "admitting powerlessness," *depresants* reshape their agentic position not only relative to their personal troubles but also, by the same gesture, to Poland's "new reality."

The program, at once universally scripted and American in provenance, becomes a cultural space and a method for "working through" the existential contradictions particular to this specific locale and its version of postsocialist neoliberalism. By that I do not only mean the set of concrete socioeconomic conditions (the increased unemployment, stratification, and exclusion; the suppression of wages and the relentlessness of the corporate grind; the heightened discrepancies in the social production of needs and desires and the distribution of means to fulfill them) or cultural forms (ideologies of free will, individual self-determination, and success) but also a *temporality* of realification.

As I discussed in the Introduction, the political and economic *urealnienie* in Poland involved two modes of realification specific to different phases in the temporality of the transformation: first, the dismantling of state-socialist "fictions" (the command economy, the rule of a workers' party not recognized by workers

as their legitimate representation); then the sustained production of realness by new means (market logic, fiscal discipline, individual free choice and self-expression, free elections and opinion polls), which came to generate new kinds of fictions not immediately recognized as such because critical positions and discourses were not easily available or actively marginalized.

Twelve-step programs arrived in Poland in the context of undoing state-socialist fictions of care. The self-help ideology, with its emphasis on sovereignty and with the aura of effectiveness and empowerment of this American solution, fit perfectly with the idea that the successful treatment of alcoholics must start with the wrenching of drunkenness from the helplessness of the *Homo sovieticus*. In the temporality of the transformation, it was also a time of hope for a better future fed by the promise of opportunity. The burdens of the "shock therapy"—carried disproportionally by those who would soon find out they stood to benefit the least—could still be considered temporary pains of the "reality check."

But as Poland's "new reality" continued into the sustained production of realness, that reality turned out to be one in which greatly expanded individual freedoms and expectations regarding what is possible came not just with expanded responsibilities, but more importantly without a corresponding distribution of the means to fulfill them.[37] Powerlessness in the face of the burdens of empowerment became the new "reality gap," only less overt. Rather than a matter of party slogans and non-operationalizable economic data and regulations, this gap became entangled with individual existential problems.

What I saw in AD's ethic of powerlessness was an exercise in limited agency, in failing to fulfill aspirations and hopes, and in failing to become the kind of self one had wished—sovereign, heroic, self-realizing, or even simply free of mortifying sorrow and worry. This individual, personal process was thus also an exercise in "working through" Poland's neoliberal present, in which the personal—the existential—is political indeed. The contemplation and repositioning of one's agency and selfhood through an ethic of powerlessness becomes a way of coming to terms with the public secret of the "new reality." It is also coming closer—though not fully—to seeing it for what it is: a new set of ideological fictions and contradictions, the always-imperfect reconciliation of that which more inevitably than ever falls on the subject herself.

In lieu of conclusion

This book has explored the ways in which depression—how it is understood, experienced, treated, and socially practiced—is multiply bound up with the dynamic od *urealnienie*, realification. The latter is understood as the ways realness of objects or "hyperobjects,"[1] like "reality," is produced: in terms of claims of necessity, urgency, and legitimacy which are made by reference to "reality" as opposed to "fiction," and in terms of the effort it takes to make a diagnostic entity real, stable, and operational. In the case of depression, the precision and technical specificity of the diagnostic is less a reflection of the nature of the "mental disorder" and more of the biomedicine as a "way of knowing" (Pickstone 2001) and of the healthcare system with its financial and organizational demands and limitations.

Following depression across various domains and over a specific period, this ethnography portrays it in concrete historical circumstances of its emergence and formation during and after postsocialist reforms, from the 1990s to the 2010s. As such it is complete. There are, however, a few last closing comments to be made from the vantage point of the present.

In the chapters above I have focused on three broad themes. One pertained to the ways realness of depression as a disorder is achieved; another concerned the broader cultural dynamic of realification at work on different scales and in different domains, often, as I showed, intersecting with depression as a way of practical and symbolic organization of distress and malaise; finally, the third issue involved the models of subjectivity and agency reworked in treatments and invoking particular conceptions of the real. Each of them merits a brief discussion and pointing to directions of further research.

As regards the realness of the disorder, it seems the particular moment in the history of depression I am describing may today be shifting into a new phase. Motivated by the launch of SSRIs and the subsequent revisions of the DSM,

starting with DSM-III and ICD-10, met with the socioeconomic and cultural conditions of neoliberalism, depression as a diagnostic category and cultural idiom enjoyed a spectacular success, part of which I was observing in Poland. What I am also describing are the costs and limits of that success—the ways the claims to realness were often in question, the frequent uncertainties and ambiguities permeating its apparent diffusion and penetration. And in so far as the protean and fluid nature of the diagnostic, its ability to attach itself, however superficially, to a wide array of situations and experiences, is part of its success, it also begs the question of the future of depression. May the category have grown too unwieldy for its center to hold?

There are good reasons to explore this question. The elements shaping the current formulation of depression are not fixed. Its legitimacy is pegged on the scientific authority of international diagnostic manuals, on market availability of pharmaceuticals deemed successful and of compelling drug action theories (the serotonin hypothesis underwriting the currently dominant view of the "disorder"), as well as on the role of the diagnostic in the financing, organization, and statistical knowledge of medical care; In Poland, as I show, depression has also come to hold a degree of popular and practical legitimacy because it allowed both to articulate new problems and propose apparent solutions in ways that signaled social burden while stopping short of full political formulation. Now, the manuals are criticized, from outside as well as from within professional psychiatry, for conflicts of interest and the influence of the pharmaceutical industry on revisions of diagnostic criteria; the provision of care, as I have shown in the case of Poland, makes use of diagnostics in ways that are ambivalent and pragmatic, often treating depression categories as a general reference rather than strict identifier; moreover, the care itself remains deficient and much of depression treatment happens in commercial outpatient contexts where diagnostics are more flexible and less important, while treatment regiments and personal conceptions of functionality gain in significance. Similarly, while the consumption of antidepressants continues to grow, worldwide as well as in Poland (Diaz-Camal et al. 2022; Krupa et al. 2022), their effectiveness doesn't necessarily follow[2]—if anything, with the growing disenchantment with psychiatric blockbuster drugs, treatment paths appear ever more winding and slippery, and patients learn that finding relief may require trying several medications and actual effectiveness is hard to measure or attribute. Preliminary ethnographic research among young outpatients in metropolitan centers in Poland suggest that they mix and match drugs and diagnostics to make do with an ever more distanced and unspecific attitude towards their own psychiatrization and ambivalence towards the realness of their depression as such (Potępa 2021). All this may serve to undermine the idea of depression as a solid "thing" that, over the last thirty years, accompanied its spread

arguably beyond the bounds of any such solidity. At the same time, within the critical mental health care community, criticisms are mounting of the collusion between the disease model of depression and the business model of health care that don't seem to align well neither with patient experience nor recovery.

A different perspective is implied by the discussion of the dynamic of *urealnienie*: the ability of the call to correct perceived "fictions" in pursuit of what is described as "real" to sanction acts performed in its name; the particular appeal held by the promise to close the gap between "what is" and its distorted representations. This perspective applies to the relatively small scale (e.g., the individual therapeutic process) but, importantly, it also concerns the realm of politics writ large, public discourse, and social imagination. Accordingly, the story unfolding in the background of this account of depression, and painted here only in very broad strokes, was that of the postsocialist market democratic reforms. Though contested, they nevertheless had the support of the broad political consensus in Poland and their legitimacy was enforced and maintained by professing to do away with the fictions of state socialism and promising a "reality-based" system in its place. With time, however, the "new reality's" claims to realness gradually began to run thin. After the initial corrective period of "shock therapy" and its effects came the sustained production of realness by new means—technical and procedural rather than substantive, as in the case of the health care system reform discussed in Chapter Two. The new system, it turned out, came to produce its own fictions, only by different means: bureaucratic and financial procedures backed by audits, distributive algorithms, calculative and faceless, still often disregarded practical realities and demands of appropriate care. Just like medical formalism and proceduralism came to feel increasingly constraining and removed from the demands of the real, so did the post-transformation order, originally propelled by the momentum of postsocialist *urealnienie*, begin to lose its hold. Obviously, there were multiple very concrete and measurable factors that contributed to the weakening of the liberal socioeconomic and political order, including the growing economic disparities in the face of rising average income and rising expectations of social security, fair compensation, and symbolic recognition in Poland's progressing pursuit of Western standards. They all played a part in the waning of the moral discipline of the transformation with its validation of austerity politics. But in view of the dynamic of *urealnienie*, it may be worth paying attention to shifts in the more subtle and intangible socially shared sense of realness versus fiction—more a "structure of feeling" (Williams 1977a: 128–136) than a hard variable. I suggest it may be worth considering the question whether, and if so, in what ways, the deficiencies of proceduralism and technical formalism as a mode and method of the production of realness may have contributed to Poland's recent turn toward a substantivist politics: the election

triumphs and continuing popularity of political forces that embrace a substantive and agentive role of the state in overriding proceduralist politics based on the rule of law.[3]

The concept of the production of realness may also contribute to broader discussions concerning the status of reality and truth in social and political life, in what has been called a "post truth" world of the media and social media dominated by a capitalist politics of attention and a fast-moving technological horizon.

Finally, the third key theme of this discussion has been the aspect of the culturally mediated relationship between the individual and "reality" that we call subjectivity and agency. In this respect, this study explores the shaping of a particular type of selfhood in response to the cultural ideal that stresses individual agency, responsibility, and success in a social reality where the resources to achieve that success remain in short, uneven, and unstable supply. The reworkings of selfhood, or existential position, that take place in the social spaces of depression, though they don't result in a uniform final product, are conducive to shaping dispositions I have discussed under the rubric of "powerlessness." It is a refusal to embrace the Occidental (Bateson 2000) notions of a powerful subject opposite the world, but instead incorporates limited agency and failure to fulfill these social ideals. In this respect, the study of depression contributes to a critical reflection on the social conditions and cultural epistemologies of subjectivity that the current moment produces and promotes.

As regards psychiatry, it is, I suggest, becoming less about "the norm"—and idea long central both to psy-disciplines and their criticisms—and increasingly about functionality and optimality. The social proliferation and penetration of psychiatric treatments, particularly the use of antidepressants and anxiolytics, it appears to me, has moved past the concern with making the individual "normal" and instead become a way of making the normal—as in "normal" life—livable. Seeking agentic limitation instead of projecting a strong subject seems to be a part of the same shift.

I started this book referencing Nikolas Rose and his contention that liberal societies, where people are governed through freedom rather than coercion, require "human technologies of government" supplied by the psy-sciences. Having studied ethnographically and concretely some aspects of this compelling, if abstract, formulation, I would like to end it with a quote from another author, wording his reflections in somewhat similar terms. "Today," writes Byung-Chul Han, "we do not deem ourselves subjugated *subjects,* but rather *projects*: always refashioning and reinventing ourselves. …" He continues:

> All the same, this projection amounts to a form of compulsion and constraint – indeed, to a *more efficient kind of subjectivation and subjugation.* … And so we find

> ourselves in a paradoxical situation. Technically, freedom means the opposite of coercion and compulsion. Being free means being free from constraint. But now freedom itself, which is supposed to be the opposite of constraint, is producing coercion. Psychic maladies such as depression and burnout express a profound crisis of freedom. They represent pathological signs that freedom is now switching over into manifold forms of compulsion. (Han 2017: 1–2)

This is not to cast the problem of depression in philosophical terms of freedom, but rather to suggest that living as "subjects deemed to be projects" confronts us with a challenge that is very incompletely and therefore inadequately captured by the problematization we know as "depression" in its current form. Depression, I have tried to show, is a way of socially—practically and symbolically—organizing distress, which is in itself, in part, also socially produced. This organization is always partial and never unprejudiced. It accommodates existing means of treatment and aligns itself with the broader forces that orchestrate social life, even though it in fact signals the limits of their validity and marks their point of exhaustion. As this ethnography has shown, the specificity of diagnostic definition and antidepressant action is inherently incommensurate with the breadth of issues they are applied to address. And the incommensurateness itself has its own politics—a *Realpolitik* of What Is.

Notes

Notes to Introduction

1 The predicted increase of prices was to be made up for, initially, by increased bonuses to salaries and pensions distributed through workplaces and social security services. This contributed to increased inflation, which in the following year reached the rate of nearly 700 percent and thus also undermined the "realification" itself—but more reforms would soon follow as part of the economic "shock therapy" introduced in 1990 (Śleszyński 2007: 84).

2 Characteristically, this "realification" takes as its parameter of reality the consumer market relations of supply and demand rather than, e.g., production costs, as some contemporary critical voices pointed out (Kołodko 1990: 48). It also already suggests the relativity and arbitrariness of what and when may count as "reality."

3 By calling "*urealnienie*" a keyword, I mean not just the use of the term itself (admittedly not very common) but also (and these were ubiquitous) explicit and implicit references to "reality" as something that is changing and that is a destination more than simply a state of affairs: something to be achieved or recovered, a matter of painful-but-necessary corrective procedures. Realification and reality were also connoted by their many opposites: fiction, falseness, but also abnormality (abnormal-ness of conditions) and absurdity. The word "*urealnienie*" came up most often in the economic sense in reference to prices or currency, or economic indicators.

4 The following short excerpt from a post hoc (2007) account of the reform offers a brief (and favorable) summary of the "shock therapy" reforms, as well as a mention of one of the key meanings of realification. For an in-depth critical analysis see, e.g., Poznanski 1996: 167–290; for a discussion bringing together economics and social psychology, see Czapiński 1995:

> The Balcerowicz plan, modeled on the ideas of American economists J. Sachs and D. Lipton, assumed economic stabilization from neoliberal positions (Lipton, Sachs 1990; Sachs 1993). First of all, steps were taken toward limiting hyperinflation (351% in 1989, 686% in 1990).

> That meant a *realification of the złoty* [currency], so in effect a drastic increase of prices (especially fuel and energy) with a relatively insignificant increase of wages (e.g., a tax on super-normative wages was introduced, the so-called *popiwek*). Prices were liberalized [deregulated] (up until that point their level was set by the state) and limits in domestic trade were lifted, e.g., numerous concessions, rationing orders, and limits in the market of commodities and services were lifted, etc. That allowed for a rapid development of business, especially in the area of sales and services. The supply of money was significantly limited by the increase in interest rates of credit. In effect, inflation fell to 60% in 1991 and it remained below 10% throughout the rest of the 1990s. In the years 1990 and 1991, the GDP fell (by 12% and 8% respectively), but in the following years it was already growing, sometimes at more than 5% annually, which situated Poland among "economic tigers." In 2004 the GDP in fixed prices reached 160% of its 1990 value, making Poland the leader among Central European countries. (Śleszyński 2007: 84)

5 In the general election of June 4, 1989, the electoral process itself was open and democratic, but only 35 percent of the seats in the lower chamber of the parliament (the Sejm) were up for a vote, all of which were won by opposition candidates representing the "Solidarity" labor union. In the newly formed upper chamber, the Senate, "Solidarity" won 99 out of 100 seats, with one seat going to an independent candidate. In other words, not a single seat was won by a candidate from the ruling Polish United Workers' Party.

6 Such as the mass murder Polish officers and members of the *inteligencja* by the Soviet secret police, the NKVD, in 1940, or the acts of political violence of the Polish communist state in the years 1944–1989.

7 Fisher defined it as "the widespread sense that not only is capitalism the only viable political and economic system, but also that it is now impossible even to *imagine* a coherent alternative to it" (2009: 2). In his popular book in critical theory, Fisher discusses what he sees as contemporary capitalist culture's ability to falsely present itself as the real, and, tellingly, he often draws a connection between depression and the capitalist realist projection of the world: "In claiming, as Badiou puts it, to have 'delivered us from the "fatal abstractions" inspired by the "ideologies of the past,"' capitalist realism presents itself as a shield protecting us from the perils posed by belief itself. … Lowering our expectations, we are told, is a small price to pay for being protected from terror and totalitarianism. … The 'realism' here is analogous to the deflationary perspective of a depressive who believes that any positive state, any hope, is a dangerous illusion" (5).

8 Such "moments of truth," Roitman writes, "might also be defined as instances when 'the real' is made bare, such as when a so-called financial 'bubble' is seemingly burst, thus divulging alleged 'false value' based on speculation and revealing 'true value,' or the so-called fundamentals of the economy. As a category denoting a moment of truth in these ways, and despite presumptions that crisis does not imply, in itself, a definite direction of change, the term crisis signifies a diagnostic of the present; it implies a certain telos – that is, it is inevitably though most often implicitly directed toward a norm" (Roitman 2011: n.p.).

9 Elements of the market economy were being introduced earlier, but at a much slower pace, narrower scale, and in an inconsistent manner.

[10] This, of course, is a trope deeply imbued with symbolic relations of power—an infantilization that engenders and justifies didactic domination and which has a rich history in colonial, racial, and class discourses as well as Western European discourse on Eastern Europe (Doty 1996; Murawska-Muthesius n.d.; Petrović 2014; Shohat and Stam 2013). Elements of this attitude permeated the relationship between workers and elites during the transformation years in Poland (Ost 2005), and they were often palpable in the clinical relationships I observed between mental health care practitioners and their patients in Warsaw.

[11] "Big" and "Little" Fiat (*duży fiat; mały fiat*) were the popular nicknames of two models of cars—one mini-, the other medium-size—produced in Poland for decades under license from the Italian carmaker, FIAT. Both dominated Poland's roads but ever remained in short supply, which made them at once objects of intense desire and, by comparison to Western makes, embodiments of the inferiority of socialist industry and quality of life. Like the East-German Trabant, they continue to hold the status of symbols of the material culture under communism.

[12] "Solidarity" ("Solidarność") was the independent workers' union established in Poland in August 1980, approved by the government only after months of nationwide strikes. Bearing the promise of democratic reforms, it enjoyed massive popular support, quickly reaching 10 million members, until it was made illegal with the introduction of the martial law in December 1981. It remained active as an underground organization of the dissident movement leading up to the political transformation of 1989.

[13] At the time (2010) still called the Warsaw Medical Academy (Polska Akademia Medyczna).

[14] In the context of psychotherapy, "dynamic" generally signals a psychoanalytic approach, as opposed to, typically in the Polish context, cognitive-behavioral.

[15] For a discussion of the concept of "working-through," see Freud 2001 and Thompson 1994: 192–204.

[16] The term "*urealnienie*" currently appears in the context of establishing value equivalency in insurance claims (i.e., bringing reimbursements in line with the actual value of items damaged or lost).

[17] Describing the emergence of a world without alternatives to capitalism, Mark Fisher (2009) talks about miner strikes in the U.K. in the early 1980s in ways that call to mind the soon-to-follow Polish transformation: "The closure of pits was defended precisely on the grounds that keeping them open was not ‚economically realistic,' and the miners were cast in the role of the last actors in a doomed proletarian romance. The 80s were the period when capitalist realism was fought for and established, when Margaret Thatcher's doctrine that 'there is no alternative' – as succinct a slogan of capitalist realism as you could hope for – became a brutally self-fulfilling prophecy" (7–8). The rise of capitalist realism in Poland just a few years later was more sudden and total, occurring on the scale of the entire economy all at once. Economic realism—capitalist realism—became realism itself. That being said, the distinction between reality and realness is helpful in that it draws attention to the variable intensities of the hold that reality exerts over people and to the work whereby this legitimacy is produced with variable effects throughout the system and over time.

18 While the market and its logic are crucial to the production of realness in today's Poland, they are not the only warrants of reality.

19 It is interesting, but not at all surprising, that Berger and Luckmann draw the boundaries of reality at the limits of sanity as opposed to madness. Discussing the fact that the unquestionable nature of reality of everyday life does not mean it is unproblematic, they say:

> The others with whom I work are unproblematic to me as long as they perform their familiar, taken-for-granted routines. … They become problematic if they interrupt these routines—say, huddling together in a corner and talking in whispers. … [Whether they are fixing a broken typewriter or planning to go on strike, it is] still well within the range of problems with which my common-sense knowledge can deal. I will deal with it, though, *as* a problem, rather than simply reintegrating it into the unproblematic sector of everyday life. If, however, I come to the conclusion, that my colleagues have collectively gone mad, the problem that presents itself is of yet another kind. I am now faced with a problem that transcends the boundaries of the reality of everyday life and points to an altogether different reality. Indeed, my conclusion that my colleagues have gone mad implies *ipso facto* that they have gone off into a world that is no longer the common world of everyday life. (1966: 39)

Problems with reality, in this image, appear at the point of delusion. As I will show, however, delusion is not the only or even the privileged position in which relationship to reality becomes problematic. Non-psychotic disorders of mood constitute a more distinct but no less important such realm.

20 For a detailed exposition of the discursive mechanics of historiography, see Barthes 1989b.

21 This is in contrast to the classical culture, which "lived for centuries on the notion that reality could in no way contaminate verisimilitude; first of all, because verisimilitude is never anything but *opinable*; it is entirely subject to (public) opinion; … then, because History was thought to be general, not particular (whence the propensity, in classical texts, to functionalize all details, to produce strong structures and to justify no notation by the mere guarantee of 'reality'); finally, because, in verisimilitude, the contrary is never impossible, since notation rests on a majority, but not on an absolute opinion. … Hence, there is a break between the ancient mode of verisimilitude and modern realism; but hence, too, a new verisimilitude is born, which is precisely *realism* (by which I mean any discourse which accepts 'speech-acts' justified by their referent alone)" (Barthes 1989a: 147).

22 Etymologically, *realification* and *reification* share the same root in Latin: *res, rei*, thing. Some uses of the word "real," e.g., in law and finance, retain that meaning: real is what relates to things material and solid (e.g., "real account").

23 In George Steiner's lucid reading of Lukács: "The realist—Balzac, Stendahl—exhibits an immediate, unworried grasp of material fact. As capitalism grows more oppressive and the artist feels more alien to his society, this grasp changes to an anxious rapacity. Flaubert attempts to recapture the real by force of accumulated detail and technical language. The words become not the voice but the inventory of experience. When Balzac describes a hat, he does so because a man is wearing it. The famous account of Charles Bovary's cap, with its fantastic accumulation of sartorial terms, is a piece of hollow bravado" (Steiner in Lukács 1964: 13).

[24] Since socialism, and all the more communism, remained under construction and in permanent delay, it had, up until that time, always been cast in the future tense: the project at hand was the building of that radiant future.

[25] Marshall's succinct definition of "real socialism" is worth quoting at length:

> Its defining feature was the primacy of politics over economics and the intertwining of the two. Although the features of capitalism (such as distinctive property rights, and markets of commodities, capital, and labour) were absent, this did not imply the existence of socialism. The latter would have required the organization of the economy along collective lines, with co-operation through a plan which articulated the interests of the direct producers, and tied consumption, production, and investment together, through the human logic of expressed (rather than imposed) needs. State ownership of productive means in fact led to a property vacuum. Absent ownership rights fostered corruption, eroded motivation, distorted managerial priorities, and diverted state energies into control rather than planning and directive functions. The power of lobbies replaced societal interest formation and articulation. The primacy of the *nomenklatura* system undermined professional and expertise criteria of performance, dissipated the mechanisms of accountability, and vested power in the hands of groups who ruled this monocentric society and whose aim was the maximization of power over a non-controllable economy. Party, state bureaucracy, security apparatus, and military formed a power élite, presiding over a bureaucratically centralized, segmented society. Extensive economic growth exhausted the natural and human resources of countries tied into patterns of dependence devoid of an economic logic but rooted within the overriding needs of the military-industrial complex. Soft budgets, poor labour discipline, the politicization of the workplace, the use of the factory-based welfare system to impose labour discipline in the absence of unemployment, all became attributes of the system of redistribution. Economic interests, rather than being based upon economic rationality, were distorted by this redistributional mechanism. Finely graded occupational and hierarchical privilege incorporated most of the population into an artificial set of dependencies. For its part, society was effectively classless, although forms of social closure existed—particularly within the *partocracy* and the intelligentsia. Social atomization and amorphous structures were juxtaposed to the burgeoning second society where social self-organization existed around the satisfaction of interstitial but authentic needs. (Marshall 2009: 630–631)

[26] This referential correctiveness may be perceived as mirrored and reversed in the way the Western left saw the socialist countries as an outside alternative, however defective and deficient, to capitalism.

[27] This was the beginning of the long-term economic reform, *reforma gospodarcza*, implemented in three stages throughout the 1980s. It was intended to gradually replace central economic command with a greater autonomization of state enterprises. The reform ultimately failed, getting bogged down in excessive regulation and resistance from party and state apparatuses, effectively leading to the dismantling of socialist economic order (Poznanski 1996).

[28] Not surprisingly, then, the return to reality was also cast as a "return to Europe," a modernization that would bring the standards of living and the very rules of social life in East Central Europe in line with those of Western European countries.

[29] As a result, Burawoy and Lukács argue, in state socialism "people live in two worlds: an ideological world and a lived world. But they are both real. What is clear is the discrepancy between these worlds" (1992: 82). This duality is one of the most

consistently recurrent tropes in anthropological literature on socialism and postsocialism. It has both enabled compelling analyses and been itself the object of lucid critique (Yurchak 2006). Discussions of the discrepancy at state socialism's core include: Burawoy and Lukács 1992; Oushakine 2003; Lampland 1995; Verdery 1996; Yurchak 2006. It has varied from discussions of ideology vs. reality (Burawoy and Lukács 1992); the official as opposed to the hidden; the private (Gal and Kligman 2000a, 2000b; Wedel 1986); the informal (Creed 1998; Dunn 2004; Horváth and Szakolczai 1992; Kornai 1992; Kideckel 1993; Ledeneva 1998); or "double reality" (Gal and Kligman 2000a; Wydra 2000). The duality of social life, in which actors acted "as if" in the "official reality" knowing it to be false and at the same time engaging in another, "true" reality in the privacy of their homes and personal relationships, produced what seemed like "split selves," a common observation regarding personhood under socialism (Havel 1985; Kharkhordin 1999; Miłosz 1953; Oushakine 2003; Verdery 2007; Zagorin 1996; Žižek 2008; see discussion in Yurchak 2006).

30 I do not mean to say that capitalism turned out to be more *real* in any absolute sense than socialism was. They both produced their realness differently and both generated their fictions, albeit differently distributed. In the words of Adam Przeworski, both were irrational, but socialism turned out to be infeasible (quoted in Burawoy and Lukács, who, however, disagree on the feasibility of capitalism, 1992: 194 fn. 5). Rather, what I am describing is a shift from a socialist mode of the production of realness to a neoliberal one.

31 For a discussion of care and its politics in the relationship between the citizen and the state see Petryna 2006; Ticktin 2011; Biehl 2005; Rivkin-Fish 2005. For a discussion of the subject and the (imagined) parent see Klein 1975a, 1975b; Chapter Three of this book.

32 See Chapter Four for a discussion of treatment of alcoholics by placebo and mandatory detoxication while at the same time extending the paternalistic relationship, rather than holding them responsible and liable for their actions before the court (cf. Raikhel 2010, 2016).

33 While this book, combining archival and ethnographic work, focuses on the specific period of the 1990s and early 2000s, appropriate updates were added during the preparation of the manuscript for publication in the fall of 2022.

34 Despite the hype surrounding the marketing of SSRIs and SNRIs, criticisms have long surrounded their widespread use and continue today, even from within psychiatry itself (Healy 1997, 2004; Moncrieff 2009, 2014, 2022).

35 All recorded interviews were formally consented to and followed the protocols set by Institutional Review Boards at The New School and at Warsaw Medical University, which reviewed the research design from the standpoint of research ethics and protection of vulnerable research subjects.

36 The press archives included those of the popular women's weekly *Przyjaciółka*, the weekly news magazine *Polityka*, and, especially, a detailed content analysis of the archives of the influential daily *Gazeta Wyborcza*. These targeted archival searches we supplemented by extensive online key-word searches that yielded hits in various publications available online. I also reviewed the complete archives of the main Polish

psychiatric professional journal, *Psychiatria Polska*, from its first issue published in 1967, focusing on the subject of depression.

Notes to Chapter One

1 'Pan' and 'pani,' sometimes abbreviated as 'p.,' are the Polish honorifics equivalent to the English Mr. and Mrs./Ms., but much more common in everyday use. I retain them in the text as that is how most persons outside one's immediate social circle are both addressed and described.

2 SSRIs, or selective serotonin reuptake inhibitors, are a class of drugs used primarily as antidepressants, including blockbusters such as fluoxetine (Prozac) or sertraline (Zoloft). Their development and marketing since the late 1980s have triggered a dramatic shift in the treatment and diagnosis of depression, described in more detailed below.

3 All diagnostic codes cited follow the ICD-10 format (the World Health Organization's International Classification of Diseases 10th Revision) current during my fieldwork. For an in-depth discussion of the classification and nosological systems, see Chapter Two.

4 The compulsory military service for most men between eighteen and twenty-eight years of age in the People's Republic of Poland lasted two years. Only in the navy did it take an additional year. Male higher education students, who were very few due to the generally low rates of college attendance, were by and large exempt from serving full term and could complete partial military training by taking courses and attending army training camps. It was not uncommon to seek exemption from compulsory army service by simulating medical conditions, including mental disorders, which often involved having oneself submitted to a psychiatric hospital for observation.

5 "One can tell from his life history that it's not a personality problem," Dr. Kamila tells me. "Personality patients rarely have such orderly and functional lives—stable relationships, stable work … there is more chaos in their biographies. One knows it's a personality disorder, because such people fail to marry when it's time to get married, their careers often take a more dramatic course." (For a discussion of normative views of depression and personality disorders, see Chapter Three).

6 There were plenty of everyday problems for sure—and differently distributed between genders, social groups, and locales—such as infamous difficulties with acquiring basic foodstuffs and most other provisions and making everyday arrangements, including getting access to appropriate medical services. Pressures on productivity and efficiency also existed, but to an overall lesser degree and were not paired with systemic underemployment and job insecurity. Overall, the everyday burdens related to the spheres of production and consumption were both qualitatively and quantitatively different.

7 The word *depresja* in Polish is not used in the economic sense it has in English. In that context the word of choice is *kryzys* (crisis) or *recesja* (recession).

8 A period of work in the countryside compulsory for some residents and early career physicians.

9 "*Uporczywe uchylanie się od pracy*." Being unemployed was, at least theoretically, unlawful in communist Poland. By law, one had to be registered as employed—if only nominally—or have an employed spouse or family member. "Avoidance of work" could eventually result in a work order.

10 On the figure of the "big child" as the image of man, see Marody and Giza-Poleszczuk 2000, Gal and Kligman 2000, and discussion below.

11 The term *Homo sovieticus* was coined by the Russian writer and sociologist Aleksandr Zinovyev in his 1982 novel depicting the life of a thoroughly collectivized, passive, and profoundly conformist Soviet man, devoid of his own individuality (Tyszka 2009). It was introduced into the Polish public discourse in the early 1990s by the influential philosopher and Catholic priest Józef Tischner and had a slightly different meaning: *Homo sovieticus* was first of all "the client of communism," dependent on it for his subsistence and existence, who now

> demands of … "capitalists" that they satisfy his needs which the communists failed to satisfy. He is like a slave that, once freed of one bondage immediately seeks another one. *Homo sovieticus* is the postcommunist form of the "escape from freedom," once so well described by Erich Fromm. (Tischner 1992)

In some of the many critical discussions of this controversial term, it has been illustrated with the following quote from an interview with a prominent economist published by one of the leading weekly magazines:

> Q: And indeed nobody lost in the recent transformations?
> A: The former workers of liquidated state farms are the only group that lost in absolute terms (not only in relation to the other groups). They are really doing badly because *they haven't learned how to* work, and after the dissolution of these deficient creations they now have no place from where they *can steal.*
>
> Q: Who has benefited the most?
> A: People who want and can work to succeed. Now it is entrepreneurship and knowledge that counts—those who have understood this first have become the biggest beneficiaries of the system.
>
> Q: Who has proved to benefit the least?
> A: *The problem of Poland is the Poles* themselves who *are waiting for manna from heaven* and think that they deserve everything *without work* and commitment. It is the passive part of society that is at fault. These people are demoralized by the previous system and by those they vote for. (Cielemęcki and Trębski 1999: 46 quoted in Buchowski 2006: 467–468, emphasis added. See also Aronoff and Kubik 2012: 242–243)

In another influential image, *Homo sovieticus* became paired with the notion of "civilizational incompetence" (Sztompka 1993), a cultural barrier preventing Poland from becoming modern, democratic, and market-liberal with the sole introduction of Western-like political and economic institutions. (The modernity of socialism, Sztompka explains evoking the notion of fiction, was a "fake" one.) Leaving aside the highly ideological language (eerily reminiscent of "civilizing" colonial discourses) and granted all the economic degradation and social anomie of bankrupt state farms, these sociological diagnoses are problematic for a number of theoretical reasons. Most importantly to me, they operate with the dichotomy of winners and losers. In his

scathing critique of the figure of *Homo sovieticus* as a form of Orientalism, anthropologist Michał Buchowski (2006) observes that this divide

> ultimately translated into those wise and able to adapt and those half-witted and unable to adapt, apt and inept. Of course, the first group defines the modes of adaptation and criteria for evaluation. If individuals or groups cannot follow suit, they simply deserve their poor fate. … These people do not know how to make sense of the new symbolic order and cannot fit into the new institutional design in which "civilizational competence" is king! (2006: 469–470)

Supporting Buchowski's criticism, several authors have shown that the pathologized and orientalized "losers" of the transformation continue to engage with their circumstances in meaningful and apt ways (Aronoff and Kubik 2012; Burawoy and Verdery 1999; Rakowski 2016).

12 For a discussion of the social history of drinking and dependence therapies as well as changing understandings of alcoholism in Poland in the context of the rise of self-help and twelve-step programs in the 1980s and 1990s, see Chapter Four.

13 As a psychiatric disorder it did, however, carry a significant social stigma. If drinking was common and accepted as a part (however condemnable) of reality, depression was not. It would take considerable efforts in the form of awareness raising campaigns to begin to change those negative attitudes.

14 For a discussion of drinking in Poland as a social problem, see Chapter Four.

15 Suicide as we know it today is a child of statistics, and it arose hand in hand with the science of society. It was through the new technology of knowledge production and accumulation of the 19th century that self-induced death could for the first time be conceptualized as a social phenomenon rather than an individual act of desperation or honor (Hacking 1998). In that way, Durkheim's seminal study was crucial to establishing both modern suicide and modern sociology (Durkheim 1997 [1897]). While it has been criticized, claiming it was based on unreliable data on the suicide rate, Durkheim's work continues to shape the ways suicide is understood in popular Western discourse. My discussion here recognizes the unreliability of most data on self-murder (Timmermans 2005), but takes this as a systematically distorted reflection of social distress and in part as an epistemic object in its own right.

16 Figures went from 14.25 per 100,000 in 1979 down to 8.8 in 1981, then climbed up again to 9.6 in 1982 and 12 in 1983, and continued to rise throughout the 1980s. See Bugajski 1986; Jarosz 2004; Sokół 2004.

17 The growth flattened and virtually came to a halt after 2004, which has been explained as the effect of Poland's accession to the E.U. and the following large labor migration of unemployed or underpaid persons to the U.K. and other Western European economies. It has since gone up again, despite decreasing joblessness, reaching new highs above 17 per 100,000 persons, before dropping once more and oscillating between 12 and 14 per 100,000 from 2016 to 2021 (Polska Policja n.d.).

18 This explanation was also offered in the article quoted above.

19 The rising suicide rate in 2013–2015 has been interpreted in media reports as an effect of growing pressure on *men*.

20 Decompensation, in psychiatry, refers to the "failure to generate effective psychological coping mechanisms in response to stress, resulting in personality disturbance

or disintegration, especially that which causes relapse in schizophrenia." http://www.oxforddictionaries.com/us/definition/american_english/decompensation accessed on August, 4, 2014.

21 Borrowing a term from sociology first introduced, with a different meaning, by Robert E. Park in the 1920s.

22 It is 2009, and the effects of the financial crisis are reaching Poland, although its economy was able to weather it without going into recession.

23 Apartments were not, in fact, "given" into ownership, but one could obtain public housing for minimal rent and with rights to perpetual tenancy. Typically, however, because of a dramatic shortage of housing throughout most of the socialist period, the waiting time would be many years, sometimes decades. Official per-person areal standards were minimal, and different social groups had different distributional privileges. Effectively, people often lived in overcrowded conditions with extended family (see, e.g., Wedel 1986).

24 Two of his brothers, he says later, are alcoholics, too. Only one is not. He got away from home quickly. I quote:

> When I go visit him, I see [the difference between] what he's like and what our home was like … he will sit me down, serve something [*stół zastawi*], make conversation, show me a tape recording of his family, a first communion or a wedding. And inside me, I start to rebel. I can't watch it. Envy. That he has it and I don't. He has children—grown up or growing up. … He is a grandfather already. It starts to boil inside me. He says they will be back in the evening, and I say I have to go catch the train and I go back to Warsaw. There is envy and falsehood in me.

25 In 2011, primary care physicians and other non-psychiatrists prescribed 39 percent of all antidepressants sold in Poland. Some of these prescriptions were for problems other than those strictly related to mood. For instance, as I witnessed during my research and heard from a number of physicians, certain antidepressants are prescribed to "treat" premature ejaculation in men. This kind of off-label use likely accounts for a significant share of antidepressant market in Poland and beyond.

26 With over 38 million people and the GDP as well as the average income steadily growing since 1993 (between 1990 and 2010, the average monthly pay expressed in USD went from $108 up to $1,140), Poland quickly became one of the largest and most promising markets in the region. "Over the decade from 1990 to 2000, the overall psychiatric drug market increased by 126 percent in Europe and a phenomenal 638 percent in the United States, where, by 2000, the value of sales of prescribed psychiatric drugs amounted to almost $19 billion" (Rose 2006). In 2012, Poland became one of the seventeen fastest-growing pharmaceutical markets, whose share in global sales was expected soon to make up nearly 50 percent. Poles are among the largest consumers of pharmaceuticals in Europe.

27 There has been an avalanche of publications—both scholarly and popular—about this issue in the last decade that trace the rise of Big Pharma back at least to the Reagan years (Angell 2004).

28 Not including the 3 million packets of antidepressants bought by public hospitals for inpatient use. This number does, however, include most of the off-label and self-

medication use of these drugs, because in those cases they are typically still acquired by prescription. Also, and in contrast to benzodiazepines, antidepressants are as a rule not used recreationally.

29 Ironically, as I discuss in the following chapter, as per the new diagnostic classification, ICD-10, introduced in Poland less than four years earlier, depression was no longer considered an illness (*choroba*) but a disorder (*zaburzenie*).

30 Interview, Dariusz Maciej Myszka, July 30, 2009.

31 This campaign was also situated within a broader constellation of forces that turned depression into an object of heightened concern of health organizations and government agencies worldwide. On the one hand, there were the changes in psychiatry: new drugs and marketing activities of pharmaceutical companies, as well as shifts in diagnostic classifications (see Chapter Two). On the other hand, a new epidemiological perspective focusing on the "global burden of disease" which emerged in the 1990s gave depression an entirely new position among health problems worldwide. This approach, first used in a global study commissioned by the WHO and the World Bank and published in 1990, relied on new metrics: DALYs (Disability Adjusted Life Years), YLLs (Years of Life Lost), and YLDs (Years Lived with Disability). One of the most striking findings these metrics made possible was that depression was the leading cause of disability worldwide and was expected to become the second largest contributor to disability and premature death by the year 2020 (Murray 1996). It catapulted depression into public attention and continues to appear regularly in popular and professional publications, internationally and in Poland. It was also a recurrent datum in the Polish awareness raising campaign.

32 In this section, I discuss depression as an idiom of distress and a "critical condition" (a condition that marks the boundaries of what is tolerable and legitimate) in public and popular discourse, i.e., press publications, rather than ethnographically as lived experience. I examine the latter dimension in what I write about the persons who shared their stories with me, such as p. Zygmunt, at the beginning of this chapter.

33 *Depresanci* is a neologism that can be translated as "depressives." It is also used in the name of the mutual help fellowship *Anonimowi Depresanci* [Depressives Anonymous] discussed at length later in this book.

Notes to Chapter Two

1 The EZOP study was conducted between 2009 and 2012 on a sample of 10,000 people, using the WHO Composite International Diagnostic Interview (CIDI) questionnaire.

2 For example, major depression had a lifetime prevalence rate of 21 percent in France (21 percent of the population met diagnostic criteria for the disorders during their life so far), 17.9 in the Netherlands, 14.6 in Ukraine, and 9.9 in Germany and in Italy. The study used DSM-IV diagnostic categories and included major and minor depressive disorders. The specific rates for Poland were 3.0 percent for major depression, only 0.4 percent for minor depression, and 0.6 for dysthymia.

[3] Because it primarily discusses diagnostics, this chapter focuses on the experiences of mental health practitioners rather than patients.

[4] It is still in use today. ICD-11 is expected in 2017 (WHO | International Classification of Diseases [ICD] n.d.).

[5] The coding system of the previous revision, ICD-9, would not accept the addition of many more subcategories of each entry due to its rigid code format, typically a number of three digits and a fourth following a decimal point, listed in numerical order (e.g., 300.4 Neurotic depression; 300.5 Neurasthenia; 300.6 Depersonalization syndrome; etc.). ICD-10, by contrast, would not become "saturated" as easily. Its basic alphanumeric codes consist of a letter and three digits, the third one following a decimal point (the total range being from A00.0 to Z99.9), however, additional subdivisions may be given up to the sixth-digit level, if required. There is plenty of space to modify or add categories in the future, not to mention a whole chapter—the letter U—reserved for potential new conditions. "Mental and behavioral disorders" are listed in chapter five (F00–F99), which is divided, like other chapters, into homogeneous three-character blocks, e.g., "Mood (affective) disorders" (F30–F39), "Neurotic, stress-related and somatoform disorders" (F40–F48), etc. (ICD-10 2011).

[6] The document claims to combine various principles of diagnostic definitions:

> The ICD has been developed as a practical, rather than purely theoretical classification in which there are a number of compromises between classification based on etiology, anatomical site, circumstances of onset, etc. There have also been adjustments to meet the variety of statistical application for which the ICD is designed, such as mortality, morbidity, social security, and other types of health statistics and surveys (ICD-10 2011: 14).

In the chapter on *Mental and behavioral disorders*, however, the move away from etiology and toward symptomatology is clear (with the predictable exception of stress-related disorders in which the stress factor is one of the criteria).

[7] The DSM, while an American document, remains a reference point for psychiatrists internationally—including many of my interlocutors in Poland—and its diagnostic philosophy has influenced consecutive revisions of the ICD. It has been the driving force of the controversial changes in the last decades and remains, arguably, in closer relationship with new research, including pharmaceutical research. The DSM famously initiated the revolutionary, if controversial, transition away from etiology to symptomatics in its third edition published in 1980 (DSM-III), establishing depression for the first time as a disease category and, arguably, laying the ground for its imminent rise as a public health concern and popular cultural phenomenon. Such a diagnostic turn was not coincidental. It reflected the new and unprecedented position of pharmacology in psychiatry—a result of intensive research in biochemistry since the mid-20th century, particularly following World War II, in the United States and Western Europe. Defining disease categories on the basis of manifestations and responses to pharmaceutical substances, DSM-III signaled a shift in American psychiatry, previously influenced by psychoanalytic theory, from a "clinically-based biopsychosocial model to a research-based medical model" (Wilson 1993 quoted in Orr 2006: 225). The psychiatrist and critic of the pharmacological approach David Healy has expressively called DSM-III

"the Trojan horse by which [neo-Kraepelinians—researchers who perceived psychiatry as just another branch of biomedicine] effected entry into the citadel of psychoanalysis" (Healy 1997: 233). This classificatory and diagnostic philosophy has been continued in the subsequent revisions DSM-IIIR (1987), DSM-IV (1994) and, most recently, DSM-5 (2013) (Wilson 1993; Kleinman and Good 1985; Lakoff 2005; Lawlor 2012; Luhrmann 2000: 46–48, 227–232; Metzl 2003; Healy 1997, 2006; Hirshbein 2009; Horwitz and Wakefield 2007; Orr 2006; Dumit 2004). See also discussion in Metzl 2003: 53.

8 For discussion of the impact of new pharmaceuticals on mood psychiatry, see Chapter Four. See also Applbaum 2006; Healy 1997, 2004, 2006; Jenkins 2011; Lakoff 2004, 2005; Martin 2007; Medawar and Hardon 2004; Petryna, Lakoff, and Kleinman 2006.

9 This flattening is a broader process. Discussing their concept of "somatic individuality," Novas and Rose (2005) write:

> [Somatization of individuality] is linked to a reshaping of the psychological space that gradually opened up between the body and its organs and the person and his or her conduct since the eighteenth century. The psy-shaped space that inhabits the human being is losing its depth—that depth that once had to be mined and interpreted. The psyche is becoming flattened out and mapped onto the corporeal space of the brain itself. Such technological developments as neurochemistry, with its models of neurotransmitter action underlying mood and affect and brain scanning, with its apparent localization of particular feelings and perceptions in real time, appear to establish direct and 'superficial' empirical and observable relations between the physiological and the ethical: between the brain and all that makes a person human. Not that the experts of psy have been made redundant—in this new distribution of personhood, they have a new vocation: managing the ways in which the somatic individual conducts him or herself in relation to their particular risks and habits. (2000: 508)

10 Talking about what she calls "*real* depression," the disease, she offers a powerful image of its symptoms:

> A deep lowering of mood: everything is sorrowful, everything shrouded in black, black past … Well, you have Norwid [19th-century romantic poet Cyprian Kamil Norwid, a canonical figure of Polish literature]: "it's miserable everywhere / the black thread is spinning / it is in me, before me and behind me …" A depressive evaluation of oneself in the past, a tragic present, and a future even worse. That is the image of deep depression in terms of mood. With self-accusations, that I've been a bad father, bad husband, that I've done harm, I've sinned, therefore I'm guilty, I am going to be punished: they will come, take me away, they will torture me, I will go to hell …
>
> G. S.: Well, those sound like psychotic traits.
>
> A. J.: Yes, we are talking about psychosis—about severe depression [here, Dr. Bugajska is following the traditional distinction reflected in ICD-9 categories]. Therefore, it must be ended, I must kill myself, and because I love my wife and children, [I must kill] them too, because they're going to suffer … the loved ones. That's the greatest tragedy. Extended suicides. … Of course, there isn't always suicide, but a negative evaluation of reality is there. Accompanied by a lack of activity, a complete lack of intentional activity [*celowej aktywności*]: he can't do anything—either there is aversion and he's sitting doing nothing, or he starts but doesn't finish. There is unrest [*niepokój*, agitation] … he'll go shut the door, here he'll write something, correct something else, rest a little, get up again … That's unrest. And the

> other [kind of] unrest: physical—usually in the chest, but also stomachaches, or back pain, or terrible and variously located headaches. Lack of appetite, or excessive eating—but that's much rarer and typically with lighter depression—and weight loss, sometimes very drastic, 10–15 kg in two-three months. Even if eating a little. Great loss of weight. Not always, but in severe depression, yes. And then the peak, which one doesn't see anymore but I've seen plenty of: depressive stupor: he's lying down, has to be fed, doesn't pass urine, has to be catheterized …

Bugajska's characterization of the depressed patient is, in fact, close to the classical presentation we find, e.g., in Freud's *Mourning and Melancholia*, his only essay on depression—one could say *explicitly* on depression if Freud had not eschewed that word, speaking of "melancholia" instead:

> The distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment. … The melancholic displays … an extraordinary diminution in his self-regard, an impoverishment of his ego on a grand scale. … The patient represents his ego to us as worthless, incapable of any achievement and morally despicable; he reproaches himself, vilifies himself and expects to be cast out and punished. He abases himself before everyone and commiserates with his own relatives for being connected with anyone so unworthy. He is not of the opinion: that a change has taken place in him, but he extends his self-criticism back over the past; he declares that he was never any better. This picture of a delusion of (mainly moral) inferiority is completed by sleeplessness and refusal to take nourishment, and—what is psychologically very remarkable—by an overcoming of the instinct which compels every living thing to cling to life. (Freud 1974: 244–246)

In Polish depressions and delusions today, there seems to be less and less guilt, I am told by Dr. Bogusław Habrat at the Institute of Psychiatry and Neurology in Warsaw. Rather than guilty conscience, we now have mostly grudges and feelings of inadequacy (cf. Ehrenberg 2010), a trait that in the old classification used to distinguish endogenous from reactive depressions:

> The feeling of guilt [*poczucie winy*] is generally incredibly rare. Today the problem of guilt has disappeared. People don't feel it and don't even use that word. It is today almost a historical word and young people, if they talk about someone's being guilty, they mean it rather in the sense of "owing someone money" [in Polish, the adjective "*winny*" derived from *wina*, guilt, fault, can also signify indebtedness: "*być winnym*" means to be guilty; "*być winnym coś komuś*" means to owe someone something, literally: "to be guilty to someone of something"]. The image of depression has changed accordingly. Society has become more and more demanding [*roszczeniowe*]. Just like in the past the measure of someone's value was what we can give or sacrifice for society, so now we have individualism: what comes first is self-growth, self-realization, and we can only hope it's not achieved at society's expense. In the past, in endogenous depressions, people were coming with a feeling of guilt and out of guilt they were committing suicide and sometimes even killing others in murder-suicides. They believed God would punish them because of their faults. Today the feeling of guilt is gone. All patients with evidently the same illness only say is that they have been wronged by life—that is, their partner left them, their disability or retirement pension is too small, their children take no interest, on TV they talk rubbish. … The whole world is bad and the whole world is doing me wrong. Guilt has disappeared—and to make it funnier—it has moved over to schizophrenia. Which means: in today's world the feeling of guilt is so absurd

> that only a madman can be talking about it, not a depressed person. Times have changed and the individual's relationship to society has changed to be more demanding [*roszczeniową*].

On the historical specificity of the content of psychotic ideations and their reflection of social and political themes, see Sadowsky 1999.

11 Such was also the case with the two inpatient hospitals I spend time at doing research, the Nowowiejski Hospital and the Institute of Psychiatry and Neurology's psychiatry clinic. The latter, because of the specializations of its clinical staff, tended to more frequently diagnose bipolar disorder and put many of its patients on lithium mood stabilizers, the standard bipolar treatment. At Nowowiejski, I rarely heard about lithium, and atypical neuroleptics seemed to be the medication of choice for bipolar. Additionally, because of the hospital's limited funds and supply of medications, the pharmaceutical culture appeared not to be diverse, and the typical entry-level drug packet comprised haloperidol, a benzodiazepine (Tranxen), and the mild anxiolytic hydroxyzine, plus a few antidepressants like the SSRI citalopram. This pharmaceutical monoculture was the subject of comments and joking remarks on the ward.

12 The current academic handbook in psychiatry for medical students (Bilikiewicz 2007) discusses it openly: "In the International Classification ICD-10, the division between psychoses and neuroses has been abandoned … In Polish psychiatry, however, that division remains, although one may agree with the objection that neither of these terms has ever been and still is not defined with sufficient precision" (Bilikiewicz 2007: 370).

13 Objective historiography was itself connected with the emergence of the modern philosophy of history and notion of temporality (Koselleck 2000; Roitman 2011, 2013).

14 In the words of discourse analyst Jonathan Potter (1996), Barthes:

> suggests that the traditional view [that] has treated denotation … as primary and connotation … as secondary … is an ideological one; it is a fiction about the nature of factuality that is used in sustaining authoritative discourses of science, literary criticism and philosophy. It is a fiction which can do this because it makes things seem simple: 'here are some words and here is what the words stand for.' It draws attention away from much more subtle, open-ended effects of connotation. (Potter 1996: 74)

15 It is clear in her frequent use of the term "*u nas*," literally meaning "at ours" (lacking a good English equivalent, it corresponds to the German "*bei uns*," or the French "*chez nous*," and Russian "у нас"). Drawing on the underlying opposition between "us" and "them," "*u nas*" denotes "here," home, the familiar, our people ("*nasi*," also used in the meaning of "our boys," whether in sports or in war).

16 In the discussion of the *Homo sovieticus* and his "learned helplessness" (Chapter One), describing the attitudes of workers-clients of the paternalist state and exhibiting "learned helplessness," Tyszka (2009), drawing on Marody (1987), says:

> … their attitude was rooted in profound fatalism, the certainty that neither on their own nor as members of some grassroots community could they possibly influence social reality and change it to suit their interests. Individuals did not see themselves as fully legitimate social agents. They viewed themselves as cogs in some machine they did not fully understand, managed by alien and often hostile groups. This attitude led to the development of another attitude, i.e., the tendency to blame others for their own misfortunes and the consequences

> of their own decisions. These "others" or the "authorities" in the broad sense meant all those who were "higher up" in the hierarchy, beginning with the government and ending with their superior at work. The conviction that they were not the masters of their own destiny led people to denounce their own responsibility and make others responsible for their lives. … On the one hand individuals had a sense of security but on the other hand they lost their ability to mould their personal lives and environments or to do anything to change their environments successfully. (Tyszka 2009: 510–511)

One of the most significant and widely read portrayals of Polish party officials was a book of interviews originally published in the "second circulation" in 1985, titled *Oni* (published in English as *Them: Stalin's Polish Puppets*, Torańska 1987). See also Chapter Three.

17 One, who had also spent some time working in the U.K. (where about 1 million Poles migrated to work after Poland joined the E.U. in 2004), told me emphatically about her astonishment when she saw a British doctor knocking on the door before entering patients' room.

18 I witnessed one situation in which patients loudly voiced their protest during a "therapeutic community" meeting (a meeting of all patients and the ward psychologists three times a week—a tradition at the Nowowiejski Hospital dating back to the 1970s) after they had been served chunks of cabbage stump for breakfast, which they considered inedible. The issue was discussed among the staff but settled in a recognition of the shortage of funds at the hospital. Money had been running out for cleaning supplies as well. Funds for maintenance were provided by the municipality and were insufficient given the ongoing and much needed renovation of one of the wards—and food was close to the bottom of the list of concerns given the financial uncertainty at Nowowiejski. It was assumed patients would be brought food by their families and could buy snacks in the little kiosk in the lobby.

19 The introductory sections of the ICD-10 make it clear: "classification of diseases can be defined as a system of categories to which morbid entities are assigned according to established criteria. The purpose of the ICD is to permit the systematic recording, analysis, interpretation, and comparison of mortality and morbidity data collected in different countries or areas and at different times. The ICD is used to translate diagnoses of diseases and other health problems from words into an alphanumeric code, which permits easy storage, retrieval, and analysis of data. In practice, the ICD has become the international standard diagnostic classification for all general epidemiological and many health management purposes" (ICD-10 2011: 3).

Diagnostic manuals are typically considered as clinical tools, but their original purpose was different. And tellingly so. The ICD's very title—it is a *classification*—places it in a lineage of a variety of systems of knowledge, or symbolic organizations of the world, that have traditionally been the objects of anthropological study (Durkheim and Mauss 1969; Lévi-Strauss 1963, 1966). In other words, classifications are prime generators of reality and its force of realness. With its explicit goal of presenting a taxonomy of morbidity, ICD-10 affiliates itself with the works of Sauvages, Linnaeus, and Cullen (ICD-10 2011: 163)—scientific orderings of the world, foundational artifacts of modernity (Foucault 1971; Bowker and Star 1999; Pickstone 2001), and distinctly

modern ways of producing reality. But the full names of both documents—*International Statistical Classification of Diseases and Health Related Problems* and *Diagnostic and Statistical Manual of Mental Disorders* have also retained the adjective "statistical." Indeed, both were originally intended as instruments of data management and storage rather than as physicians' handbooks—they were *statistical* not *therapeutic* tools. A unified nomenclature facilitated the compilation and comparison of medical data from different locales; it allowed it to be operationalized by state bureaucracies and insurance agencies—as was indeed its purpose. Establishing, for the first time, a vantage point from which the health of the population could be assessed and acted upon, such documents and the international organizations they served, from the mid-19th century until today, were therefore part and parcel of the biopolitical armory of modern states (Foucault 1980a, 1980b; Hacking 1990; Porter 2000) and imperial formations—the "active and contingent process of [the] making and unmaking [of empires]" (Stoler, McGranahan, and Perdue 2007: 8). If classification and standardization in the service of policy may themselves be viewed as "colonizing" processes, and if "statistics" stays true to its etymology that links it to "the state," such a perspective puts the history of the ICD as an instrument at once statistical and therapeutic in a new light (cf. Mitchell 2002). The original *International List of Causes of Death* was compiled by William Farr—the "founding father" of health statistics—and adopted by the International Statistical Congress in 1855. However, it wasn't until the WHO, as part of the newly established United Nations, endorsed a list of causes *both* of death *and* diseases in 1948 that a uniform international classification came into existence (ICD-10 2011: 163–174). The rise in its significance was still to come, though, brought about by the development of welfare states as well as the independence of former colonies with their often continuing dependence on international help, which would give rise to the new paradigm of "global health"—and "global mental health" (cf. Biehl and Petryna 2013; Janes and Corbett 2009). The transposability of the ICD categories facilitated the recording of data on population health, designing and reporting on the effects of health policies and interventions by governments and international agencies, as well as financing (cf. Bowker and Star 1999). The ICD-10 called itself a *practical classification* favoring the *a-theoretical approach* (ICD-10 2011: 14, 172). It claimed to replace ideological truths with the pragmatic truth of technical formalism, bringing phenomena observed in different locations, circumstances and in varying clinical traditions into a single plan of commensurability.

20 Cf. Lukács in Steiner 1964: 13, as I discuss in the Introduction. For a discussion of the symptom in terms of alienation, see Žižek 2008.

21 The main legal acts in this regard have been the new Psychiatry Law (1994), which brought the civil protection of patients up to liberal-democratic European standards, and the Health Care Reform of 1999–2003.

22 It was part of a package of four major reforms introduced by the center-right government in the late 1990s. They also included reforms of education, the pension system, and regional administration intended to complete Poland's shift away from socialist institutional forms.

[23] This new system followed the so-called Bismarck model (first introduced in the unified Germany in 1883). Initially, starting in 1999, financing was disbursed by sixteen Regional Health Insurance Funds (*Kasy Chorych*), one for each *voivodeship* (province), which had considerable freedom in setting up their own rules and regulations concerning payment rates and mechanisms. They were centralized and unified in what became the NFZ in 2003.

[24] The value of each service would now be expressed in a fixed number of units of account, or so-called "points," corresponding to a specific sum paid to the provider over a pre-set amount of time (e.g., a patient with a depressive episode in standardized therapy brings in XX per day for a period of XX days).

[25] For an anthropological analysis of contemporary audit cultures, see Strathern 2000.

[26] Although the pastoral disregard for patients' rights was arguably widespread and the neglect of long-term hospital patients was occasionally documented by the press, psychiatric institutions in Poland were not used as direct tools of state oppression, as was the case in the Soviet Union (Fireside 1979; cf. Marks 2015). In fact, psychiatric institutionalization was often used to obstruct state power, as in obtaining medical documentation (through simulation or bribes) to avoid compulsory military service.

[27] I am relying on an extensive review of press archives I conducted as well as on interviews with physicians and mental health activists in Warsaw.

[28] This question is explored in depth in the recent work of anthropologist Elizabeth Anne Davis (2012a, 2012b, 2013, 2015), and it particularly applies to the clinical and legal treatment of patients with diagnoses other than depressive disorders, whose rationality and capability for self-determination has been questioned in the modern Western tradition.

[29] The National Program, a roadmap for the transformation of mental health care provision in Poland, outlines goals that most specialists and advocates agree would be advantageous: mainly the replacement of the still largely hospital-based care with a community-type model based on local Mental Health Centers (*Centra Zdrowia Psychicznego*, CZP), where a variety of medical, psychological and social services—from outpatient psychiatry and counselling to inpatient care and social work—would be easily accessible and better suited to patients' specific needs. All in all, in seeking the generally worthy goals of deinstitutionalization and destigmatization, large hospitals are to be gradually phased out and replaced by CZPs. However, as with many such reforms, the risk is that the closing of hospitals—and the financial relief that offers to local governments—would never be sufficiently offset by establishing a network of well-functioning Mental Health Centers (bringing to mind, e.g., the deinstitutionalization efforts in the United States, see Estroff 1981). Importantly, in the envisioned model, care would rely in part on mobilizing the patients' own resources—the support provided by family and local community, without cutting the patients off their social environment, which may be beneficial, though it may also result mainly in conveniently relocating the burden of care away from the state and is not recommended in cases where temporarily removing the patient from their surroundings is exactly the relief that is needed. In other words, the passing of mental health services to local entities suits two quite different approaches: a community-based logic of care and a market-

based logic of choice and responsibilization (Mol 2008), out of which, for structural reasons, the latter tends to emerge dominant at the expense of the most vulnerable. At this point, however, these issues remain difficult to assess: the National Program, first envisioned in the 1994 Mental Health Care Act, then drafted over many years, finally passed by the Parliament in 2010, has never been sufficiently financed and put into effect, even though the document specifies a financing mechanism whereby most of the costs are to be covered jointly by the central and local governments on the one hand and the NFZ on the other. Whereas the first attempt to introduce it (2011–2015) failed—the state Supreme Audit Office issued a report where it openly called it "a fiasco" (Fiasko Narodowego Programu Ochrony Zdrowia Psychicznego – Najwyższa Izba Kontroli n.d.; Realizacja Zadań Narodowego Programu Ochrony Zdrowia Psychicznego 2016)—a second attempt, spanning 2017–2022, which involves pilot programs test-running Mental Health Centers in a couple of dozen locations with the declared goal of having 300 centers up and running by 2027, remains experimental. Meanwhile, Polish psychiatry, like much of the public health care system, continues to be plagued by underfinancing, insufficient staffing, and organizational problems. Wards are closing without adequate resources created in their wake, particularly in child psychiatry, whose services come in ever higher demand. Currently, only about three percent of the NFZ's medical service spending has gone to mental health care, as compared to a required minimum of five percent and corresponding levels of six to eight percent in Western Europe (Zdrowie w Liczbach: Opieka Psychiatryczna w Polsce Po Pandemii 2020). The total number of psychiatrists in Poland—a country of over 38 million—was 4,274 (2020), incl. only about 455 child psychiatrists. According to the Eurostat, Poland, along with Bulgaria, has the lowest number of psychiatrist per capita in all of Europe—9 (2016), the average being 19 (Number of Psychiatrists: How Do Countries Compare? n.d.). Due to limited access—the average wait time to see a psychiatrist in the public system is 3.6 months—about 60 percent of mental health care is provided in private practice, and that, of course, is only available to those better off and disproportionately in urban centers. In other words, despite the ever-discussed reform plans, the poor condition of public mental health care in Poland over the course of my research up until the moment the last edits to this book were made—2022—remained unchanged.

30 "Those patients who can afford it have, of course, long figured it out and come to us in private practice" Komorowski told me. "We can't prohibit that, but it raises serious ethical questions that half of the patients in the ward are also our private patients."

31 The notion of transition and "transitology" have been critiqued by anthropologists of postsocialism (see, e.g., Burawoy and Verdery 1999). Here I am using the term in a colloquial sense.

32 The hospital's supply was in part dependent on the "generosity" of pharmaceutical firms that offered samples in various amounts, hoping patients would be "set" on their drugs and continue buying them after being discharged. While the promotional activities of pharmaceutical sales reps had been largely regulated by the end of the first decade of the 2000s, and their ability to exert pressure on doctors had been greatly limited, the hospital's short supply or shortage of drugs, especially the expensive new, "atypical" ones, was a constant issue. I witnessed at least one situation in which

physicians from across different wards were virtually rounded up by the head nurse to put their signatures and stamps down on a list when a firm was offering "per physician" samples.

33 The difference in expenses for the patient can be huge. As one of the doctors explained to me, a month's supply of an atypical neuroleptic may cost the patient with a diagnosis of schizophrenia (F20) as little as 3.20 złotys (about one dollar); the same medication with the diagnosis of schizoaffective disorder (F25) may come close to 500 złotys (about $160).

34 For an in-depth discussion of this problem see especially Davis (2012a), also Ticktin (2006, 2011). See also Chapter Three of this book.

Notes to Chapter Three

1 This form of therapy had been developed and practiced in Polish clinics since the 1970s, though on a very marginal scale. Offering focused and intensive therapeutic work (comprehensive ten-week-long programs with 150 therapy sessions) rather than even fewer meetings (twelve, ten, or even two largely symptom-focused sessions), it went against the trend already being set in the U.S. at the time. Access was already very limited at the time and places that offered such therapies (neuroses treatment centers) were very few and limited to large cities, such as Warsaw and Kraków. (There were 13 of them in 1987 with several-months-long wait times.) (Leder et al. 1987; Bilikiewicz and Rybakowski 2002). Arguably, with the gradual shift from large psychiatric clinics to smaller units in general hospitals as well as day wards, and towards outpatient care, the number of places offering this form of treatment has increased, but the demand has grown manifold.

2 Those are typically larger companies and international corporations. They may offer their employees private insurance with commercial medical service providers operating outside of the public system, where one can typically see a psychiatrist but not access psychotherapy.

3 A psychiatrist, like any physician, could issue a sick leave for up to six months at a time, the first month paid by the employer, the following months by the Social Security Office—the ZUS.

4 Full disability would typically not be issued for the generally less severe diagnoses the CP had contracts for, such as neurotic, stress-related, and personality disorders. The amount of *renta* depended on the number of years of documented employment (while paying social security deductions) but typically came to a mere fraction of past salary. While disability pensions in Poland, on average, come to about forty percent of the average income, roughly $450–$500 with the average salary in Poland at the time of my research at about $1,100 per month (broadly accounting for the changes in the exchange rate to the dollar), psychiatric pensions tend to be somewhat lower due to demographic and statistical reasons; for a young person with little or no employment history, the amount of *renta* would be as little as the equivalent of $150–$200 per month (data from interviews and the Main Statistical Office at http://www.stat.gov.pl/).

5 Following the 2008 financial crisis and the rise in unemployment, the ZUS increased its restrictions and audit of benefits issuance—as the overall proportion of persons with depression, neurotic (adjustment), and personality disorders went up, it became much harder to claim benefits on that basis.

6 Only to remain at a two-digit level for well over a decade, often reaching twenty percent, with a significant drop in the mid- and late 2000s to around ten percent, which was due largely to a boom of labor migration, especially to the U.K., after Poland joined the E.U. in 2004. During the time of this research the unemployment rate remains between ten and fifteen percent and has since dropped to under six percent in 2020.

7 From 2.7 million in 1999 to 1.2 million in 2010 and 1 million in 2014. As the Acting Director of the ZUS, Elżbieta Łopacińska, said in an interview in 2015:

> As a result of the systemic transformation we underwent in the early 1990s, a portion of previously employed persons permanently fell out of the labor market and—unfortunately—weren't able to find their a place in the new, much changed, reality. During that period, the number of persons receiving disability pensions (*renciści*) increased because the number of applications increased and the adjudication (*orzekanie*) system allowed for granting *renty* even to persons capable of working.
>
> …
>
> Today we are in a different reality (*mamy inną rzeczywistość*). The social insurance reform has, among other things, introduced changes in the rules of adjudication to make *renty* available to people who are really incapable of working. Not the sick, not the disabled, but precisely those incapable of working, because not every sick or disabled person is incapable of working („Gdzie zniknęło 1,7 mln rencistów?" 2015).

8 Obscure, because, as I show in Chapter Two, such statistical figures directly tell us very little.

9 Under ICD-10 after 1997, it would largely translate into depressive disorder.

10 One such case, a town in southeastern Poland where a large appliance factory closed down, was discussed in Kaczmarek and Kuta (2009), another came up in my interviews with mental health care professionals in Nowy Targ, in the south of Poland, where a large state enterprise had closed, leading to a 50 percent decrease in non-agricultural employment during the 1990s and a rapid increase in psychiatric and other disability pension entitlements.

11 In fact, several of the patients I interviewed at Dolna and elsewhere had first gone on sick leave due to back pain, whether or not it was clear to the doctors that their complaints were psychiatric in nature (see p. Zygmunt in Chapter One, p. Roman below). For a classic anthropological study of the somatization of mental distress shown in economic and political context, see Kleinman (1986).

12 While many patients clearly understood their condition as an illness, most mental health professionals didn't share that view. "A personality disorder is not an illness but an element of a person's structure, like whether they are short or tall," Dr. Rataj once told me, arguing that the oft-repeated statistic suggesting that most suicides are by people with mental illness is incorrect, because it includes a large proportion of people with personality disorders. "Their reactions to situations are inadequate."

"But," I replied, "that's saying that one presumes a norm according to which a person in an existential dead-end should endure it." "Well, that's a philosophical question," he answered, pushing the topic beyond the realm of medicine.

13 This notion of "laziness" is a common trope beyond Poland and it has a long history both colonial and European (see, e.g., Sahlins 1974b; Weber 2005) and is especially relevant in the context of the welfare state (Morgen and Maskovsky 2003).

14 For a discussion of substantive and formal economic and political forms of organization in social and political theory, including anthropology, see, e.g., Polanyi 2001, Sahlins 1974a, Foucault 2008b, Eriksen et al. 2015; see also discussion below.

15 Writing a genealogy of panic disorder, cultural sociologist Jackie Orr paraphrases Foucault's concept of "biopower" and uses the term "psychopower" to refer to "the technologies of power and techniques of knowledge developed by a normalizing society to regulate the psychological life, health, and disorders of individuals and entire populations" (2006: 11). This affective terrain is different than that of biopower and the body pure and simple. Psychopower involves a specifically experiential dimension: it works through the experience of panic itself. "If one aim … of psychopower has been to manage panic, another aim has been to learn how to make it" (14). As I show in Chapter One, depression can be similarly claimed to be produced by the "new reality" in Poland. Here, however, I treat psychopower in a twofold way: as the bio-political relationship to the state as the manager of life of individuals and the population (Foucault 1980a) via provision, through increasingly technical means (Chapter Two), of medical care and social insurance; and, further, as the Other towards whom the patient's purported dependent position is oriented. For further theoretical engagement with the concept of "psychopower" in response to Foucault's "biopower," see for example Butler 1997 and Orr 2006: 11–15.

16 This, they show, stands in stark contrast to the formal and individualistic understandings and implementation of liberal democracy in Western Europe and especially the United States. As they convincingly argue, comparing the examples of the American Revolution and Poland's democratic revolution of 1989, the two differ in a way that puts the Polish revolution's success in question. In the American case, the articulation of democracy (formal and procedural, based on a reading of natural rights as grounded in "the individual's worth" and productive capacities and thus formulated in direct opposition to the substantive order of European monarchic and aristocratic tradition) resonated with the interests of critical social groups (in the American case, individual property owners and independent artisans). This created a powerful feedback loop. In the Polish case, by contrast, the groups who articulated democracy (in substantive, collective, and self-governing terms) were also "the very groups threatened by the institutionalization of democracy in its liberal capitalist form"—intellectuals and workers dependent on the state for its provisions (Cirtautas and Mokrzycki 1993: 788).

17 Though the political developments in Poland since 2015 towards "illiberal democracy," emphasizing sovereign exercise of centralized power within the nation state rather than formalist and distributed governance in a European Union framework, may seem to be motivated, in part, by exactly this dynamic.

18 As one therapist, Dr. Orłowicz, put it: "[They don't have depression, they] are personality patients: *they have problems with reality, which does not adjust to their expectations*. And they unload their anger into themselves" (Emphasis added). Importantly, these "problems with reality" are not psychotic or delusional, i.e., the patients are not seen as suffering from a loss of contact with reality. Freud makes a parallel distinction between a psychotic loss of one's grip on reality and the role of "the reality principle" in neuroses. For Freud, while neurosis was "the result of a conflict between the ego and its id," psychosis was "the analogous outcome of a similar disturbance in the relations between the ego and the external world" (Freud cited in Thompson 1994: 27). In neurosis, where the direct perceptual contact with reality—"the external world"—is not per se disturbed, the notion of "reality" that is relevant is that of the "reality principle." When the "real world" disrupts the bliss of the pleasure principle's attempts to achieve satisfaction by hallucinatory means, the psychical apparatus ha[s] to decide to form a conception of the real circumstances in the external world and to endeavor to make a real alteration in them. A new principle of mental functioning [i]s thus introduced; what [i]s presented in the mind [i]s no longer what [i]s agreeable but what [i]s real, even if it happen[s] to be disagreeable. (Freud cited in Thompson 1994: 21–22)
On Freud's discussion of the role of reality in psychosis and neurosis see Thompson 1994, see also Caper 1988, Fullinwider 1998.

19 This distance, of course, depends exactly on our modern conceptualization of personhood (Antze 1996; Macpherson 1962; Carrithers, Collins, and Lukes 1985; Strathern 1988; Verdery 2007; White and Kirkpatrick 1987).

20 It included the extended, twelve (rather than six) month-long sick leave to which teachers are entitled in Poland.

21 A term still in common use in Polish, *rodzina patologiczna* refers to families with domestic violence, sexual abuse, alcoholism, or drug addiction.

22 Examples of the struggles to obtain benefits by applicants are plentiful on internet discussion fora. One patient, denied rehabilitation benefits after months of sick leave for depression, felt so poorly that she wasn't even able to put together the documentation needed to register as unemployed, and finally it was her husband who did it for her. On her next visit to the ZUS, she tells the forum, she was told: "You must consider yourself capable to work if you registered as unemployed." Asked to straighten out her arms and clench her fists, she heard: "Your hands are functional. There are plenty of jobs you can do with your hands rather than your head" (Depresja a renta? – Depresja – Forum dyskusyjne | Gazeta.pl n.d.).

23 Working there from January to June 2010, I interviewed current patients and candidates for therapy groups, talked to the staff, observed visits with psychiatrists and psychologists, and sat in on several group therapy sessions. And I spent innumerable hours waiting in the hallways between therapy rooms, doctors' offices, and the reception desk—waiting for potential patients to be interviewed, for the staff to have time for me, for both to give me their permission to observe a visit.

24 For example, in early 2012 the six groups running at the CP had the following profiles: A—analytic for neurotic and personality disorders (Dr. Werner); B—psychodynamic and behavioral for bulimia; C—eclectic with emphasis on systemic therapy for neurotic and

personality disorders; D—psychodynamic / analytic with elements of music therapy; E—cognitive-behavioral with elements of existential therapy (Dr. Zientarski); F—CBT with elements of mindfulness and body work—movement and dance therapy for social phobia.

25 In this case, a tradition of existential therapy based mainly on the work of the Austrian psychiatrist Victor Frankl, whose logotherapy was a humanist response to the experience of the Holocaust centered on the notion of meaning.

26 Technically, this group's main target were neurotic disorders (the F40s). It ran from April through June, 2010, and I observed it only occasionally, coming in for specific sessions or days (not an analytic group, it was less prone to disruption by such irregular presence). The majority of my work at the CP consisted in observing intake interviews and conducting screening interviews with candidates for patients.

27 Titles included: *The Magdalene Sisters*, *Notes on a Scandal*, *Kinsey*, *Other People*, *The Piano Teacher*, and the brilliant portrait of male neurosis in the 2002 Polish comedy, *Day of the Wacko*.

28 Whereas for Durkheim anomie was synonymous with normlessness, often due to societal upheavals of the type that the postsocialist transformation constituted in Poland and other East and Central European countries, Merton's theory of the gap between aspirations and means and various forms of adaptation seemed a better starting point for thinking about the already congealed—although for many no less challenging—"new reality" two decades later. Indeed, many of the patients whose problems manifested as depression were diagnosed at the CP as "*adaptacyjni*," "adaptation patients," meaning they had "*zaburzenia adaptacyjne*," the Polish translation of the ICD-10 category of "Adjustment disorders," F43.2, related to difficulties adjusting to new conditions.

29 Crucial to the depressive position is progress in the integration of the ego and "a measure of synthesis between love and hatred" that begins to replace the paranoid-schizoid splitting between the good and the bad breast and the corresponding splitting of the ego unable to integrate love and hatred. Effectively, a more complex and reality-near perception of the external world becomes possible:

> The various aspects—loved and hated, good and bad—of the objects come closer together, and these objects are now whole persons. The processes of synthesis operate over the whole field of external and internal object-relations. … The continued experience of facing psychic reality, implied in the working through of the depressive position, increases the infant's understanding of the external world. Accordingly the picture of his parents, which was at first distorted into idealized and terrifying figures, comes gradually nearer to reality. (Klein 1975a: 75)

30 The relationship between reality and fantasy and the desire that the former adapt to the latter, and not the other way around, is well captured in the following quote from one of Klein's early essays, *Criminal Tendencies in Normal Children* (1927):

> The normal child, as well as the abnormal child, uses repression to deal with his conflicts, but since these are less intense the whole circle will not be so strong. There are other mechanisms, too, which both the normal and the neurotic child use, and again only the degree will determine the issue: one is the flight from reality. Much more than would appear

> on the surface, the child resents the unpleasantness of reality and tries *to adapt it to his phantasies* and not *his phantasies to reality*. Here we have the answer I put off at one point, how it is possible that the child does not show its inward suffering much outwardly. We see that a child is very often soon consoled after it has wept bitterly; we see it sometimes enjoying the most insignificant trifles and conclude that it is happy. It can do this because it has a refuge which is more or less denied to the grown-up: this is the flight from reality. Those who are familiar with the play-life of children know that this play-life is concerned entirely with the child's impulse-life and desires, performing them and fulfilling them through his phantasies. From reality, to which it is more or less apparently well adapted, the child takes only as much as is absolutely essential. Therefore we see that a number of difficulties arise at periods in the child's life when the demands of reality becomes more urgent, as for example, when school is begun. (Klein 1975b: 180)

31 I joined Dr. Orłowicz's group as an ethnographer at the very beginning of its second month—I had been waiting for my local IRB approval to be processed by the bioethics board of the Warsaw Medical University. My presence was made possible first by one of my main contacts in the Warsaw psychiatric world and, at the time, the Medical Director of the Nowowiejski Hospital of which the Dolna unit was a part. He ran this idea by Dr. Orłowicz, who agreed to grant me access to the group (the extent to which his approval was motivated by a recognition of institutional ranks of superiority is unknown to me, and the thought of it would be only one among many discomforts of my ethnographic work in these highly sensitive settings). They had had interns before, and even though my presence would take a slightly different format—I would sit in the corner of the room, outside of the circle of chairs that included everyone else, and take notes without participating in the sessions in any other way—they deemed it acceptable. To make my presence as undisruptive as possible, I had to commit to not missing a single day of the remaining two months. I also offered my help in filling out paperwork required by insurance after each daily session.

32 Patients in this group had mostly been referred internally from the hospital or the outpatient center run by the hospital. The CP, across the yard, had its own open recruitment—one could contact it directly and come in for a consultation with one of the staff psychiatrists and psychologists, and then come back for a recruitment interview, which focused on the patient's life history (conducting such entry interviews was one of my functions at the CP).

33 CBT, an increasingly popular form of psychotherapy worldwide since its development in the 1970s by the American psychiatrist Aaron Beck in reaction to the domination of psychoanalysis in the United States, had been becoming the dominant form of psychotherapy in Poland since the 1990s, although at the time of my research that trend was slowing down and, at least in Warsaw, a psychodynamic trend was becoming more pronounced. Compared with the notoriously unscientific and long-term psychoanalysis, CBT, with its standard of ten to twelve sessions and focus on predefined testable outcomes, is far more compatible with the evidence-based and insurance-focused environment of contemporary health care systems. Similarly, in Poland, to the extent that psychotherapy was offered in public mental health care, CBT was the method of choice with psychodynamic approaches not even listed as eligible for NFZ funding in the first years after the reform (see Chapter Two).

[34] The developmental framing of the group was also manifest in the two films patients and therapists watched together on a large TV screen in the therapy room on the first and last day of treatment. The inaugural screening was of *The Lion King*, the Disney animated coming-of-age story about the struggles of leaving childhood and entering adulthood; the closing movie was *Madagascar*—a similar feature, this time from DreamWorks, telling the story of a pack of animals—indeed, a *peer group*—who, after spending their adolescent years in blissful captivity of the Central Park Zoo, find themselves in their ancestral Africa having now to survive on their own and *for real*. This developmental figure of *urealnienie* is what connects the narratives of coming of age and leaving a protective-oppressive forced enclosure to enter the therapeutic process itself—but it also strongly resonates with the discourses of immaturity of the post-socialist population dependent on the paternalist command economy I analyzed in Chapter One.

[35] I joined the group on a Monday. According to the schedule, it was a day of psycho-dynamic therapy, followed by assertiveness training on Tuesday, cognitive-behavioral therapy on Wednesday and Thursday, and on Friday morning psychological tests (1 hour) would be followed by psychoeducation and pharmacological checkup at the end of the day.

[36] At the beginning of therapy, the room was equipped with upright folding chairs; a few weeks later, both the day unit and the CP were furnished with light armchairs one could comfortably lean back in—important especially for the semi-hypnotic relaxation sessions practiced by some of the therapists at the CP.

[37] Poland was amidst debates about religious symbols in public buildings, from classrooms to the Parliament hall, and it was common, if striking, to see devotional elements in many a medical room. The closed unit at the Nowowiejski Hospital offered patients a weekly gathering and communion with a visiting priest in the ward's meeting room, where a small crucifix also hung over the doorframe. Many of the patients and mental health care professionals would bring up faith (typically Catholicism) and its role in mental health.

[38] Indeed, FNM was the object of an official intervention of the Polish Catholic Church and the leaders of the movement were removed by a papal decree in 2007.

[39] Polish has two words that translate as "experience"—*doświadczenie* and *przeżycie*—a distinction similar to that between *Erfahrung* and *Erlebnis* in German, discussed in hermeneutics from Dilthey to Gadamer. The former, etymologically related to "consciousness" and "witnessing," emphasizes the lasting impact of the event and the knowledge gained from it on the subject, including knowledge that accumulates with a person's age; the latter literally means "live-through" and brings out the emotional aspect and the power the event has as it is happening. Karolina speaks exclusively of *przeżycie* (noun, the act) and *przeżywanie* (gerund, the activity).

[40] Her approach is influenced by "schema therapy"—an eclectic modality developed on the basis of CBT by Aaron Beck's student, Jeffrey Young. Schema therapy includes elements from psychoanalysis and object relations and Gestalt therapy; Karolina's practice also involves elements of other non-mainstream approaches, such as Buddhist meditation-based "mindfulness" (whose founder, Jon Kabat-Zinn, gave a lecture to

a full auditorium at the Institute of Psychiatry in Warsaw during my work at Dolna) and "acceptance-commitment therapy."

41 The English words *feeling* and *emotion* correspond to a single Polish word, *uczucie*. The word *emocja* also exists, but isn't clearly distinguished from *uczucie*, nor was it in frequent use during the course of the therapy group. Dr. Zientarski often emphasized his "bodily" and behaviorist understanding of emotion by qualifying it with additional words like *odczucie* (sensation) and *przeżycie* (experience).

42 These broad aspects of emotionality have been explored by the rich tradition of anthropology of emotions (Lutz 1988; Lutz and Abu-Lughod 1990; Rosaldo 1983; Rosaldo 1984; Shweder and LeVine 1984; Stoler 2004; cf. Reddy 2001).

43 The following quotes are paraphrased from notes and therefore condensed, but they convey both the content and the tone of Dr. Zientarski's introduction.

44 Referring to the media campaign from the early 2000s that significantly contributed to changing the popular perception of depression, Dr. Werner brought up an "ideal type" reminiscent of p. Honorata:

> The campaign created an awareness that if, say, a woman suddenly stops to wash, clean, and iron, it doesn't mean she broke down or became lazy, but that she has depression. Meaning, don't say to her "get yourself together, woman" but "you need treatment." And there is truth in that—only that later, things have gone too far the other way. Because stopping to wash and clean and iron doesn't mean she has endogenous depression, that is, she's mentally ill, but that her defense mechanisms used to be effective, but after so many years they stopped being functional and she simply has reactive depression. And treatment in this case would be to look closely at what has actually happened … Prozac won't help her—it will only help her so that a moment later she'll have another situation again, another decompensation—if not depressive, then anxiety, or a somatic representation, or something else. That's how it is. And it makes sense—epidemiologically, we know that the number of people with affective disorders [meaning: "endogenous depression" so bipolar or unipolar depressive disorder] doesn't go up. What goes up is all the adaptation disorders [i.e., adjustment disorders], our [disorders] (*nasze*) [i.e., those treated at the CP].

45 This Catholic movement, started in the United States in 1967 and influenced by Pentecostal theology, focuses on a personal relationship with Christ and is very popular in Poland, where national prayer meetings can draw as many as 200,000–300,000 participants (Rozwój w Polsce – Katolicka Odnowa w Duchu Świętym n.d.). It testifies to the influences of Pentecostal charismatic spirituality in the Polish Catholic Church, including in various forms of spiritual healing and psychotherapy practiced in the Church (WIĘŹ: Bóg w Psychoterapii?, vol. 606 (4) 2009; Sokol 2008).

46 In this way, Catholicism, with its ethics of entrustment, personal dignity, and charity, may come to complement, rather than contradict, neoliberal policies (see Muehlebach 2013).

Notes to Chapter Four

1 All names of persons have been changed. While all AD meetings are open to the public, I made it clear from the start that I was a researcher and asked for permission to conduct participant observation with an interest in learning about the twelve steps, but also

in learning from them. I was invited in and treated like any other person around the table, but I never self-identified as a *depresant*. A sympathetic observer with deep respect for the men and women I met during my work with AD, I am not a member of the fellowship and do not speak on its behalf. I do, however, comply with the principle of anonymity that constitutes one of the cornerstones of twelve-step culture and applies not only to names, but also to what is said during meetings. For more on conducting research in AD, see note 21 below.

2 The affective quality of the Pope's relationship to the nation and his exposure of weakness and frailty in his last days were, in fact, referred to by several men with whom I talked as an example to be followed. This effect was made possible by the extensive media coverage and the unusual sharing of public emotion, as well as, more broadly, the very influential position of the Catholic Church in Poland.

3 In my work with AD, I attended about fifty meetings and workshops of three different groups over ten months of my fieldwork and I continued to visit them occasionally in the following three years (I attended one group regularly and the other two on an irregular basis). I participated in about ten Friday workshops—sessions of "working" a particular step, when they were being held—and one "national convention" with guests from two other cities. I conducted extended in-depth interviews, sometimes several, with seven members, including some of the fellowship's founders in Poland.

4 The way I use the term "ethical" is another borrowing from Foucault's conceptual oeuvre, where "ethics" is understood as the relationship one has to oneself (Foucault 1988).

5 For classic works in this tradition, see Lasch 1979 and Hochschild 1983, 2003, while a more recent and extensive analysis has been offered by Illouz 2008. For an extensive overview with references to the contemporary Polish context, see Jacyno 2007; for a discussion of the liberal notion of free will in the context of AA, see Valverde 1998; for a broader discussion of the politics of the culture of "empowerment," see Cruikshank 1999.

6 Although in AD emotions, or feelings (*uczucia*), are said to be coming from the "soul" as a direct source of information about oneself and one's higher power, or God, in fact the specific ways of learning to understand one's emotions mirror—and indeed borrow from—that of professional psychology, particularly cognitive-behavioral therapy (which I describe in Chapter Three). Emotions are understood as one's natural, immediate bodily reactions to ongoing circumstances and are conceived as the source of truth about oneself—and it is that truth one must allow to inform one's conduct, rather than blindly following the traditional cultural norms and values that regulate individuals' relationships to others at the apparent expense of freedom and self-determination. Such practices of individuation were explicit in the workshops and meetings and explained to me in no uncertain terms by several AD members, including Marek:

> An important part of the program is coming to realize that the beliefs that our parents must love us or we must love them, or that one should sacrifice oneself for others, are harmful. … These beliefs seem unquestionable to us, because everyone around us says so. … It is a false image of the world, that loving means giving, that one must not lie … Everything that exists has its place. But it's for me to decide and I must be in accord with my emotions, not with what someone else has told you, no matter who that might have been—a friend, your wife, your parents, the priest, or society.

In other words, it is the individualized, emancipated subject herself that is positioned at the moral and decision-making center—and it is done in what appears as a realifying gesture seeking to close the gap between proclamations of moral codes and liberal social practice.

The traditional valence of the norms of altruism and AD emancipation from their hold was once made poignantly clear by Halina, a middle-aged woman, who shared with the group an epigraph her father had written in her diary when she was a girl: "The noblest stone will cut others but itself not get even a scratch / The noblest heart itself will perish but never even graze another." Many years later, she realized that this had become the motto of her life—she had not been taking care of herself, she didn't know how to benefit from life, and the way she understood forgiveness was as noble gestures akin to sacrifice.

7 The phrase "life itself" is used here in the existential rather than biopolitical sense. Some groups and programs that have formed in Poland in recent years bring together Catholics who use the twelve steps to grow spiritually. Calling it a "program for life" or "for life in freedom" they replace the word "alcohol" with such general terms as "problems" or sometimes "sin." I follow Nikolas Rose in referring to the knowledges and practices concerned with (and positing the existence of) the human psyche as the "psy-disciplines," or just "psy-," i.e., "the heterogeneous knowledges, forms of authority and practical techniques that constitute psychological expertise" (Rose 1989: vii).

8 Recent studies in anthropology include: Brandes 2002; Carr 2011; Wilcox 1998; and Valverde 1998.

9 "Technologies of the self," as theorized by Foucault (1988, 1993), constitute the dimension of power where the work of governing is performed by the individual on him- or herself in efforts towards self-improvement. As Foucault put it, these technologies "permit individuals to effect … 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 et al. 1988: 18). For that reason, the concept has been of use in examining social life and human experience in neoliberal economies (Rose 1996; Barry, Osborne, and Rose 1996; Rose 1989; Inda 2005; Sue-Taussig, Rapp, and Heath 2005; Matza 2009; Ong 2006).

Twelve-step programs may indeed be considered an exceptionally good instantiation of this kind of techniques: they are precisely codified and involve clearly defined practices and knowledges—an entire theory of the person that group members take on through learning to understand and practice the twelve steps and by listening to and engaging in confessional narrative. Self-work is at the very core of the program: changing, through practical rules, one's conduct in the realm of thinking, feeling, and action. It is not surprising, then, that the program has often been considered in terms of the making of the neoliberal subject (Zigon 2010; Raikhel 2016; cf. Valverde 1998). What I am suggesting, however, is that twelve-step programs are also a form or realification, a technique of realness in that they are a form of relating to what is, accepting one's limited control and power over it in order to create the space to act within its narrow parameters.

10 While an in-depth discussion of each step is beyond the scope of this chapter, below I provide a brief overview of the steps and their practical interpretations in AD. First,

I list each of the twelve steps in their original English version (which only differs from the original AA version in that the word "depression" replaces the word "alcohol") followed by a commentary offered to me by Marek and Joasia in one of our many conversations over the years:

1. *We admitted we were powerless over depression—that our lives had become unmanageable.*
   Joasia: The first step is … acknowledging that all the efforts [I have] made so far … cannot make me happy. That is, my way of living has met with … a flop [*poniósł … klapę*].
2. *Came to believe that a power greater than ourselves could restore us to sanity.*
   The second step is that somewhere someone else has found a way.
3. *Made a decision to turn our will and our lives over to the care of God as we understood Him.*
   Third, that I will try to apply that way to my case. That is, if it helped someone else, it might perhaps help me too.
   Marek: It's letting go. It's not up to me and I'm not going to try to control reality.
4. *Made a searching and fearless moral inventory of ourselves.*
   Fourth: I take a look at myself and my life. That is, I make an inventory: what do I have, what kind of a person am I?
5. *Admitted to God, to ourselves and to another human being the exact nature of our wrongs.*
   Fifth step: I share all that, that is, I open up [*odkrywam się*]. Frankly and honestly, I stop hiding myself. I am the way I am.
6. *We're entirely ready to have God remove our shortcomings.*
   Sixth step is, looking at my inventory I see my mistakes, where I did harm to myself, what faults I have, what deficiencies, what lacks …
   Marek: What traits of character that I used too often. There are no faults here. We have [only] traits of character. If we use them too often, they become our faults.
7. *Humbly asked him to remove our shortcomings.*
   Joasia: So, seventh—living, I try to make changes. That is, so far I used to act this way, so now I have, I regain my freedom of choice and I try new ways.
8. *Made a list of all persons we had harmed, and became willing to make amends to them all.*
9. *Made direct amends to such people wherever possible, except when to do so would injure them or others.*
   Eighth [and ninth]: because in my life I have, say, both been hurt and hurt others, I now have to stop that and in some way fight to free myself from the burden and different past issues [*zaszłości*]. That is, come clean. So that I don't have to carry any heavy stones.
10. *Continued to take personal inventory and when we were wrong promptly admitted it.*
    Tenth: atonement and making the inventory as I go. That is, I'm not keeping any grudges, I forgive at once, I have insight into myself as I go, I am [in touch] with myself, with my life, with what I do, how I do it. I am aware of what I'm doing. Currently, as I go! [*na bieżąco!*] [a lot of power and emphasis in her voice]
11. *Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of his will for us and the power to carry that out.*
    Marek: [Eleventh,] … sometimes we get ahead of ourselves … and in order to calm down and make a choice we need a kind of meditation [to learn to return to the present]. …

You really need it … your own technique, so that in thirty seconds you can bring yourself to a state [of calm], get your answer, and function normally.
Joasia: But for me it's also … it was a very important step of accepting that what I desire is not the most important for me, but what I get [is]. That what I am getting in this very moment, what I have in the present, here, is sufficient for me to benefit from and be content with.
Marek: … Expectations begin to arise in us and [with them] anxiety that stands behind them. … I do a quick mediation, I get rid of expectations, and the anxiety goes away. And I can make the right choice. In short, that's the principle.

12. *Having had a spiritual awakening as the result of these steps, we tried to carry this message to others, and to practice these principles in all of our affairs.*
Marek: The twelfth step is very important. It's about carrying on the message. Because it's not complete if you don't share it. And here we're open to talk about it. And sharing it with others I keep discovering myself anew, I have contact with other human beings. Helping others helps me.

11 I owe this phrase to Dariusz Stola. One could add that this infrastructure would be social and material, but to a much lesser extent one of *the self*. The building of the "socialist man," to the extent that it was pursued, was effectuated through his concrete social environment—the factory, the home—and values, rather than through work on the self (although, as Oleg Kharkhordin has shown, that also had its place in state communist cultures; see Kharkhordin 1999). For a discussion of the changing regulations concerning alcoholism treatment in Poland, see Moskalewicz 1985; Wald and Moskalewicz 1987; Woronowicz 2009 .

12 The relative liberalization of the Communist Party's political line marking the end of Stalinism.

13 In addition to literature, this brief reconstruction of the history of the twelve steps in Poland also relies on interviews I conducted in Warsaw with people involved in the movement from its beginnings—Wiktor Osiatyński, Ewa Woydyłło, and Feliks D.

14 Theoretically, the First Phase of the Economic Reform was introduced in the years 1982–1987, but due to the inconsistency and provisionality of changes it was never executed, leading the way to a more decisive Second Phase, 1987–89 (Economic Reforms in the European Centrally Planned Economies: Symposium Proceedings 1989).

15 Her point and her tone are summarized by the title of another one of her articles: "Our alcoholism treatment system is full of lies just like the alcoholic himself" (Woydyłło 1988).

16 In 2012, Woydyłło published the book *Because You're Human: Living with Depression, Not in Depression*, where she applies broadly understood twelve-step thinking, as described in this chapter, to depression. Notably, the book argues that depression be understood and managed as a part of life, just as many other factors, beyond one's control. As such depression could be included in what could still be a "healthy" life; a life *with*, but not *in*, depression (Woydyłło 2012).

17 Polish AA then contributed to further international dissemination of AA and twelve-step-based addiction therapies to the former USSR, most notably to Russia (Raikhel n.d.: 265).

[18] Though the first NGO devoted to issues of mental health, the "Integration" Association of Families and Friends of Persons with Mental Illness, was established as early as 1990, and many other NGOs have followed since, "civil society" actors are yet to be treated as partners by the mental health care system. As discussed in Chapter Two, the current legal act regulating the development of Polish psychiatric care, the NPOZP, which promotes a turn to community care and posits the establishment of local Mental Health Centers (*Centra Zdrowia Psychicznego*), remains practically dead, since appropriate funds have not been disbursed. When I was concluding my fieldwork in 2013, the centers that had come into being were often run by existing health care providers hoping to absorb future NFZ contracts. Such had been the case in the southern borough of Warsaw, Ursynów-Wilanów, where what was intended to produce small, local community centers had become an addition to the city's largest psychiatric hospital, the Institute of Psychiatry and Neurology.

[19] While the name AA is recognizable in Poland, twelve-step recovery groups are not as popular or as much a part of common knowledge as they are in the United States, even though the program and method are today at the very basis of most addiction treatment in Poland (Woronowicz 2009).

[20] Twelve-step groups are, by their nature, a difficult and delicate site for ethnographic fieldwork (cf. Brandes 2002). This requires a methodological disclaimer. AD meetings are open to everyone, but at the beginning of each meeting, after reciting the preamble and reading out loud the twelve steps and traditions, the person leading the meeting asks if there is anyone in the room who has never attended a meeting before. That person is then asked whether they are willing to give up excessive worry [*zrezygnować z zamartwiania się*]. That will is the only condition of becoming a member of the global AD community. The newcomer can then say a few words about him- or herself. At my first meeting, I explained that while I do tend to worry too much and am familiar with the feeling of depression—and I am definitely willing to give that up—I was there primarily as a researcher working on my doctorate on the changing understandings of mood disorders in Poland. I asked for permission to stay and learn. That permission was granted, but I was obliged to respect the rules of meetings: what is said in the room stays in the room; anonymity and confidentiality are the basic premise. Accordingly, while I became familiar with the program and the lives of many of its participants, I am not using any personal information disclosed during meetings. I am, however, using field notes taken at workshops at the discretion of participants and transcripts of interviews conducted outside of meeting settings and recorded with the approval of my interlocutors.

[21] Indeed, I struggled to recall any similarly formalized but non-hierarchical social space in Poland. Citizens' associations, depending on the kind, were tightly controlled in state socialism—indeed, often another element of "fiction," in which apparently grassroot structures were in fact run top-down and acted as agencies of the state. With the liberalization of late 1989, and especially with the introduction of the association law in 1989, citizens' associations started to emerge relatively quickly. On this aspect of twelve-step programs, see Zajdow 1998 and Valverde 1998.

22 As Łukasz, a recovering gambler and drug addict as well as a successful organizer of twelve-step programs for Christians and owner of a media production company (achievements of his life in recovery), told me:

> [Y]ou see people who you think are dumber than you, who may even smell a little, or look like there's something wrong with them, but it turns out they say things that absolutely apply to you. And they say those things with confidence, because they have proved through their life that whatever problem they have, this disease can be stopped.

23 I had, at that time, not yet attended groups at the CP, which were similarly balanced in terms of the patients' gender, and which did not formally focus on depression (see Chapter Three).

24 *Zrezygnować z zamartwiania się*, "to give up mortifying sorrow," which corresponds to AA's more straightforward "to stop drinking," is an important phrase. First *zrezygnować*, meaning "to give up, to resign" (from Latin *resignare*). More than just "to stop," it implies and emphasizes that the nature of the attachment to sadness is a desire or need to hold on to it; one can only "give up" what one to some extent "wants" to keep doing. Second, while the referent of "drinking" is relatively definite ("consumption of alcohol"), *zamartwianie się* is a more complex activity to abstain from. The word itself is not commonly used in everyday language and does not refer directly to depression (*depresja*) or to any terms frequent in psychomedical usage, such as "lowered mood" (*obniżony nastrój*), nor does it simply mean "sadness" (*smutek*). Rather, the reflexive verb *zamartwiać się* comes from Latin *mortificare* "kill, subdue" and ultimately *mors, mortis* "death" (just like the English "to mortify") and signifies the active and incessant driving oneself into deep despondency and anguish, which I here translate as "mortifying sorrow." It carries an important dual connotation with the common *martwić się* "to worry, to be concerned," but also with *umartwiać się*, *umartwianie się*, a term denoting the Catholic doctrine of mortification and ascetic exercise of "mortification of the flesh" in penance.

I am not implying that this choice of words is intentional, or that *depresants'* "mortifying despondency" is equated with a sanctifying subduing of the flesh. Quite to the contrary, AD members want to see nothing holy in their recurring sorrows. But I am suggesting that the choice of name for *depresants'* problem isn't completely accidental, either. It draws, if subtly, on the poetics and pathos of Catholic piety. As I discuss below, it is one of a number of elements connecting the new twelve-step practice to an existing and culturally prevalent tradition of the care of the self in Catholicism.

25 Most often, it is God, making the "higher power" a well-known and controversial concept of twelve-step theology. As one *depresant* told me, "[H]igher power is just a trick. It all leads to God. That's where you inevitably arrive."

26 The workshops made use of AD materials originally obtained from the Depressed Anonymous based in Louisville, Kentucky, as well as fragments, in samizdat translation, of a book on *Coping with Depression in Twelve-Step Recovery* by a Jack O., published in the U.S. They also included material from AA, some of which had been developed by Polish members. While a lot of twelve-step literature had been published in Poland—from the *Big Book* to daily reflections and manuals for "working the steps" in workshops—

AD materials had still only been translated and printed by collective effort and distributed in photocopies. They were very "American" in their frequent references to U.S. locations, elements of everyday life, names of persons whose life stories were given as examples, and an occasional quote from Abraham Lincoln—but all that was in line with both the AA tradition and the general culture of psychological and self-help literature in Poland, the overwhelming majority of which is translated from English. Incidentally, most of the twelve-step literature in Polish is brought out by the publishing house Media Rodzina (Family Media), established by Robert Gamble—an Episcopal pastor living in Poland and one of the Americans involved in popularizing AA in the country since the 1980s. Besides AA literature, Media Rodzina publishes books in psychology and self-help, literature based on Christian values, and children's literature, including Polish editions of the Harry Potter series.

27 Explicit references to the hardships of living in the Polish society were not infrequent and they went beyond complaints about rudeness and aggression. "In this country," the phrase would often be, "we haven't been taught the most important things about life"—things that the program can teach. The reasons were often only implied but appeared to be located in Poland's turbulent past over the last generations—the destructive war, then communism, then the rapid transformation people had not been equipped to cope with.

28 For Berlant, cruel optimism amounts to sustaining the attachment to unachievable fantasies of the good life despite evidence that liberal-capitalist societies can no longer be counted on to provide opportunities for individuals to fulfill them.

29 Jesuits, with their strong tradition of individual spiritual exercises founded by Ignacio de Loyola himself and practiced to this day in Catholicism, in Poland as elsewhere, were a recurrent reference in conversations I had with recovering *depresants*. Emphasizing Ignatian meditation as both a mystical and ethical exercise, the Jesuits have a strong interest in psychology and I had often come across Jesuit publications, online as well as in print, discussing terms and ideas I had encountered in my research. (Examples can be found on the website deon.pl and from the publishing house WAM, run by the Society of Jesus and focusing on Catholic spirituality, psychology, and self-help.)

30 *The Imitation of Christ* was a central text of the Devotio Moderna movement in late-medieval Europe, which deeply influenced the Catholic devotional culture but also paved the way for the Reformation. However, its combination of what Max Weber called "world-rejecting asceticism" with "world-fleeing mysticism" set it clearly apart from the active "inner-worldly asceticism" that was at the heart of the "spirit of capitalism" (Weber 1978: 541–551, 2005). Considering the twelve-step philosophy and practice in Weberian terms, the presence of both ascetic and mystical elements would seem key to the ethic of powerlessness. For the AD groups in Warsaw, it seemed to consist in a constant negotiation of "world-rejection" and "inner-worldliness" as well as aspects of "mysticism" in their practices of selfhood.

31 Bateson's (2000) concept of a "system exhibiting mental characteristics" and his cybernetic critique of the notion of the self built around an Occidental idea of agency may be summarized in the following quote:

> Consider a man felling a tree with an axe. Each stroke of the axe is modified or corrected, according to the shape of the cut face of the tree left by the previous stroke. This self-corrective (i.e., mental) process is brought about by a total system, tree-eyes-brain-muscles-axe-stroke-tree; and it is this total system that has the characteristics of immanent mind. … But this is not how the average Occidental sees the event sequence of tree felling. He says, "I cut down the tree" and he even believes that there is a delimited agent, the "self," which performed a delimited "purposive" action upon a delimited object (317).

[32] Either system may be disastrous—in Bateson's wording, may lead to "schismogenesis" by uncorrected positive feedback in the system—but schismogenesis is necessarily reduced in mixed systems.

[33] A sense of helplessness—and a corresponding passivity in many areas of life—is part of a general and summary view of depression as it has emerged from AD theory and practice—in AD literature, conversations in workshops and accounts in meetings, as well as interviews. It is also in line with the general psychiatric as well as psychological views of depression, where helplessness is considered to be either one of its symptoms or part of its mechanism.

[34] Of course, the difference is to some extent relative. As AA understands it, theirs is also a problem of immaturity in relating to the world. Accordingly, the twelve steps are not just a treatment of alcohol addiction, but rather a "program for life" or "for living" [*program na życie*]. The differences in some practical elements of the program between AA and AD were brought up with some regularity, however. *Depresants* were said not to respond well to the strictness, rigidity, and roughness that is believed necessary in dealing with alcoholics, who can both take such treatment and need it to break through their pride and manipulations. Powerlessness in AD means "no longer acting by force. It is non-forcefulness"—an emphasis on gentleness that suggests a relative lack of rigidity and a certain kind of flexibility (Martin 1994). Some of the members felt they were getting worse while doing their moral inventory and confronting their faults under the no-nonsense supervision of an AA sponsor in the first years of AD. But from an AA perspective, that difference seems more like involving passivity and expectation, otherwise confirmed by the relative lack of self-organization and service in AD—barely existing sponsorship, problems with organizing and attending workshops. I heard this from, among others, Julek, a veteran of Polish AA, who helped get AD up and running. "*Depresants* are not easy to work with—so downcast, often wishy-washy, I don't get them. And they always want you to give them something," Julek told me, as we sat in his kempt living room in an east Warsaw residential project, recently renovated thanks to E.U. revitalization funds.

[35] Granted, prior to the late capitalist corporation, there were state enterprises and institutions—central to both work and distribution of social provisions in command economies—to which one also had to "adjust." However, as I make clear throughout this book, particularly in Introduction and Chapters One and Two, the pervasiveness of the corporate form and the fears, demands, and desires related to work into the spheres of life previously kept out of its reach has been one of the main characteristics of postsocialist Poland and is a central feature of contemporary capitalism (see, e.g., Dunn 2004).

[36] Explicit references to the political and economic arrangements of "new reality" were common in interviews with *depresants*. (During meetings they were avoided, as political opinions, as well as religious beliefs, were prohibited topics.) One person who brought them up repeatedly was Stanisław, a slender and soft-spoken man of fifty-six. He had grown up on a small farm in the countryside not far from Warsaw in, as he puts it, "materially difficult conditions" and struggling with poor health and both physical and mental abuse. Already as a child he sought refuge in learning about religion in his parish—that's what he tells me when I ask if he had any psychological care as a child and youth. Later in life, encouraged by his sister, he also started attending Al-Anon, as both his brother and brother-in-law were alcoholics. He worked as a locksmith and in construction, but was drawn to natural medicine, philosophy, and spirituality, and started practicing reflexology. "Depression has many causes. I liked what one psychiatrist said: Man wants too much autonomy from other people, from God, and from nature. That's the source of most his problems," he tells me. "That's the current trend. Liberalism, individualism … It has been in the West for a long time, it's been here [*u nas*] for short, but I think people will soon have enough of it and it will cause a crisis. Too much freedom in fact takes one's freedom away," he said, referencing Ryszard Legutko, a conservative philosopher, author, and one of the intellectual leaders of the conservative revolution that, four years after my conversation with Stanisław, in 2016, would indeed begin to reverse Poland's turn to liberal market democracy. After talking extensively and critically about "the market, that is rivalry, competition, individualism, leading to stratification and concentration of wealth in just a few hands" and what he sees as a "crisis—economic and moral, stemming from individualism, deregulation, and the reign of the invisible hand and big corporations," Stanisław addresses powerlessness directly:

> Powerlessness is something you can apply to things you have no control over. There are things I barely have any power over, and others I have considerable power over. E.g., I am powerless over the system that we have here. Through elections, etc. I still go and vote, but I'm aware my power over this is pretty much null. I have no power over the weather. Over social stratification. Over the fact I have little work. Here my power is much greater than over politics, but not too big either.
> G. S.: But is that something you would try to have more power over, or just relinquish it to the higher power?
> S.: Hm. That's not exactly how it works. I recently read in a little brochure published by the Church that [says] one has to count *both* on God *and* on oneself. And not cede too much to God, in other words. That makes us passive, you need some balance there. Ask God, but at the same time do all that you can. My life depends both on God and myself. It's not either-or.

[37] On the relationship between expectations and chances in liberal capitalism, see, e.g., Bourdieu 2000: 206–245.

Notes to In lieu of conclusion

[1] My use of the term is inspired by, though not equivalent to, Timothy Morton's definition of hyperobjects as "things that are massively distributed in time and space relative to

humans" defeating traditional ideas about what a thing is in the first place (Morton 2013: 1).

2 The well-known datum that antidepressants across the board show about twenty percent greater effectiveness over placebo (between 20 and 40 percent of people with depression show improvement over a period of six to eight weeks when taking placebo; the figure changes to 40 to 60 percent when taking antidepressant drugs) (Depression: How Effective Are Antidepressants? 2020). I am not in a position to debate the specific effectiveness of the substances used in treatment—if anything, I note the physicians' practical commitment to their use, which I believe to be more than groundless and purely opportunistic, but also the ongoing questioning, coming also from within psychiatry, regarding the validity of their use.

3 On recognizing the significance of the agentive and substantivist position of the state in the success of "illiberal democracy" in Poland, see, e.g., Gdula 2017.

List of figures

References cited

Agamben G. 1998. *Homo Sacer: Sovereign Power and Bare Life*, Stanford University Press, Stanford, CA.

Alcoholics Anonymous. 1976. *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*, 3rd ed., Alcoholics Anonymous World Services, New York.

Althusser L. 2001. *Lenin and Philosophy, and Other Essays*, Monthly Review Press, New York.

Angell M. 2004. "The Truth About the Drug Companies," *The New York Review of Books*, July 15. http://www.nybooks.com/articles/2004/07/15/the-truth-about-the-drug-companies/; accessed July 29, 2016.

Antze P. 1996. "Telling Stories, Making Selves. Memory and Identity in Multiple Personality Disorder," [in:] *Tense Past: Cultural Essays in Trauma and Memory*, Routledge, New York, pp. 3–23.

Appadurai A. 1996. *Modernity at Large: Cultural Dimensions of Globalization. Public Worlds*, vol. 1, University of Minnesota Press, Minneapolis, MI.

Appadurai A. 2004. "The Capacity to Aspire: Culture and the Terms of Recognition," [in:] *Culture and Public Action*, eds. V. Rao, M. Walton, Stanford University Press: Stanford Social Sciences, Stanford, CA, pp. 59–84.

Appadurai A. 2013. *The Future as Cultural Fact: Essays on the Global Condition*, Verso Books, London–New York.

Applbaum K. 2006. "Educating for Global Mental Health: The Adoption of SSRIs in Japan," [in:] *Global Pharmaceuticals: Ethics, Markets, Practices*, eds. A. Petryna, A. Lakoff, A. Kleinman, Duke University Press, Durham, NC, pp. 85–110.

Aronoff M.J. and Kubik J. 2012. *Anthropology and Political Science: A Convergent Approach*, Berghahn Books, New York.

Barry A., Osborne T., and Rose N.S. 1996. *Foucault and Political Reason: Liberalism, Neo-Liberalism, and Rationalities of Government*, University of Chicago Press, Chicago.

Barthes R. 1989a. "The Reality Effect," [in:] *The Rustle of Language*, University of California Press, Berkeley, pp. 141–148.

Barthes R. 1989b. "The Discourse of History," [in:] *The Rustle of Language*, University of California Press, Berkeley, pp. 127–140.

Bateson G. 2000. "The Cybernetics of 'Self': A Theory of Alcoholism," [in:] *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology*, University of Chicago Press, Chicago.

Béhague D.P. and MacLeish K. 2020. "The Global Psyche: Experiments in the Ethics and Politics of Mental Life," *Medical Anthropology Quarterly* 34(1), John Wiley & Sons, Ltd., pp. 5–20.

Bemme D. and Kirmayer L.J. 2020. "Global Mental Health: Interdisciplinary Challenges for a Field in Motion," *Transcultural Psychiatry* 57(1), pp. 3–18.

Berenson D. 1991. "Powerlessness – Liberating or Enslaving?: Responding to the Feminist Critique of the Twelve Steps," [in:] *Feminism and Addiction*, ed. C. Bepko, Haworth, New York, pp. 67–86.

Berger P.L. and Luckmann T. 1966. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, Doubleday, Garden City, NY.

Berlant L. 2007. "Slow Death (Sovereignty, Obesity, Lateral Agency)," *Critical Inquiry* 33(4), pp. 754–780.

Biehl J.G. 2005. *Vita: Life in a Zone of Social Abandonment*, University of California Press, Berkeley.

Bilikiewicz A., ed. 2007. *Psychiatria: podręcznik dla studentów medycyny*, Wydawnictwo Lekarskie PZWL, Warszawa.

Bilikiewicz A. and Rybakowski J., eds. 2002. *Images in Psychiatry: Poland*, Via Medica, Gdańsk.

Bliźniewska-Kowalska K., Chęcińska J., and Gałecki P. 2020. "Antidepressant Use in Poland in the Years 2010–2018," *Archives of Psychiatry and Psychotherapy* 22(1), pp. 34–39.

Borovoy A. 2001. "Recovering from Codependence in Japan," *American Ethnologist* 28(1), pp. 94–118.

Borovoy A. 2005. *The Too-Good Wife: Alcohol, Codependency, and the Politics of Nurturance in Postwar Japan*, University of California Press, Berkeley.

Bourdieu P. 2000. *Pascalian Meditations*, Stanford University Press, Stanford, CA.

Bowker G.C. and Star S.L. 1999. *Sorting Things Out: Classification and Its Consequences*, MIT Press, Cambridge, MA.

Brandes S. 2002. *Staying Sober in Mexico City*, 1st ed., University of Texas Press, Austin.

Brenner N. and Theodore N. 2002. "Cities and the Geographies of 'Actually Existing Neoliberalism,'" *Antipode* 34(3), pp. 349–379.

Buchowski M. 2006. "The Specter of Orientalism in Europe: From Exotic Other to Stigmatized Brother," *Anthropological Quarterly* 79(3), pp. 463–482.

Bugajski J. 1986. "Poland's Rising Suicide Rate," [in:] *Soviet/East European Survey, 1984–1985: Selected Research and Analysis from Radio Free Europe/Radio Liberty*, ed. V. Mastny, Duke University Press, Munich–Durham, NC, pp. 325–327.

Burawoy M. and Lukács J. 1992. *The Radiant Past: Ideology and Reality in Hungary's Road to Capitalism*, University of Chicago Press, Chicago.

Burawoy M. and Verdery K. 1999. *Uncertain Transition: Ethnographies of Change in the Postsocialist World*, Rowman & Littlefield Publishers, Lanham.

Butler J. 1997. *The Psychic Life of Power: Theories in Subjection*, Stanford University Press, Stanford, CA.

Butler J. 2002. "What Is Critique? An Essay on Foucault's Virtue," [in:] *The Political*, ed. D. Ingram, Blackwell Publishers, Malden, MA, pp. 212–228.

Cahill D. 2010. "'Actually Existing Neoliberalism' and the Global Economic Crisis," *Labour & Industry: A Journal of the Social and Economic Relations of Work* 20(3), pp. 298–316.

Callon M. 1984. "Some Elements of a Sociology of Translation: Domestication of the Scallops and the Fishermen of St Brieuc Bay," *The Sociological Review* 32(1_suppl), pp. 196–233.

Canguilhem G. 1991. *The Normal and the Pathological*, Zone Books.

Caper R. 1988. *Immaterial Facts: Freud's Discovery of Psychic Reality and Klein's Development of His Work*, Aronson, Northvale, NJ.

Capps L. and Ochs E. 1997. *Constructing Panic: The Discourse of Agoraphobia*, Harvard University Press, Cambridge, MA.

Carr E.S. 2011. *Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety*, Princeton University Press, Princeton.

Carrithers M., Collins S., and Lukes S., eds. 1985. *The Category of the Person: Anthropology, Philosophy, History. Cambridge Cambridgeshire*, Cambridge University Press, New York.

Cichocka E. 1990. "Najpierw powoli, jak żółw ociężale…," *Gazeta Wyborcza*, November 3, pp. 6–7.

Cielemęcki M. and Trębski K. 1999. "Polacy kontra Polska. Rozmowa z profesorem Janem Winieckim," *Wprost* 50, p. 46.

Cirtautas A.M. and Mokrzycki E. 1993. "The Articulation and Institutionalization of Democracy in Poland," *Social Research* 60(4), pp. 788–819.

Clarke A.E., Shim J.K., Mamo L., Fosket J.R., and Fishman J.R. 2003. "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine," *American Sociological Review* 68(2), pp. 161–194.

Collier S. 2005a. "Budgets and Biopolitics," [in:] *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, eds. A. Ong, S. Collier, Blackwell, Malden, MA, pp. 373–390.

Collier S. 2005b. "The Spatial Forms and Social Norms of 'Actually Existing Neoliberalism': Toward a Substantive Analytics," *International Affairs Working Paper*, The New School, New York. http://milanoschool.org/wp-content/uploads/2013/04/Collier_2005-04.pdf; accessed October 6, 2016.

Collier S. 2011. *Post-Soviet Social: Neoliberalism, Social Modernity, Biopolitics*, Princeton University Press, Princeton, NJ.

Crapanzano V. 2003. *Imaginative Horizons: An Essay in Literary-Philosophical Anthropology*, University of Chicago Press, Chicago.

Creed G.W. 1998. *Domesticating Revolution: From Socialist Reform to Ambivalent Transition in a Bulgarian Village*, Pennsylvania State University Press, University Park, PA.

Cruikshank B. 1999. *The Will to Empower: Democratic Citizens and Other Subjects*, Cornell University Press, Ithaca, NY.

Ćwieluch J. 2012. "Depresanci," *Polityka*, March 14, pp. 25–27.

Czabała Cz., Dudek B., Krasucki P. et al. 2000. *Mental Health in the Workplace: Situation Analysis: Poland*, ILO, Geneva.

Czapiński J. 1995. "Społeczne koszty transformacji: Makropsychologiczny dowód, że pieniądze to nie wszystko," *Czasopismo Psychologiczne* 1(1–2), pp. 33–54.

Das V. and Das R.K. 2006. "Pharmaceuticals in Urban Ecologies: The Register of the Local," [in:] *Global Pharmaceuticals: Ethics, Markets, Practices*, eds. A. Petryna, A. Lakoff, A. Kleinman, Duke University Press, Durham, NC, pp. 171–205.

Daston L.J. and Galison P. 2010. *Objectivity*, Zone Books, New York–Cambridge, MA.

Davis E.A. 2012a. *Bad Souls: Madness and Responsibility in Modern Greece*, Duke University Press, Durham, NC.

Davis E.A. 2012b. "The Antisocial Profile: Deception and Intimacy in Greek Psychiatry," *Cultural Anthropology* 25(1), pp. 130–164.

Davis E.A. 2013. "'It Wasn't Written for Me': Law, Debt, and Therapeutic Contracts in Greek Psychiatry," *PoLAR: Political and Legal Anthropology Review* 36(1), pp. 4–34.

Davis E.A. 2015. "'We've Toiled without End': Publicity, Crisis, and the Suicide 'Epidemic' in Greece," *Comparative Studies in Society and History* 57(04), pp. 1007–1036.

Depresja a renta? – Depresja – Forum dyskusyjne | Gazeta.pl n.d., *Forum.gazeta.pl*. http://forum.gazeta.pl/forum/w,99,108391637,108391637,Depresja_a_RENTA_.html; accessed August 7, 2016.

"Depression: How Effective Are Antidepressants?" 2020. *InformedHealth.org*. https://www.ncbi.nlm.nih.gov/books/NBK361016/; accessed October 15, 2022.

Diaz-Camal N., Cardoso-Vera J.D., Islas-Flores H., Gómez-Oliván L.M., and Mejía-García A. 2022. "Consumption and Ocurrence of Antidepressants (SSRIs) in Pre- and Post-COVID-19 Pandemic, Their Environmental Impact and Innovative Removal Methods: A Review," *Science of The Total Environment* 829: 154656.

Doty R.L. 1996. *Imperial Encounters: The Politics of Representation in North-South Relations*, University of Minnesota Press, Minneapolis.

Dreyfus H.L. and Rabinow P. 1983. *Michel Foucault: Beyond Structuralism and Hermeneutics*, vol. 2, University of Chicago Press, Chicago.

Dumit J. 2004. *Picturing Personhood: Brain Scans and Biomedical Identity*, Princeton University Press, Princeton, NJ.

Dumm T.L. 1999. "Resignation," [in:] *A Politics of the Ordinary*, New York University Press, New York, pp. 51–70.

Dunlop B.W. and Mletzko T. 2011. "Will Current Socioeconomic Trends Produce a Depressing Future for Men?," *The British Journal of Psychiatry* 198(3), pp. 167–168.

Dunn E. 2004. *Privatizing Poland: Baby Food, Big Business, and the Remaking of Labor*, Cornell University Press, Ithaca, NY.

Dunn E. 2005. "Standards and Person-Making in East-Central Europe," [in:] *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, Blackwell Publishing, Malden, MA, pp. 173–193.

Durkheim É. 1997. *Suicide: A Study in Sociology*, Free Press, New York.

Durkheim É. and Mauss M. 1969. *Primitive Classification*, Cohen & West, London.

Eagleton T. 1976. *Marxism and Literary Criticism*, Metheun, London.

Economic Reforms in the European Centrally Planned Economies: Symposium Proceedings. 1989. United Nations, New York.

Ehrenberg A. 2010. *The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age*, McGill-Queen's University Press, Montreal.

Eriksen T.H., Laidlaw J., Mair J., Martin K., and Venkatesan S. 2015. "'The Concept of Neoliberalism Has Become an Obstacle to the Anthropological Understanding of the Twenty-First Century': Debate," *Journal of the Royal Anthropological Institute* 21(4), pp. 911–923.

Estroff S.E. 1981. *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community*, University of California Press, Berkeley.

Faravelli C., Ravaldi C., and Truglia E. 2005. "Unipolar Depression," [in:] *Mood Disorders: Clinical Management and Research Issues*, eds. E.J.L. Griez, C. Faravelli, D.J. Nutt, J. Zohar, John Wiley & Sons, New York, pp. 79–102.

Farmer P. 2005. *Pathologies of Power: Health, Human Rights, and the New War on the Poor: With a New Preface by the Author*, 2005 ed., University of California Press, Berkeley.

Fiasko Narodowego Programu Ochrony Zdrowia Psychicznego – Najwyższa Izba Kontroli n.d. https://www.nik.gov.pl/aktualnosci/fiasko-narodowego-programu-ochrony-zdrowia-psychicznego.html; accessed October 6, 2022.

Filas R. and Płaneta P. 2009. "Media in Poland and Public Discourse," [in:] *Press Freedom and Pluralism in Europe: Concepts and Conditions*, eds. A. Czepek, M. Hellwig, E. Nowak, Intellect Books, Bristol, pp. 141–164.

Fireside H. 1979. *Soviet Psychoprisons*, 1st ed., Norton, New York.

Fisher M. 2009. *Capitalist Realism: Is There No Alternative?*, Zero Books, Winchester.

Foucault M. 1965. *Madness and Civilization: a History of Insanity in the Age of Reason*, Pantheon Books, New York.

Foucault M. 1971. *The Order of Things: An Archaeology of the Human Sciences*, 1st American ed., Pantheon Books, New York.

Foucault M. 1972. *The Archaeology of Knowledge*, 1st American ed., Pantheon Books, New York.

Foucault M. 1973. *The Birth of the Clinic: An Archaeology of Medical Perception*, 1st American ed., Pantheon Books, New York.

Foucault M. 1977. *Discipline and Punish: The Birth of the Prison*, 1st American ed., Pantheon Books, New York.

Foucault M. 1980a. *The History of Sexuality*, vol 1: *An Introduction*, Vintage Books, New York.

Foucault M. 1980b. "Two Lectures," [in:] *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*, 1st American ed., ed. Colin Gordon, Pantheon Books, New York, pp. 78–108.

Foucault M. 1984. "Polemics, Politics, and Problematizations: An Interview," [in:] *The Foucault Reader*, ed. P. Rabinow, Pantheon Books, New York, pp. 381–390.

Foucault M. 1988. *The History of Sexuality*, vol. 2: *The Use of Pleasure*, Vintage Books, New York.

Foucault M. 1990. *The History of Sexuality*, vol. 3: *The Care of the Self*, Vintage Books, New York.

Foucault M. 1997. "What Is Critique?," [in:] *The Politics of Truth*, eds. S. Lotringer, L. Hochroth, Semiotext(e) [Distributed by the MIT Press], New York, pp. 23–82.

Foucault M. 2008a. *Psychiatric Power: Lectures at the Collège de France, 1973–1974*, eds. J. Lagrange, G. Burchell, Macmillan, New York.

Foucault M. 2008b. *The Birth of Biopolitics: Lectures at the Collège de France, 1978–1979*, Palgrave Macmillan Limited, New York.

Foucault M., Martin L.H., Gutman H., and Hutton P.H. 1988. *Technologies of the Self: A Seminar with Michel Foucault*, University of Massachusetts Press, Amherst.

Freud S. 1989. *Civilization and Its Discontents*, W.W. Norton & Company, New York.

Freud S. 2001. "Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psycho-Analysis II)," [in:] *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol. 12, eds. J. Strachey, A. Freud, A. Strachey, A. Tyson, Institute of Psychoanalysis, Vintage, London, pp. 145–156.

Friberg T. 2009. "Burnout: From Popular Culture to Psychiatric Diagnosis in Sweden," *Culture, Medicine, and Psychiatry* 33(4), pp. 538–558.

Friedman J.R. 2009. "The 'Social Case,'" *Medical Anthropology Quarterly* 23(4), pp. 375–396.

Fullinwider S.P. 1998. *Towards a Rogue Reality: Kant to Freud, and Beyond*, P. Lang, New York.

Gal S. and Kligman G. 2000a. *The Politics of Gender After Socialism: A Comparative-Historical Essay*, Princeton University Press, Princeton, NJ.

Gal S. and Kligman G. 2000b. *Reproducing Gender: Politics, Publics, and Everyday Life After Socialism*, Princeton University Press, Princeton, NJ.

Gdula M. 2017. *Dobra zmiana w Miastku. Neoautorytaryzm w polskiej polityce z perspektywy małego miasta*, Instytut Studiów Zaawansowanych. Stowarzyszenie im. Stanisława Brzozowskiego, Warszawa.

"Gdzie zniknęło 1,7 mln rencistów?," 2015. *Onet Biznes*. http://biznes.onet.pl/wiadomosci/finanse/gdzie-zniknelo-1-7-mln-rencistow/k9k42b; accessed August 5, 2016.

Greenberg G. 2010. *Manufacturing Depression: The Secret History of a Modern Disease*, Simon and Schuster, New York.

Hacking I. 1990. *The Taming of Chance*, Cambridge University Press, Cambridge.

Hacking I. 2002a. *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*, Harvard University Press, Cambridge, MA.

Hacking I. 2002b. *Historical Ontology*, Harvard University Press, Cambridge, MA.

Han B.-Ch. 2017. *Psychopolitics: Neoliberalism and New Technologies of Power*, trans. E. Butler, Verso Futures, Verso, London, NY.

Hansen H. 2012. "The 'New Masculinity': Addiction Treatment as a Reconstruction of Gender in Puerto Rican Evangelist Street Ministries," *Social Science & Medicine* 74(11), pp. 1721–1728.

Harvey D. 2007. *A Brief History of Neoliberalism*, Oxford University Press, Oxford.

Havel V. 1985. *The Power of the Powerless: Citizens Against the State in Central-Eastern Europe*, eds. J. Keane, M.E. Sharpe, New York.

Healy D. 1997. *The Antidepressant Era*, Harvard University Press, Cambridge, MA.

Healy D. 2004. *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression*, New York University Press, New York.

Healy D. 2006. "The New Medical Oikumene," [in:] *Global Pharmaceuticals: Ethics, Markets, Practices*, eds. A. Petryna, A. Lakoff, A. Kleinman, Duke University Press, Durham, NC, pp. 61–84.

Heitzman J. 2010. "Zagrożenie Stanu Zdrowia Psychicznego Polaków," *Nauka* 4/2010, pp. 53–59.

Herndon S.L. 2001. "The Paradox of Powerlessness: Gender, Sex, and Power in 12-Step Groups," *Women & Language* 24(2), p. 7.

Hirshbein L.D. 2009. *American Melancholy: Constructions of Depression in the Twentieth Century*, Rutgers University Press, New Brunswick, NJ.

Hochschild A.R. 1983. *The Managed Heart: Commercialization of Human Feeling*, University of California Press, Berkeley.

Hochschild A.R. 2003. *The Commercialization of Intimate Life: Notes from Home and Work*, University of California Press, Berkeley.

Holbraad M. and Pedersen M.A. 2014. "The Politics of Ontology," *Society for Cultural Anthropology*, January 13. https://culanth.org/fieldsights/461-the-politics-of-ontology, accessed August 8, 2016.

Holbraad M. and Pedersen M.A. 2017. *The Ontological Turn: An Anthropological Exposition*, Cambridge University Press, New York.

Horváth Á. and and Szakolczai Á. 1992. *The Dissolution of Communist Power: The Case of Hungary*, Routledge, London.

Horwitz A.V. and Wakefield J.C. 2007. *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*, Oxford University Press, Oxford.

ICD-10: International Statistical Classification of Diseases and Related Health Problems. 2011. World Health Organization, Geneva.

Illouz E. 2007. *Cold Intimacies: The Making of Emotional Capitalism*, John Wiley & Sons, New York.

Illouz E. 2008. *Saving the Modern Soul: Therapy, Emotions, and the Culture of Self-Help*, 1st ed., University of California Press, Berkeley.

Inda J.X. 2005. *Anthropologies of Modernity: Foucault, Governmentality, and Life Politics*, John Wiley & Sons, New York.

Irvine L. 1999. *Codependent Forevermore: The Invention of Self in a Twelve Step Group*, University of Chicago Press, Chicago.

Isakiewicz E. 2010. "Dusze drugiego obiegu," *Tygodnik Powszechny*, December 7. http://tygodnik.onet.pl/30,0,56585,dusze_drugiego_obiegu,artykul.html; accessed December 7, 2010.

Jackson A., ed. 1987. *Anthropology at Home*, Tavistock, London.

Jackson S.W. 1990. *Melancholia and Depression: From Hippocratic Times to Modern Times*, Yale University Press, New Haven.

Jacyno M. 2007. *Kultura indywidualizmu*, Wydawnictwo Naukowe PWN, Warszawa.

Jakubowska L. 1990. "Political Drama in Poland: The Use of National Symbols," *Anthropology Today* 6(4), pp. 10–13.

James W. 2007. "Chapter XXI: The Perception of Reality," [in:] *The Principles of Psychology*, Cosimo, Inc., pp. 283–322.

Janes C.R. and Corbett K.K. 2009. "Anthropology and Global Health," *Annual Review of Anthropology* 38(1), pp. 167–183.

Janion M. 2006. *Niesamowita słowiańszczyzna: fantazmaty literatury*, 1st ed., reprint, Wydawnictwo Literackie, Kraków.

Jarosz M. 2004. *Samobójstwa. Ucieczka przegranych*, PWN, Warszawa.

Jenkins J.H., ed. 2011. *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology*, 1st ed., SAR Press, Santa Fe.

Jutel A. and Nettleton S. 2011. "Towards a Sociology of Diagnosis: Reflections and Opportunities," *Social Science & Medicine* 73(6), pp. 793–800.

Kaczmarczyk I. 2008. *Wspólnota Anonimowych Alkoholików w Polsce: alkoholowe dno i co to znaczy trzeźwieć*, "Eneteia" – Wydawnictwo Psychologii i Kultury, Warszawa.

Kaczmarek A. and Kuta W. 2009. "Opieka psychiatryczna: poznajmy prawdę o kosztach – psychiatria," *www.rynekzdrowia.pl*, October 9. http://www.rynekzdrowia.pl/Rynek-Zdrowia/Opieka-psychiatryczna-poznajmy-prawde-o-kosztach,52010.html, accessed August 3, 2016.

Kharkhordin O. 1999. *The Collective and the Individual in Russia: A Study of Practices*, vol. 32, University of California Press, Berkeley.

Kideckel D. 1993. *The Solitude of Collectivism: Romanian Villagers to the Revolution and Beyond*, 1st ed., Cornell University Press, Ithaca, NY.

Kiejna A., Piotrowski P., Adamowski T. et al. 2015. "The Prevalence of Common Mental Disorders in the Population of Adult Poles by Sex and Age Structure – an EZOP Poland Study," *Psychiatria Polska* 49, pp. 15–27.

Kitanaka J. 2012. *Depression in Japan: Psychiatric Cures for a Society in Distress*, Princeton University Press, Princeton, NJ.

Klein M. 1952. "Some Theoretical Conclusions Regarding the Emotional Life of an Infant," [in:] *Envy and Gratitude*, pp. 61–93.

Klein M. 1975a. *Envy and Gratitude & Other Works 1946–1963*, Delacorte Press/Seymour Lawrence.

Klein M. 1975b. *Love, Guilt, and Reparation & Other Works, 1921–1945*, Delacorte Press/S. Lawrence.

Kleinman A. 1986. *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China*, Yale University Press, New Haven.

Kleinman A. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*, Basic Books, New York.

Kleinman A. and Good B. 1985. *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder*, University of California Press, Berkeley.

Klędzik M. 1990. "Zmuszanie do bankructwa," *Gazeta Wyborcza*, January 4, p. 4.

Kochanowicz J. 1993. "The Disappearing State: Poland's Three Years of Transition," *Social Research* 60(4), pp. 821–834.

Kokanovic R., Bendelow G., and Philip B. 2013. "Depression: The Ambivalence of Diagnosis," *Sociology of Health & Illness* 35(3), pp. 377–390.

Kołodko G.W. 1990. *Inflacja, Reforma, Stabilizacja*, 1st ed., Studencka Oficyna Wydawnicza ZSP, Warszawa.

Kornai J. 1992. *The Socialist System: The Political Economy of Communism: The Political Economy of Communism*, Oxford University Press, Oxford.

Koselleck R. 2000. *Critique and Crisis: Enlightenment and the Pathogenesis of Modern Society*, MIT Press, Cambridge, MA.

Kostrzewski L. 2015. "Komu się należy świadczenie rehabilitacyjne," *Wyborcza.pl*. http://wyborcza.pl/1,97654,18583904,komu-sie-nalezy-swiadczenie-rehabilitacyjne.html, accessed August 3, 2016.

Krupa D., Czech M., Pinkas J., and Mosiołek A. 2022. "Impact of COVID-19 Pandemic on the Use of Antidepressant and Antianxiety Pharmaceuticals as Well as Sick Leave in Poland," *International Journal of Environmental Research and Public Health* 19(4). Multidisciplinary Digital Publishing Institute: 2135.

Kubik J. 1994. *The Power of Symbols Against the Symbols of Power: The Rise of Solidarity and the Fall of State Socialism in Poland*, Pennsylvania State University Press, University Park, PA.

Kurkiewicz R. 1993. "Od Redakcji," *Gazeta Wyborcza*, March 25, p. 3.

Lakoff A. 2004. "The Anxieties of Globalization: Antidepressant Sales and Economic Crisis in Argentina," *Social Studies of Science* 34(2, Intersections of Pharmaceutical Research and Marketing), pp. 247–269.

Lakoff A. 2005. *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry. Cambridge Studies in Society and the Life Sciences*, Cambridge University Press, Cambridge, UK–New York.

Lampland M. 1995. *The Object of Labor: Commodification in Socialist Hungary*, University of Chicago Press, Chicago.

Lane C. 2008. *Shyness: How Normal Behavior Became a Sickness*, Yale University Press, New Haven.

Lasch C. 1979. *The Culture of Narcissism: American Life in an Age of Diminishing Expectations*, 1st ed., Norton, New York.

Latour B. 1993a. *We Have Never Been Modern*, Harvard University Press, Cambridge, MA.

Latour B. 1993b. *The Pasteurization of France*, Harvard University Press, Cambridge, MA.

Latour B. 2003. "The Promises of Constructivism," [in:] *Chasing Technoscience: Matrix for Materiality*, eds. D. Ihde, E. Selinger, Indiana University Press, Bloomington and Indianapolis, pp. 27–46.

Latour B. 2004. "Why Has Critique Run out of Steam? From Matters of Fact to Matters of Concern," *Critical Inquiry* 30(2), pp. 225–248.

Latour B. 2007. *Reassembling the Social: An Introduction to Actor-Network-Theory*, Oxford University Press, Oxford.

Latour B. 2008. *A Cautious Prometheus? A Few Steps Toward a Philosophy of Design (with Special Attention to Peter Sloterdijk). Keynote lecture presented at the Networks of Design meeting of the Design History Society, Falmouth, Cornwall, September 3*. http://www.bruno-latour.fr/sites/default/files/112-DESIGN-CORNWALL-GB.pdf, accessed July 13, 2016.

Lawlor C. 2012. *From Melancholia to Prozac: A History of Depression*, Oxford University Press, Oxford.

Ledeneva A.V. 1998. *Russia's Economy of Favours: Blat, Networking, and Informal Exchange*, Cambridge University Press, Cambridge, UK–New York.

Leder A. 2014. *Prześniona rewolucja. Ćwiczenie z logiki historycznej*, Wydawnictwo Krytyki Politycznej, Warszawa.

Leder S., Czabala Cz., Siwiak-Kobayashi M., and Aleksandrowicz J. 1987. "Psychotherapy in Poland," *Journal of Integrative and Eclectic Psychotherapy* 6(1), pp. 88–95.

Leder S., Kuliszkiewicz D., Grzelak J., Hoser J., and Potocka A. 1968. "Rozpowszechnienie zaburzeń nerwicowych wśród pracowników handlu m. St. Warszawy a czynniki społeczne," *Psychiatria Polska* 2(4), pp. 413–420.

Leibing A. and Cohen L. 2006. *Thinking About Dementia: Culture, Loss, and the Anthropology of Senility*, Rutgers University Press, New Brunswick, NJ.

Lévi-Strauss C. 1963. *Structural Anthropology*, Basic Books, New York.

Lévi-Strauss C. 1966. *The Savage Mind*, University of Chicago Press, Chicago.

Lewis B. 2011. *Depression: Integrating Science, Culture, and Humanities*, Routledge, New York.

Lipton D. and Sachs J. 1990, "Creating a Market Economy in Eastern Europe: The Case of Poland," *Brooking Papers on Economic Activity* 1, pp. 75–133.

Luhrmann T.M. 2000. *Of Two Minds: The Growing Disorder in American Psychiatry*, vol. 1, Knopf, New York.

Lukács G. 1964. *Realism in Our Time: Literature and the Class Struggle*, Harper & Row, New York.

Lukács G. 1971. *The Theory of the Novel: A Historico-Philosophical Essay on the Forms of Great Epic Literature*, trans. A. Bostock, MIT Press, Cambridge, MA.

Lutz C. 1988. *Unnatural Emotions: Everyday Sentiments on a Micronesian Atoll & Their Challenge to Western Theory*, University of Chicago Press, Chicago.

Lutz C. and Abu-Lughod L. 1990. *Language and the Politics of Emotion*, Cambridge University Press, Cambridge, UK–New York–Paris.

Macpherson C.B. 1962. *The Political Theory of Possessive Individualism: Hobbes to Locke*, Clarendon Press, Oxford.

Mäkelä K. 1996. *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*, University of Wisconsin Press, Madison, WI.

Marcuse H. 1964. *One-Dimensional Man: Studies in the Ideology of Advanced Industrial Society*, Beacon Press, Boston.

Margree V. 2002. "Normal and Abnormal: Georges Canguilhem and the Question of Mental Pathology," *Philosophy, Psychiatry, & Psychology* 9(4), pp. 299–312.

Marks S. 2015. *Psychiatry in Communist Europe*, Palgrave Macmillan, Basingstoke.

Marody M. and Giza-Poleszczuk A. 2000. "Changing Images of Identity in Poland: From the Self-Sacrificing to the Self-Investing Woman?," [in:] *Reproducing Gender: Politics, Publics, and Everyday Life After Socialism*, eds. S. Gal, G. Kligman, Princeton University Press, Princeton.

Marshall G. 2009. "Real Socialism," [in:] *A Dictionary of Sociology. Oxford Paperback Reference*, eds. J. Scott, G. Marshall, Oxford University Press, Oxford–New York.

Martin E. 1994. *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS*, Beacon Press, Boston.

Martin E. 2007. *Bipolar Expeditions: Mania and Depression in American Culture*, Princeton University Press, Princeton, NJ.

Mattingly C. 1994. "The Concept of Therapeutic 'Emplotment,'" *Social Science & Medicine* (1982) 38(6), pp. 811–822.

Mattingly C. and Garro L.C. 2000. *Narrative and the Cultural Construction of Illness and Healing*, 1st ed., University of California Press, Berkeley.

Matza T. 2009. "Moscow's Echo: Technologies of the Self, Publics, and Politics on the Russian Talk Show," *Cultural Anthropology* 24(3), pp. 489–522.

Matza T. 2012. "'Good Individualism'? Psychology, Ethics, and Neoliberalism in Post-socialist Russia," *American Ethnologist* 39(4), pp. 804–818.

Matza T. 2018. *Shock Therapy: Psychology, Precarity, and Well-Being in Postsocialist Russia*, Duke University Press, Durham, NC.

Medawar C. and Hardon A. 2004. *Medicines Out of Control?: Antidepressants and the Conspiracy of Goodwill*, Aksant, [Amsterdam].

Melegh A. 2011. "Living to Ourselves: Localizing Global Hierarchies in State Socialist Hungary in the 1970s and 1980s," *Journal of Modern European History* 9(2), pp. 263–283.

Merton R.K. 1938. "Social Structure and Anomie," *American Sociological Review* 3(5), pp. 672–682.

Merton R.K. 1968. *Social Theory and Social Structure*, Simon and Schuster, New York.

Metzl J. 2003. *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs*, Duke University Press Books, Durham, NC.

Metzl J. 2010. *The Protest Psychosis: How Schizophrenia Became a Black Disease*, 1st ed., Beacon Press, Boston.

Miłosz Cz. 1953. *The Captive Mind*, Knopf, New York.

Mitchell T. 2002. *Rule of Experts: Egypt, Techno-Politics, Modernity*, University of California Press, Berkeley.

Mol A. 2002. *The Body Multiple: Ontology in Medical Practice*, Duke University Press, Durham, NC.

Mol A. 2008. *The Logic of Care: Health and the Problem of Patient Choice*, Routledge, New York.

Moncrieff J. 2009. *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*, Rev. ed., Palgrave Macmillan, Basingstoke.

Moncrieff J. 2014. "The Medicalisation of 'Ups and Downs': The Marketing of the New Bipolar Disorder," *Transcultural Psychiatry* 51(4), pp. 581–598.

Moncrieff J., Cooper R.E., Stockmann T. et al. 2022. "The Serotonin Theory of Depression: A Systematic Umbrella Review of the Evidence," *Molecular Psychiatry*. https://www.nature.com/articles/s41380-022-01661-0, accessed October 12, 2022.

Morgen S. and Maskovsky J. 2003. "The Anthropology of Welfare 'Reform': New Perspectives on U.S. Urban Poverty in the Post-Welfare Era," *Annual Review of Anthropology* 32(1), pp. 315–338.

Morton T. 2013. *Hyperobjects: Philosophy and Ecology after the End of the World*, University of Minnesota Press, Minneapolis.

Moskalewicz J. 1985. "Monopolization of the Alcohol Arena by the State," *Contemporary Drug Problems* 12, p. 117.

Moskalewicz J., Kiejna A., and Wojtyniak B. 2012. *Kondycja psychiczna mieszkańców Polski: raport z badań „Epidemiologia zaburzeń psychiatrycznych i dostęp do psychiatrycznej opieki zdrowotnej – EZOP Polska,"* Instytut Psychiatrii i Neurologii, Warszawa.

Muehlebach A. 2013. "The Catholicization of Neoliberalism: On Love and Welfare in Lombardy, Italy: The Catholicization of Neoliberalism," *American Anthropologist* 115(3), pp. 452–465.

Murawska-Muthesius K. n.d. "Distinguishing White from White: Images of East Central European Difference after the Fall of the Wall," a paper presented at the conference *The Contours of Legitimacy in Central Europe*, St. Anthony's College, Oxford.

Murray C.J.L., ed. 1996. *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries, and Risk Factors in 1990 and Projected to 2020: Summary*, Harvard School of Public Health, Cambridge.

Novas C. and Rose N. 2000. "Genetic Risk and the Birth of the Somatic Individual," *Economy and Society* 29(4), pp. 485–513.

Number of Psychiatrists: How Do Countries Compare? n.d. https://ec.europa.eu/eurostat/web/products-eurostat-news/-/ddn-20181205-1, accessed October 6, 2022.

Ong A. 2006. *Neoliberalism as Exception: Mutations in Citizenship and Sovereignty*, Duke University Press, Durham, NC.

Ong A. and Collier S.J., eds. 2005. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, Blackwell Publishing, Malden, MA.

Orr J. 2006. *Panic Diaries: A Genealogy of Panic Disorder*, Duke University Press, Durham, NC.

Ost D. 2005. *Defeat of Solidarity: Anger and Politics in Postcommunist Europe*, Cornell University Press, Ithaca, NY.

Ost D. 2006. *The Defeat of Solidarity: Anger and Politics in Postcommunist Europe*, vol. 1, Cornell University Press, Ithaca, NY.

Oushakine S.A. 2003. "Crimes of Substitution: Detection in Late Soviet Society," *Public Culture* 15(3), pp. 426–452.

Pacewicz P. 1989. "Jak ratować gospodarkę (wywiad z Tomaszem Gruszeckim)," *Gazeta Wyborcza*, June 15.

Patel V., Boyce N., Collins P.Y., Saxena Sh., and Horton R. 2011. "A Renewed Agenda for Global Mental Health," *The Lancet* 378(9801), pp. 1441–1442.

Patel V., Garrison P., de Jesus Mari J. et al. 2008. "The Lancet's Series on Global Mental Health: 1 Year On," *The Lancet* 372(9646), pp. 1354–1357.

Petrović T. 2014. "Introduction: Europeization and the Balkans," [in:] *Mirroring Europe: Ideas of Europe and Europeanization in Balkan Societies*, ed. T. Petrović, BRILL, Leiden and Boston, pp. 3–19.

Petryna A. 2002. *Life Exposed: Biological Citizens After Chernobyl*, Princeton University Press, Princeton, NJ.

Petryna A., Lakoff A., Kleinman A., eds. 2006. *Global Pharmaceuticals: Ethics, Markets, Practices*, Duke University Press, Durham, NC.

Pickstone J.V. 2001. *Ways of Knowing: A New History of Science, Technology, and Medicine*, University of Chicago Press, Chicago.

Polanyi K. 2001. *The Great Transformation: The Political and Economic Origins of Our Time*, Beacon Press, Boston.

Polska Policja n.d. *Zamachy samobójcze. Statystyka*. https://statystyka.policja.pl/st/wybrane-statystyki/zamachy-samobojcze, accessed September 28, 2022.

Poławski P. and Buczek J. 2011. "Medykalizacja kontroli społecznej. Opieka zdrowotna, sprzedaż i konsumpcja leków w Polsce," *Prace Katedry Socjologii Norm, Dewiacji i Kontroli Społecznej* 12, pp. 82–100.

Poovey M. 1998. *A History of the Modern Fact: Problems of Knowledge in the Sciences of Wealth and Society*, University of Chicago Press, Chicago.

Porter T.M. 2000. "Life Insurance, Medical Testing, and the Management of Mortality," [in:] *Biographies of Scientific Objects*, ed. L. Daston, University of Chicago Press, Chicago, pp. 226–246.

Potępa E. 2021. *Neurotyczna normalność: Realizm depresyjny i praktyki normalizacji depresji we współczesnej Polsce*, MA diss., University of Warsaw.

Potter J. 1996. *Representing Reality: Discourse, Rhetoric and Social Construction*, Sage, London–Thousand Oaks, CA.

Poznanski K. 1996. *Poland's Protracted Transition: Institutional Change and Economic Growth 1970–1994*, Cambridge University Press, Cambridge, UK–New York.

Rabinow P. and Rose N. 2006. "Biopower Today," *BioSocieties* 1(2), pp. 195–217.

Raikhel E. 2010. "Post-Soviet Placebos: Epistemology and Authority in Russian Treatments for Alcoholism," *Culture, Medicine, and Psychiatry* 34(1), pp. 132–168.

Raikhel E. 2016. *Governing Habits: Treating Alcoholism in the Post-Soviet Clinic*, Cornell University Press, Ithaca, NY.

Rakowski T. 2009. *Łowcy, zbieracze, praktycy niemocy: etnografia człowieka zdegradowanego*, Wydawnictwo słowo/obraz terytoria, Gdańsk.

Rakowski T. 2016. *Hunters, Gatherers, and Practitioners of Powerlessness: An Ethnography of the Degraded in Postsocialist Poland*, Berghahn Books, New York.

Rausing S. 2004. *History, Memory, and Identity in Post-Soviet Estonia: The End of a Collective Farm*, Oxford University Press, Oxford.

Realizacja Zadań Narodowego Programu Ochrony Zdrowia Psychicznego 2016. *Informacja o wynikach kontroli*, KZD.430.006.2016, Najwyższa Izba Kontroli, Warszawa. https://www.nik.gov.pl/plik/id,12692,vp,15090.pdf, accessed October 2, 2016.

Reddy W.M. 2001. *The Navigation of Feeling: A Framework for the History of Emotions*, Cambridge University Press, Cambridge, UK–New York.

Ries N. 1997. *Russian Talk: Culture and Conversation during Perestroika*, Cornell University Press, Ithaca, NY.

Risør M.B. and Nissen N., eds. 2018. *Diagnostic Fluidity: Working with Uncertainty and Mutability*, URV, Tarragona.

Rivkin-Fish M. 2004. "Change Yourself and the Whole World Will Become Kinder: Russian Activists for Reproductive Health and the Limits of Claims Making for Women," *Medical Anthropology Quarterly* 18(3), pp. 281–304.

Rivkin-Fish M. 2005. *Women's Health in Post-Soviet Russia: The Politics of Intervention*, Indiana University Press, Bloomington, IN.

Roitman J. 2011. *Crisis. Political Concepts (One)*. http://www.politicalconcepts.org/issue1/crisis/, accessed March 2, 2015.

Roitman J. 2013. *Anti-Crisis*, Duke University Press, Durham, NC.

Rosaldo M.Z. 1983. "The Shame of Headhunters and the Autonomy of Self," *Ethos* 11(3), pp. 135–151.

Rosaldo M.Z. 1984. "Toward and Anthropology of Self and Feeling," [in:] *Culture Theory: Essays on Mind, Self, and Emotion*, Cambridge University Press, Cambridge, UK–New York, pp. 137–157.

Rose N. 1989. *Governing the Soul: The Shaping of the Private Self*, Routledge, London–New York.

Rose N. 1996. *Inventing Our Selves: Psychology, Power, and Personhood*, Cambridge University Press, Cambridge, UK–New York.

Rose N. 2006a. "Disorders Without Borders? The Expanding Scope of Psychiatric Practice," *BioSocieties* 1, pp. 465–484.

Rose N. 2006b. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century (In-Formation)*, Princeton University Press, Princeton, NJ.

Rose N. 2007. "Genomic Susceptibility as an Emergent Form of Life? Genetic Testing, Identity, and the Remit of Medicine," [in:] *Biomedicine as Culture: Instrumental Practices, Technoscientific Knowledge, and New Modes of Life*, Routledge, New York, pp. 141–150.

Rostkowski D. 1993. "Zabić się we wtorek," *Gazeta Wyborcza*, March 9, p. 5.

Rottenburg R. 1994. "From Socialist Realism to Postmodern Ambiguity: East German Companies in Transition," *Organization & Environment* 8, pp. 71–91.

Rozwój w Polsce – Katolicka Odnowa w Duchu Świętym n.d. http://www.odnowa.org/?page_id=25, accessed August 6, 2016.

Ryan M. 2015. "Contesting 'Actually Existing' Neoliberalism," *Journal of Australian Political Economy* 76, pp. 79–102.

Sachs J. 2005. *The End of Poverty: Economic Possibilities for Our Time*, Penguin Press, New York.

Sadowsky J.H. 1999. *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria*, University of California Press, Berkeley.

Sahlins M. 1974a. *Stone Age Economics*, Transaction Publishers, New Brunswick, NJ.

Sahlins M. 1974b. "The Original Affluent Society," [in:] *Stone Age Economics*, Transaction Publishers, New Brunswick, NJ, pp. 1–39.

Salecl R. 1994. *The Spoils of Freedom: Psychoanalysis and Feminism After the Fall of Socialism*, Routledge, London–New York.

Schütz A. 1945. "On Multiple Realities," *Philosophy and Phenomenological Research* 5(4), pp. 533–576.

Sedgwick E.K. 1993. "Epidemics of the Will," [in:] *Tendencies*, Duke University Press, Durham, NC, pp. 131–142.

Shamir R. 2008. "The Age of Responsibilization: On Market-Embedded Morality," *Economy and Society* 37(1), pp. 1–19.

Shohat E. and Stam R. 2013. *Unthinking Eurocentrism: Multiculturalism and the Media*, Routledge, New York.

Showalter E. 1987. *The Female Malady: Women, Madness, and English Culture, 1830–1980*, Penguin Books, New York.

Shweder R.A. and LeVine R.A. 1984. *Culture Theory: Essays on Mind, Self and Emotion*, Cambridge University Press, Cambridge, UK.

Skultans V. 1995. "Neurasthenia and Political Resistance in Latvia," *Anthropology Today* 11(3), pp. 14–18.

Skultans V. 2007. "The Appropriation of Suffering: Psychiatric Practice in the Post-Soviet Clinic," *Theory, Culture & Society* 24(3), pp. 27–48.

Śleszyński P. 2007. *Gospodarcze funkcje kontrolne w przestrzeni Polski*, IGiPZ PAN.

Sloterdijk P. 1987. *Critique of Cynical Reason*, University of Minnesota Press, Minneapolis.

Sokół G. 2004. "Nie chcą żyć bez nadziei" [Interview with Prof. Maria Jarosz], *Gazeta Wyborcza*, July 27, p. 13.

Sokół G. 2008. *Sins and Genes: Exorcists and Neurobiologists on Cross-Generational Transmission of Illness Susceptibility*, Paper presented at the NYU Science Studies Workshop, New York University, March.

Sowa J. 2011. *Fantomowe ciało króla. Peryferyjne zmagania z nowoczesną formą*, Towarzystwo Autorów i Wydawców Prac Naukowych Universitas, Kraków.

Staw 1992. "Stary i nowy 'Rasztów,'" *Gazeta Stołeczna*, July 1, p. 4.

Steiner G. 1964. "Georg Lukács. A Preface," [in:] *Realism in Our Time; Literature and the Class Struggle*, ed. G. Lukács, Harper & Row, New York, pp. 7–17.

Stoler A.L. 2004. "Affective States," [in:] *A Companion to the Anthropology of Politics*, Blackwell, Oxford, pp. 4–20.

Stoler A.L., McGranahan C., and Perdue P.C., eds. 2007. *Imperial Formations*, School for Advanced Research Press, Santa Fe.

Strathern M. 1988. *The Gender of the Gift: Problems with Women and Problems with Society in Melanesia*, University of California Press, Berkeley.

Strathern M. 2000. *Audit Cultures: Anthropological Studies in Accountability, Ethics, and the Academy*, Routledge, London–New York.

Sue-Taussig K., Rapp R., and Heath D. 2005. "Flexible Eugenics: Technologies of the Self in the Age of Genetics," [in:] *Anthropologies of Modernity: Foucault, Governmentality, and Life Politics*, Blackwell Publishing, Malden, MA.

Suszek H., Holas P., Wyrzykowski T., Lorentzen S., and Kokoszka A. 2015. "Short-Term Intensive Psychodynamic Group Therapy versus Cognitive-Behavioral Group Therapy in Day Treatment of Anxiety Disorders and Comorbid Depressive or Personality Disorders: Study Protocol for a Randomized Controlled Trial," *Trials* 16(1), pp. 1–12.

Sztompka P. 1993. "Civilizational Incompetence: The Trap of Post-Communist Societies," *Zaitschrift Für Soziologie* 22(2), pp. 85–95.

Taussig M.T. 1992. *The Nervous System*, Routledge, New York.

The Families of Nazareth Movement: About Us n.d. http://www.familiesofnazareth.us/about-us, accessed August 5, 2016.

Thompson M.G. 1994. *The Truth About Freud's Technique: The Encounter with the Real. Psychoanalytic Crosscurrents*, New York University Press, New York.

Ticktin M.I. 2006. "Where Ethics and Politics Meet," *American Ethnologist* 33(1), pp. 33–49.

Ticktin M.I. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*, University of California Press, Berkeley.

Timmermans S. 2005. "Suicide Determination and the Professional Authority of Medical Examiners," *American Sociological Review* 70(2), pp. 311–333.

Tischner J. 1984. *Spirit of Solidarity*, 1st ed., Harper & Row, San Francisco.

Tischner J. 1987. *Marxism and Christianity: The Quarrel and the Dialogue in Poland*. Georgetown University Press, Washington, DC.

Tischner J. and Życiński J. 1994. *The Philosophy of Person: Solidarity and Cultural Creativity*, CRVP, Washington, DC.

Torańska T. 1987. *"Them": Stalin's Polish Puppets*, Harper & Row, New York.

Trzebiatowska I. 2010. "Orzecznictwo lekarskie w zaburzeniach psychicznych. Część 2," *Via Medica* 7(4), pp. 168–172.

Turkle S. 1992. *Psychoanalytic Politics: Jacques Lacan and Freud's French Revolution*, Free Association Books, London.

Tyszka K. 2009. "'Homo Sovieticus' Two Decades Later," *Polish Sociological Review* (168), pp. 507–522.

Valverde M. 1998. *Diseases of the Will: Alcohol and the Dilemmas of Freedom*, Cambridge University Press, Cambridge, UK–New York.

Verdery K. 1996. *What Was Socialism, and What Comes Next?*, Princeton University Press, Princeton, NJ.

Verdery K. 2007. *The Propertied Person in a Socialist State: Romanian Collectivization in the 1950s*. [Unpublished talk given at New York University in the Department of Anthropology Colloquium Series, October 11, 2007]

Veyne P. 1988. *Did the Greeks Believe in Their Myths?: An Essay on the Constitutive Imagination*, University of Chicago Press, Chicago.

Viveiros de Castro E. 2015. *The Relative Native: Essays on Indigenous Conceptual World*, HAU Books, Chicago.

Wald I. and Moskalewicz J. 1987. "From Compulsory Treatment to the Obligation to Undertake Treatment: Conceptual Evolution in Poland," *Contemporary Drug Problems* 14, p. 39.

Warunki życia ludności w 1997 r. Wstępna analiza wyników badania ankietowego 1998. GUS [Main Statistical Office], Warszawa.

Watters E. 2010. *Crazy Like Us: The Globalization of the American Psyche*, Free Press, New York.

Weber M. 1978. *Economy and Society: An Outline of Interpretive Sociology*, eds. G. Roth, C. Wittich, University of California Press, Berkeley.

Weber M. 2005. *The Protestant Ethic and the Spirit of Capitalism*, Routledge, New York.

Wedel J. 1986. *The Private Poland*, Facts on File, Oxford–New York.

White G.M. and Kirkpatrick J. 1987. *Person, Self and Experience: Exploring Pacific Ethnopsychologies*, University of California Press, Berkeley.

White H.V. 1966. "The Burden of History," *History and Theory* 5(2), pp. 111–134.

WHO | International Classification of Diseases (ICD) n.d. WHO. http://www.who.int/classifications/icd/en/, accessed March 7, 2015.

WIĘŹ: Bóg w Psychoterapii? 606 (4), 2009. http://www.wiez.pl/czasopismo/Bog-w-psychoterapii-;s,czasopismo_szczegoly,id,542, accessed August 6, 2016.

Wilcox D.M. 1998. *Alcoholic Thinking: Language, Culture, and Belief in Alcoholics Anonymous*, Praeger, Westport, CT.

Williams R. 1977a. *Marxism and Literature*, Oxford University Press, Oxford.

Williams R. 1977b. "A Lecture on Realism," *Screen* 18(1), pp. 61–74.

Wilson M. 1993. "DSM-III and the Transformation of American Psychiatry: A History," *American Journal of Psychiatry* 150(3), pp. 399–410.

Witeska-Młynarczyk A. 2019. *Dziecięce doświadczenia ADHD: etnografia spornej jednostki diagnostycznej*, Oficyna Naukowa, Warszawa.

Woronowicz B.T. 2009. *Uzależnienia. Geneza, terapia, powrót do zdrowia*, Media Rodzina, Poznań.

Woydyłło E. 1989. "Odwyk dla narodu," *Polityka*, July 22, p. 6.

Woydyłło E. 1991. *Wybieram wolność czyli Rzecz o wyzwalaniu się z uzależnień*, Iskry, Warszawa.

Woydyłło E. 2012. *Bo jesteś człowiekiem: żyć z depresją, ale nie w depresji*, Wydawnictwo Literackie, Kraków.

Wróblewski M. 2018. *Medykalizacja nadpobudliwości: od globalnego standardu do peryferyjnych praktyk*, Towarzystwo Autorów i Wydawców Prac Naukowych Universitas, Kraków.

Wydra H. 2000. *Continuities in Poland's Permanent Transition*, Macmillan Press–St. Martin's Press, Basingstoke.

Yurchak A. 2006. *Everything Was Forever, Until It Was No More: The Last Soviet Generation*, Princeton University Press, Princeton, NJ.

Zagorin P. 1996. "The Historical Significance of Lying and Dissimulation," *Social Research* 63(3), pp. 863–912.

Zajdow G. 1998. "Civil Society, Social Capital and the Twelve Step Group," *Community, Work & Family* 1(1), pp. 79–89.

"Zdrowie w liczbach: opieka psychiatryczna w Polsce po pandemii" 2020. *PolitykaZdrowotna.com*. https://politykazdrowotna.com/artykul/zdrowie-w-liczbach-opieka-psychiatryczna-w-polsce-po-pandemii/829749, accessed October 6, 2022.

Zigon J. 2010. "'A Disease of Frozen Feelings': Ethically Working on Emotional Worlds in a Russian Orthodox Church Drug Rehabilitation Program," *Medical Anthropology Quarterly* 24(3), pp. 326–343.

Žižek S. 2008. *The Sublime Object of Ideology*, Verso, London–New York.

Zyss T. 2005. "Orzecznictwo rentowe z zakresu psychiatrii – z perspektywy biegłego sądowego," *Archiwum Medycyny Sądowej i Kryminologii* LV, pp. 338–348.

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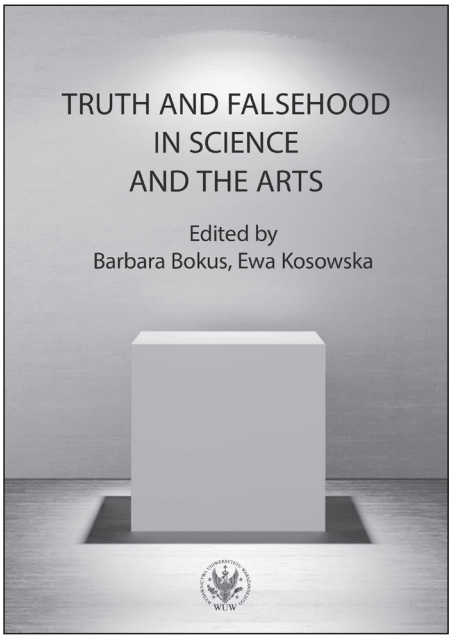

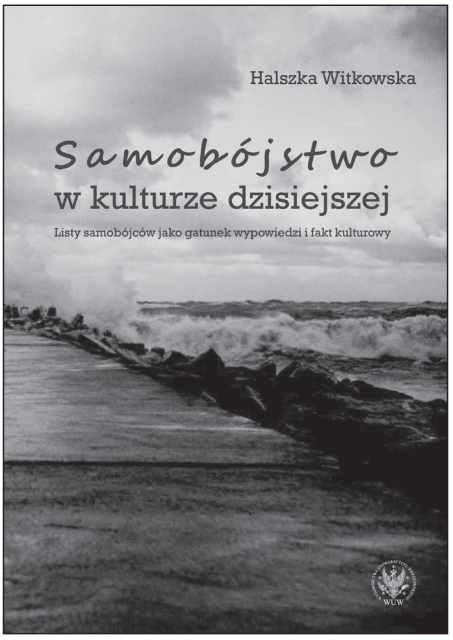

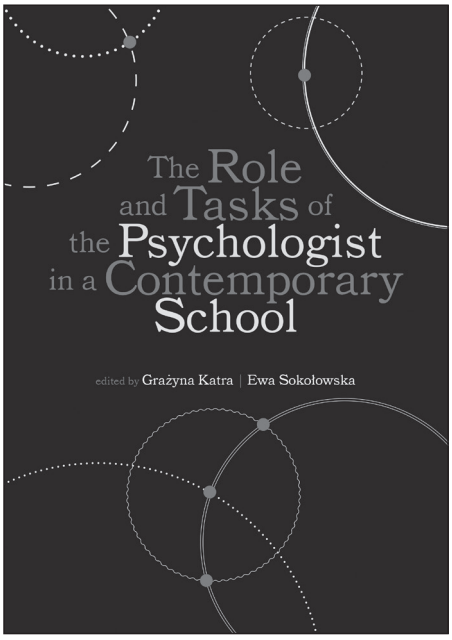

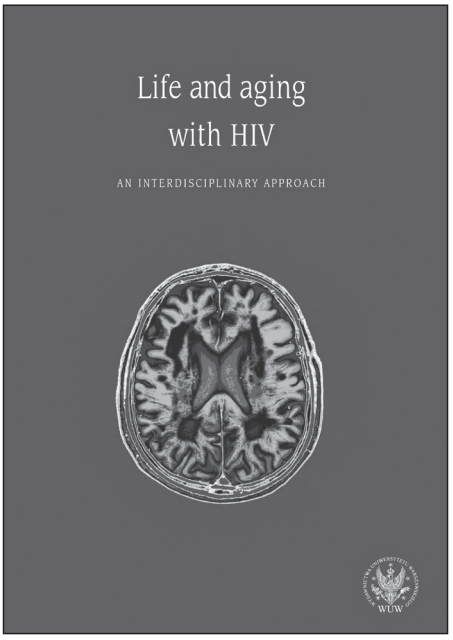

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How do we account for the current proliferation of depression as a diagnostic and cultural category? How has its rise interplayed with the postsocialist transformation and the construction of the neoliberal order? This monograph of contemporary Polish depression sheds light on the social, political, and semantic processes that have shaped its meanings, experiences, understandings, and treatments. Examining depression's history in Poland after 1989, the author not only considers the social conditions of clinical practice, but also explores a broader phenomenon of the cultural dynamic of realification (*urealnienie*)—the socially produced sense of realness of the world around us. The book thus touches upon various aspects of cultural theory while keeping an ethnographic, empirical character. It is addressed to the academic audience in the field of social sciences, cultural studies, or humanities, as well as anyone with an interest in the social factors shaping mental health and the cultural dimensions of capitalism.

GRZEGORZ SOKÓŁ, PhD, received his doctorate in sociocultural anthropology from The New School for Social Research in New York and is currently an assistant professor in the Faculty of "Artes Liberales" at the University of Warsaw. His interests include medical and psychiatric anthropology, cultural dimensions of politics and intimacy, and social production of reality. He also works as a journalist and a documentary producer.

In his book, Grzegorz Sokół brings together the best traditions of the humanities: a deep consideration of the observable, tangible reality of individual people and a sophisticated theoretical reflection. The author's starting point is the concrete ethnographic object of depression, understood not just as a specific diagnostic category, but also as a construct used in everyday discourse, in media, and at meetings of Depressed Anonymous. The author shows that depression has become a new idiom of suffering characteristic of the Polish post-transformation reality. Ultimately, the book is a very original and compelling microhistory of Poland.

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The area of research and range of experiences examined by the author are truly impressive. Reaching beyond official and stereotypical descriptions of psychiatric practice, this book may interest current and potential patients. The category of "realification" constitutes a unique research contribution and offers a better understanding of the dynamic behind the production of social reality.

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