

Depression, Shock and Stimulation: Regimes of Touch in the Field of Psychiatry

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No other therapies of mental illnesses have been confronted so harshly and strongly with criticism as brain surgery and brain stimulation. Terms like electroshock, psychosurgery and lobotomy are firmly anchored as traumatic experiences in the collective memory of historic delusions in psychiatric care.

Nevertheless, therapy and research in the field of brain stimulation have not been abandoned. Quite on the contrary, psychiatric research on brain stimulation for treating depression is widespread and growing. Apart from the development of antidepressants, forms of brain stimulation and brain surgery are the most important innovations of biological psychiatry in the twentieth century.

Electroconvulsive therapy (ECT) has been experiencing a renaissance since its decline in the 1960s and 1970s.¹ Some forms of brain stimulation – especially transcranial magnetic stimulation (TMS) and deep brain stimulation (DBS) – have been developed only since the 1980s. There is no comparable history of stigmatisation for these new technological developments.

In the following, I will discuss the *regimes of touch* underlying practices of therapeutic help in the context of biological and neurological psychiatry.² In order to illustrate the regime of touch underlying biological psychiatry, I will deal with the example of brain stimulation in the case of major depression. A regime is defined as a social order of norms, experiences and affects structuring the net in which human beings and their bodies are embedded. It cannot be reduced to mere semantics, discourses, institutions or other emergent social structures. It directly affects the bodily self, its sensitiveness, its vulnerability.

In what follows, I show that biological psychiatry presupposes an inadequate and insufficient regime of touch. As an alternative, I suggest a regime of touch informed by the tradition of body-oriented phenomenology. Body phenomenological approaches focus on the ‘sense of

¹ Timothy W. Kneeland and Carol A. Warren. *Pushbutton Psychiatry: A Cultural History of Electroshock in America* (Westport: Praeger Publishers, 2002), 85–102.

² Biological psychiatry is one of the most important fields of modern psychiatry. Psychiatric thinking also entails traditions like social psychiatry and anti-psychiatry. Since the 1980s, biological psychiatry has increasingly become the most dominant discourse in psychiatric research.

atmosphere' ('Gespür für Atmosphärisches') as a central dimension of psychiatric and psychotherapeutic help.³ Here, the structures, continuities and disruptions of touch can never easily be decoded, they never become emergent structures of unambiguous orientation. Practices of therapeutic help are exchanged and negotiated within the contingent situation between those who seek, and those who offer help. Any therapeutic success in the field of mental illness and suffering relies on practices of touching and being touched.

The text is divided into four sections. The first section elaborates on the theoretical concept of regime and its relation to the question of touch in the tradition of body phenomenology following Helmuth Plessner. In the second section, I briefly reconstruct the decline and renaissance of brain stimulation in the modern history of psychiatry. I then discuss some ethical issues raised by modern psychiatry in order to deepen the contextual understanding of psychiatric research on brain stimulation. I conclude in the fourth section by pointing at the role of body phenomenology as a mediator between psychiatric research on the one side and the phenomenon of depression on the other.

1. Body Phenomenology and Regimes of Touch

The suggested understanding of regime follows a theoretical position mediating between phenomenological and

³ Hubertus Tellenbach. *Geschmack und Atmosphäre. Medien menschlichen Elementarkontaktes* (Salzburg: Otto Müller Verlag, 1968), 49.

poststructuralist, between subject-oriented and structuralist perspectives. It is informed by a body phenomenological tradition from Helmuth Plessner and Maurice Merleau-Ponty to Gesa Lindemann and Thomas Fuchs, replacing the concept of the subject by concepts of ‘corporeity’ and of the ‘Leib’ (‘living body’).⁴ Here, the body is always both: a subjective form of lived experience, and an objective form of material being. The living body can neither be reduced to an apperception (Husserl), nor to a material entity separated from any understanding of the conscious self. Plessner suggests another interpretation of the ‘Leib’, described in the following formula: ‘this strange relation of indirect directness, of mediated immediacy between organism and world.’⁵ The ‘Leib’, the living body, is a relational phenomenon that cannot be reduced to an illusion of human consciousness or to a material form. Plessner considers the living body as a relational operation embedded in the ecology of organism and its environment. He states: ‘Only indirectness creates directness, only separation allows touch.’⁶ Thus, the concepts

⁴ Helmuth Plessner. *Die Stufen des Organischen und der Mensch: Einleitung in die philosophische Anthropologie* (Berlin: de Gruyter, 1975); Thomas Fuchs. *Leib – Raum – Person: Entwurf einer phänomenologischen Anthropologie* (Stuttgart: Klett-Cotta, 2000); Gesa Lindemann. ‘Leiblichkeit und Körper’, in *Handbuch Körpersoziologie. Band 1: Grundbegriffe und theoretische Perspektiven*, eds. Gugutzer, Klein and Meuser (Wiesbaden: Springer VS, 2017); Thomas Fuchs. *Ecology of the Brain. The Phenomenology and Biology of the Embodied Mind* (Oxford: Oxford University Press, 2017); Maurice Merleau-Ponty. *Phenomenology of Perception* (New York: Routledge, 2012).

⁵ Plessner. *Die Stufen des Organischen und der Mensch*, 260, own translation.

⁶ *Ibid.*, 332, own translation.

of 'Leib' and eccentric positionality also entail a certain understanding of touching and being touched.

This understanding of touch is based on the principle of 'mediated immediacy' ('vermittelte Unmittelbarkeit') also formulated by Plessner.⁷ The principle requires that any form of touch – as well as any other form of human experience – must be understood from two sides: as an inner experience and as a material body. The principle of 'mediated immediacy' is here used as a theoretical and methodological instruction that allows us to identify the artificial nature of bodily experience. Even if bodily experiences are always unique and irreducible, they are embedded and folded into material, social and cultural systems; even if they are highly symbolic and representative, they also remain the situational experience of living beings.

The mediated immediacy of touch does not only presuppose mediated encounters between humans and other bodies – things, technological objects, plants, animals, other human beings. It also implies a concept of the human being as a living body different from other bodies. Plessner differentiates human existence from other living beings by assigning human nature a specific form of 'positionality'. The human body presupposes the mediated and relational nature of the human body *to itself*. Plessner calls this the 'eccentric positionality' of human existence.⁸ Human beings are bound by their own bodies but they are also detached from them. The 'Leib' is the centre, the absolute inner core that enables its paradox

⁷ Ibid., 321–341.

⁸ Ibid., 288–346.

and conflicting positionality. The 'Leib' is the material *and* symbolic operation combining self-reflection and inner experience. The radical relational nature of the 'Leib' forbids any subjective understanding of human experience. At the same time, it considers eccentric positionality as the specific form of living existence that reflects itself *as* subjective. Here, one should not make the mistake of categorising the operation of reflection as the rational act of a conscious subject. Reflection is an operation of living beings embedded in the artificial nature of the relational body. There is no singular, detached and isolated subject. There are living bodies reflecting on the relations in which they are situated and in which they situate themselves.

Here we also find one crucial difference to recent literature on affect theory.⁹ Poststructuralist and ontological accounts following Spinoza, Deleuze and Massumi argue in favour of a symmetric anthropology including nonhuman bodies.¹⁰ This sometimes leads to the idea of a symmetrical relation between various bodies – humans, animals, plants, technological objects, etc. If we are to follow Plessner's anthropology, however, we must reject any form of radical symmetry while avoiding a relapse into anthropocentric accounts. Body phenomenology underlines the specific features of human existence without supporting any ethics of human dominance. Eccentric

⁹ Patricia Ticineto Clough and Jean Halley, ed. *The Affective Turn: Theorizing the Social* (Durham: Duke University Press, 2007); Melissa Gregg and Gregory J. Seigworth, ed. *The Affect Theory Reader* (Durham: Duke University Press, 2010).

¹⁰ Robert Seyfert, 'Beyond Personal Feelings and Collective Emotions: Toward a Theory of Social Affect', *Theory, Culture & Society* 29, 6 (2012).

positionality is not a concept of human hegemony. It is rather a methodological tool that further investigates the tragedy of human existence.

This leads to an analytical concept widening the perspective on the phenomenon of touch. We can now further investigate the operation of touch itself. The operation of touch is based on two central theoretical assumptions.¹¹ Both of these assumptions aim at a more coherent, broader definition of touch.

First, skin contact is understood as only one possible form of touch. The intimidating power of gazing, the violence of spoken words and the atmospheric materiality of interior spaces are dimensions of touching without any actual skin contact. Here, the regime of touch refers to inner bodily experiences like being affected and moved, protected and loved, embarrassed and assaulted. Thus, touch is not restricted to a form of sensual or synaesthetic experience. Touch appears as a state of bodily immanence embedded in the immaterial and material ecology of human existence.

Second, reflection and tact on the one side, and touch and affection on the other side, do not face each other as mutually exclusive oppositions. There is no clear-cut definition of touch as a sensation of direct, immediate and vulnerable, even physical contact. This definition of touch appears as a mystification of never-occurring direct

¹¹ Here I follow the remarks of Christian Fritz-Hoffman, who has brought forward some theoretical and methodological suggestions to reconcile phenomenological and poststructuralist traditions of thinking about touch. See Christian Fritz-Hoffmann, 'Grundzüge eines erweiterten Berührungsbegriffs. Zur Materialität des Hautkontakts und darüber hinaus', *Soziale Welt* 68, nos.2–3 (2017).

affection. Instead, touch is a mediated social operation as any other sensual experience. This entails that any understanding of touch as a more *direct* or *immediate* form of sensual experience than seeing, smelling or hearing is strongly rejected. Touching is not to be equated with naturally given feelings, emotions and moods, but it also isn't an exclusion of event-based moments of contingent and spontaneous affection. At the same time, touching and being touched *can* imply great intensity. Intensity is a feature of the paradoxical nature of touch. But there is no hierarchy of intensity with regard to different forms of sensual experience. The reason is rather simple: touching and being touched is not one sensual experience among others. Following the ideas of body phenomenology, we can consider touch as an operation embedded in all of the senses.

Any experience of human existence must be understood as a relational form embedded in a variety of environments. Here, Plessner's idea of mediated immediacy is understood, among other things, as a sociological thought.¹² In this sense, any form of direct touch is always mediated by social norms and symbolic structures, as well as the material and technological environments involved. Human beings and their bodies are characterised by their expressive and immanent position within the social world and its ecologies.

¹² Gesa Lindemann has comprehensively contributed to this interpretation of Plessner's work. See Gesa Lindemann, *Weltzugänge: die mehrdimensionale Ordnung des Sozialen* (Weilerswist: Velbrück Wissenschaft, 2014); Gesa Lindemann, 'The Body of Gender Difference', *European Journal of Women's Studies* 3, no. 4 (1996).

Following this sociological understanding of Plessner's anthropology, any form of touch is a twofold phenomenon. On the one side, touch is understood as a form of bodily experience. On the other side, touch relies upon norms, constraints, and conventions of social orders and cultural traditions. This also means that the social, cultural and symbolic embeddedness of affection and touch does not entail any ontological basis or moral need for anticipation, discipline or control. It only points at the inevitability of *ecological embeddedness and relationality*. There is no institutional, normative or social instruction resulting from this understanding of touch. Nevertheless, the socially contingent nature of touch has to be taken into account.

Now, this understanding of touch must be understood as an alternative to the widespread conception of biological and neurological reductionism in the field of psychiatry. However, it does not simply oppose the field of psychiatry. It rather uncovers the contradicting and inadequate assumptions of biological psychiatry; it reacts to the insufficient and inadequate concepts of neurological reductionism.

Neurobiological psychiatric research is based on the hypothesis that the clinical diagnosis of mental illness is *primarily* caused by brain dysfunctions. Therefore, the history of psychiatry is inseparably linked with the rise of biological and neurological reductionism. From a body phenomenological perspective, the human brain is not an isolated control centre of one's behaviour, personality and feelings.¹³ Rather, it is embedded in the environ-

¹³ Fuchs. *Ecology of the Brain. The Phenomenology and Biology of the Embodied Mind*.

ment of the human body (here as the ‘Leib’) as a relational operation. I will now look at the medical procedure of brain stimulation in order to illustrate the theoretical differences between body phenomenological and neurobiological approaches. This enables a closer look at the regime of touch underlying the practices of biological psychiatry.

2. Decline and Renaissance: Psychiatry and Brain Stimulation

Let me now elaborate on the historical rise of brain stimulation in order to provide the context of the empirical examples I am referring to. The history of brain stimulation is a history of gaining experience about the mystery of mental illness. Since the eighteenth century modern psychiatry has dreamt of the discovery of biological grounds for schizophrenia, melancholia or depression. Protagonists like Philippe Pinel, Jean Esquirol and William Cullen were trying to locate the causes of mental illness inside the body, as a disorder of the nervous system and the brain. To this day, modern psychiatry relies upon the premise of being able to find the biological or neurological reasons for mental suffering. However, the use of electricity in medical care has a much longer tradition than electric brain stimulation. Since the sixteenth century, amber stones and different fish (catfish, eel, ray) have served as sources of electric medical treatment.¹⁴ In the nineteenth century, ‘electrotherapeutics’ became a key

¹⁴ Kneeland and Warren. *Pushbutton Psychiatry*, vii–ix.

concept of medical terminology – and a common practice beyond the medical realm. Kneeland and Warren note: ‘There were machines in public spaces that would, for a penny or nickel, provide a charge of electricity to cure nervous ailments or rheumatism. Congress had a cellar room in the Capitol filled with electrical medical apparatus in the 1880s [...].’¹⁵ The end of the nineteenth century also marks the first ever experiments of electric *brain* stimulation – with the first one probably taking place in 1874.¹⁶

Modern psychiatry continued the search for the biological causes of symptoms of depression in the beginning of the twentieth century. The invention of electroshock therapy in the 1930s can be considered the breakthrough of brain stimulation. For the first time, modern psychiatry was able to refer to a concrete treatment bridging the gap between medical speculations and individual cases.¹⁷ Electroshock therapy – or Electroconvulsive therapy (ECT) – fulfilled two purposes. First, it somehow worked for some patients. Second, it satisfied the needs of psychiatric research and its medical industry. Even if the mechanism of ECT was poorly understood – and still is today¹⁸ – it served as an experimental basis for the treatment of

¹⁵ Ibid., xix.

¹⁶ James P. Morgan. ‘The First Reported Case of Electrical Stimulation of the Human Brain’, *Journal of the History of Medicine and Allied Sciences* 37, no. 1 (1982).

¹⁷ Alain Ehrenberg. *The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age* (Montreal: McGill-Queen’s University Press, 2010), 45–69.

¹⁸ Tom G. Bolwig. ‘How Does Electroconvulsive Therapy Work? Theories on its Mechanism’, *The Canadian Journal of Psychiatry* 56, no. 1 (2011).

depression. Alain Ehrenberg has shown how the invention of ECT led to the requirement of a clinical understanding of melancholia.¹⁹ This is how the diagnosis of depression has become much more relevant to the medical discourse than ever before. In fact, the invention of ECT is the beginning of the diagnosis of depression as a mass phenomenon.

Today, the technology and the diagnosis of depression go hand in hand. ECT and other forms of brain stimulation are meant to prove the (neuro)biological grounds of depression; and psychiatrists can emancipate depression from the rather unpopular and 'old-fashioned' concept of melancholia. As Susan Sontag put it in the 1970s: 'Depression is melancholy minus its charms—the animation, the fits.'²⁰ That is exactly what biological, modern psychiatry needed: a more clinical, undecorated definition.

Recent studies on the history of psychiatric brain stimulation and shock therapy remember – some painfully – the strong public impact of the powerful images shown in *One Flew over the Cuckoo's Nest* from 1975.²¹ The movie showed electroshock therapy as one element within a 'mechanized, machine-centered, emotionless world'.²² It also visually exemplified electroshock as an effective regime of touch at the service of political and social control, with the power of reducing human beings to

¹⁹ Ehrenberg. *The Weariness of the Self*, 45–69.

²⁰ Susan Sontag. *Illness as Metaphor* (New York: Farrar, Straus and Giroux, 1977), 50.

²¹ David Healy and Edward Shorter. *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness* (Piscataway: Rutgers University Press, 2007), 9, 213–214.

²² Kneeland and Warren. *Pushbutton Psychiatry*, 64.

helpless bodies, to submissive elements of society. However, the slow decline of ECT and other forms of brain stimulation and surgery had already started in the 1950s. Many patients unknowingly became part of dangerous experiments of psychiatrists, and many of them suffered long-term damage. Especially the so-called lobotomy (or leucotomy) stands as evidence for the brutality and ruthlessness of modern psychiatry. António Egas Moniz received the Nobel Prize for his neurosurgical innovations in the field of lobotomy in 1949. Only fifteen years later, however, the bad reputation of the treatment led to its disappearance.

Several reasons have paved the way for the rebirth of non-invasive as well as invasive forms of brain stimulation since the 1980s. The situation of psychiatry in the twenty-first century is highly influenced by these developments. First, the disappointment in pharmaceutical products like antidepressants has reached the heart of the medical industry. It became clear that the industry would have to seek for alternative research fields that promise better efficacy and reduced side-effects. Second, new technologies of neuroimaging have led to an explosion of research on the function of different brain areas in order to correlate their activities with different forms of mental illness and suffering. In this way the digital revolution of neuroimaging has extensively contributed to the renaissance of brain stimulation. Research on TMS and DBS are the results of this process. Third, the publication of the third (1980) and fourth catalogue (1994) of the *Diagnostic and Statistical Manual* (DSM) developed by the American Psychiatric Association (APA) put an even

larger emphasis on the somatic, genetic and biological symptoms of mental disorders. Thus, the DSM manuals provided a narrative and justification in order to call for more research on neuroimaging and brain stimulation to tackle those symptoms in a more efficient way. The DSM and its 'checklist of symptoms' reflected and rigidified the 'tone of medical authority' in psychiatric diagnosis and treatment.²³ Fourth, the conditions of performing ECT have comprehensively improved. New anaesthetics, muscle relaxants and refinements in electrode placement enable psychiatrists and surgeons to increase effectiveness and minimise side-effects. Furthermore, the effectiveness of generalised seizures for therapeutic purposes has never been completely negated or refuted. Now, psychiatry could connect older achievements with technological innovations.

The efficacy of brain stimulation in the treatment of movement disorders like Parkinson's, tremor and dystonia since the 1990s has encouraged psychiatric research to tackle mental illnesses with identical methods. Here, hopes were raised that the precise stimulation of different areas of the brain can relieve individuals from the heavy burden of long-term depression.

Nevertheless, the causes of many forms of mental illness remain an open question to psychiatric and neuroscientific research to the present day. In recent research literature we find descriptions like the following about ECT: 'Any formulation of the mechanism of ECT will

²³ Ann Cvetkovich. *Depression. A Public Feeling* (Durham: Duke University Press, 2012), 99.

encounter numerous difficulties. ECT is effective in various illnesses such as depression, mania, schizophrenia, and catatonia, but it remains an unresolved issue whether ECT exerts differential effects, or whether these obviously different disorders have common pathophysiological bases.²⁴ We might add here: it also remains unclear whether there is a pathophysiological base for all of those mental disorders *at all*. This applies in particular to the diagnosis of severe depression. With regard to research on deep brain stimulation, it is not even clear which area of the brain can be considered as an effective and reliable target of stimulation to treat severe depression.²⁵ During informal discussions, psychiatrists tend to judge prospective research on brain stimulation in the case of major depression with great caution or scepticism. This leaves the impression of neurobiological psychiatry building its theories on false concepts of stimulation, shock and therapy. In other words: touch. I will come back to the understanding of touch and the body underlying neurobiological psychiatry. But before that, I will discuss some ethical issues discussed in recent psychiatric literature dealing with brain stimulation.

3. The Ethics of Brain Stimulation

A regime is a bundle of norms, experiences and affects embedded in discourses and their practical operations. It

²⁴ Bolwig. 'How Does Electroconvulsive Therapy Work?', 14.

²⁵ Sibylle Delaloye and Paul E. Holtzheimer. 'Deep Brain Stimulation in the Treatment of Depression', *Dialogues in Clinical Neuroscience* 16, no. 1 (2014).

entails normative and ethical issues concerning a heterogeneous field of social phenomena. I will not investigate any further ethical dimensions underlying the treatment of severe depression in the context of psychiatric brain stimulation. Instead, I will briefly summarise the criticism raised against brain stimulation in the twentieth century, and show how psychiatry has reacted to this criticism with regard to the diagnosis of major depression. Since the 1980s, the field of neurobiological psychiatry has been highly engaged with questions of medical ethics in order to position itself in the public debate about psychiatric care. I will discuss the problems of free will and personal identity as two key debates in this context.

Today, brain stimulation still carries the stigma of behavioural control and suppression, of capitalist ruthlessness and modern torture. Various issues can be mentioned here. First, we have already seen that psychiatry has widely contributed to this image of megalomania. Prominent psychiatrists like Ugo Cerletti, António Egas Moniz, Walter Freeman and others have violated patient rights in order to develop their ideas in hidden experimental studies. Second, modern psychiatry did not only produce violent hierarchies of all sorts, it also implied a persistent gender bias from its very beginning.²⁶ In 1994, New York psychologist and ECT specialist Harold Sackheim threw a party in honour of ECT icon Max Fink to celebrate the founding of the journal *Convulsive Therapy*. The picture of the most prominent guests shows eleven

²⁶ Kneeland and Warren. *Pushbutton Psychiatry*, 21–40, 69–75.

men.²⁷ Third, forms of brain stimulation evoke pictures of political manipulation, state control and modern torture. The 'Birth of Electroshock' in 1938 already supports this impression. Ugo Cerletti, Lucio Bini and other psychiatrists and neurosurgeons developed ECT with the support of Italian fascism: 'The research, funded by and conducted during the Italian fascist movement, formed part of broader efforts of a variety of experts in medicine and social science to assume the role of social managers and engineers.'²⁸ Later on, many key figures of ECT further developed the treatment in the United States. But the relation of ECT to greater ideas of political control remains. Naomi Klein has shown how electroshock therapy has been used by governments as part of a greater strategy of neoliberal oppression, brain-washing and ideological struggle.²⁹ Here, electroshock therapy enables societal authorities to break the will and spirit of individuals just as social catastrophes open the way for neoliberal policy reforms.

Recent psychiatric research on brain stimulation in the case of severe depression is very aware of this history of stigmatisation and critique. It has tried to bring forward an active response to these challenges. During the last twenty years, neuropsychiatric publications have dealt with several dimensions of ethical concerns with forms of brain stimulation in the case of depression. This applies in

²⁷ Healy and Shorter. *Shock Therapy*, 239.

²⁸ Kneeland and Warren. *Pushbutton Psychiatry*, 48.

²⁹ Naomi Klein. *The Shock Doctrine: The Rise of Disaster Capitalism* (London: Penguin Group, 2007).

particular to the debate about deep brain stimulation.³⁰ I pick out two prominent examples to illustrate some contents of this debate: the problem of autonomy and free will, and the problem of personality and identity.

First, adherents of new technologies in brain stimulation have discussed the question of *autonomy* and *free will*. The philosophical debate about autonomous decision-making and freedom of consent has been adapted to defend treatments like DBS in interdisciplinary and public debates.³¹ The general argument is the following: even if people suffer from severe depression, they cannot be deprived of the ability to speak up for themselves and they should not be deprived of the right to refuse treatments – including brain stimulation. The possibility of using brain stimulation technology in order to prevent convicted offenders from committing further crimes is considered a very rare exception to this general principle, restricted to the realm of forensic psychiatry.

³⁰ Frederic Gilbert. 'Self-Estrangement and Deep Brain Stimulation: Ethical Issues Related to Forced Explanation', *Neuroethics* 8, no. 2 (2015); W Glannon. 'Stimulating Brains, Altering Minds', *Journal of Medical Ethics* 35, no. 5 (2009); Matthis Synofzik and Thomas E. Schlaepfer. 'Stimulating Personality: Ethical Criteria for Deep Brain Stimulation in Psychiatric Patients and for Enhancement Purposes', *Biotechnology Journal* 3, no. 12 (2008); Christian Katzenmeier, Björn Schmitz-Luhn and Christiane Woopen. 'Law and Ethics of Deep Brain Stimulation', *International Journal of Law and Psychiatry* 35 (2012).

³¹ Joseph J. Fins, Thomas E. Schlaepfer and Matthis Synofzik. 'How Happy Is Too Happy? Euphoria, Neuroethics, and Deep Brain Stimulation of the Nucleus Accumbens', *AJOB Neuroscience* 3, no. 1 (2012); Timo Beeker, *Tiefe Hirnstimulation als Ultima Ratio? Eine medizinethische Untersuchung am Beispiel der therapieresistenten Depression* (Münster: Mentis, 2014).

In order to maintain and guarantee the use of such an exception, psychiatry has focused on two objective standards. The criterion of *treatment resistancy* enables the pre-selection of patients by only choosing individuals with an ‘adequate’ history of failed treatments. In the case of brain stimulation, this usually includes up to four unsuccessful attempts of medication. However, only one third of depressive patients are actually classified as ‘treatment-resistant’.³² The second standard is the concept of *informed consent*.³³ In the case of brain stimulation for severe depression this is characterised by three criteria. All relevant information has to be disclosed to the patients. The patients need to demonstrate competence to understand the information. And finally, the decision based on this medical information has to be taken voluntarily and free from manipulative influence. The criterion of informed consent lacks clarity, however, particularly with regard to the nature of treatments with brain stimulation. The history of treating depression with brain stimulation – as well as medication – is a history of highly experimental studies with no reliable biological basis. The ontological situation of brain stimulation always remains a non-hierarchical situation of interacting amateurs. Both – experts and patients – gain their knowledge by being involved within a dynamic situation of mutual touch and

³² Timo Beeker, Volker Coenen and Thomas Schlaepfer. ‘Autonomy in Depressive Patients Undergoing DBS-Treatment: Informed Consent, Freedom of Will and DBS’ Potential to Restore It’, *Frontiers in Integrative Neuroscience* 11, no. 11 (2017): 2.

³³ *Ibid.*, 3; Katzenmeier, Schmitz-Luhn and Wooten, ‘Law and Ethics’, 133–136.

experience. ‘Therapeutic misconception’ is not a form of self-deception on the patients’ side; it is rather a possible risk of any form of brain stimulation with severe depression. However, the legal, moral and medical hierarchical position of psychiatrists often hides this fundamental uncertainty. Furthermore, the use of external assessments – psychiatrists assessing the patients’ autonomy – is very common and widespread. This procedure also affects the inner wishes and hopes of suffering patients, who may experience major disappointment if those desires remain unfulfilled.

This brings us to the second example of ethical issues concerning brain stimulation with major depression. Even if autonomy is considered an attainable goal, the problem of manipulation with regard to one’s *personal identity* remains. Brain stimulation still implies the stigma of behavioural control in terms of changing one’s personality. This is the psychiatric rationale in response to this critique: even if brain stimulation changes the individual’s personality and identity, there is no reason to consider this as exceptional and unusual.³⁴ Quite the contrary, the development and change of personality and identity is considered a natural process of becoming one’s self throughout different stages in one’s life. Additionally, patients suffering from severe depression usually *wish* to change their lives and personalities in order to have a fresh start. Since the 1950s neurologists and psychiatrists have been speculating about the existence of some kind of ‘pleasure centre’, usually identified with the nucleus

³⁴ Gilbert, ‘Self-Estrangement’; Beeker, ‘Tiefe Hirnstimulation.’

accumbens. Simply by increasing the voltage amount for DBS patients suffering from depression, it is now possible to change the mood of some patients from 'anxious' to 'relaxed' and 'too euphoric'.³⁵ In this context, the standard of 'self-estrangement' is suggested as one possible red line to distinguish unwanted side-effects from the 'normal feeling of self'.³⁶ The neuro-ethical philosopher Frederic Gilbert elaborates: 'In that respect, postoperative self-estrangement may enhance or restore one's control over one's life or illness. However, in some cases, DBS radical modifications of the self may lead to a loss of control or experiencing feelings of powerlessness.'³⁷ This also implies suicidality.

All these philosophical reflections consist of non-binding speculations and blurred ethical lines. They seek to reconcile the very basic principles of modern biological psychiatry with public and ethical criticism. At the same time, they continue a tradition of neurological reductionism. They limit the human body to its material form and brain functions.

4. Brain Stimulation and its Regime of Touch

In this last section, the regime of touch underlying recent psychiatric research about brain stimulation is contrasted with the understanding of touch developed in the beginning of this chapter. I argue that neurological reductionism

³⁵ Fins, Schlaepfer and Synofzik, 'Too Happy?'.
³⁶ Gilbert, 'Self-Estrangement', 109.
³⁷ Ibid.

has to be confronted with a different perspective on the human body and its regime of touch.

Until today, psychiatric research has not found any definitive pathophysiological base of depression. Despite the great efforts since the renaissance of ECT, it is very unlikely that effective forms of brain stimulation will be found in order to provide a long-lasting treatment for severe depression. All concerned patients depend on pharmacological and social support to cope with everyday life. And there is strong evidence that depression must be considered an ‘intercorporeal’, social phenomenon.³⁸ However, neurological regimes of touch in psychiatry still exclude any form of social and cultural embeddedness from possible therapeutic approaches. Rather, the neurological status of the human body is considered the source of depression. Consequently, the regime of brain stimulation tends to neglect the radical individual contingency of effects and outcomes in order to reinforce these underlying basic principles.

The concept of stimulation evokes the image of causal effects between the brain stimulus and a person’s life and health. Thus, it implies powerful hopes for patients suffering from depression. This opens up doors for great hopes and even greater risks and dangers. On the one side, it contains the promise of healing the person as a whole while avoiding any further moments of painful inner and social touch. Patients are presented with seemingly miraculous healing powers. On the other side, an abyss of even greater

³⁸ Thomas Fuchs. ‘Depression, Intercorporeality and Interaffectivity’, *Journal of Consciousness Studies* 20, nos. 7–8 (2013).

detachment and vulnerability appears, situated between the suspicion of possible manipulations and profound disappointments.³⁹ If the miracle fails to occur, the consequences are unforeseeable. Shock and stimulation equally create hopes and dangers. Affects may be a source of criticism but they are also the source of emptiness and horror.⁴⁰ Post-traumatic stress disorder is one of the greatest blind spots in this context.

From a body phenomenological perspective, this understanding of the human body and of touch is disconnected from any concept of human existence and the 'Leib'. This leads to a different description of the self and of depression. Severe depression is the most extreme case of self-destructive, inwardly turned intensity. It appears as a threat to any assurance of one's self, one's identity as the necessary *centre*, *perspective* and *presence* of self-becoming *within* the inevitable, ontological fundament of ecological existence. Any 'biological dysfunction' must be understood as 'the meaningful expression of a disorder of intercorporeality and interaffectivity on the psychosocial level'.⁴¹ Individuals suffering from depression are thrown back on themselves, to their own flesh and body, to their very own individualised vulnerability.

This also entails a different perspective on the ethical issues discussed in this text. First, autonomy and free

³⁹ One setback is mapped out long before the treatment has even begun. The vast majority of patients of brain stimulation rely on antidepressants to receive brain stimulation, and depend on antidepressants long after the treatment.

⁴⁰ Clough and Halley, eds., *The Affective Turn*.

⁴¹ Fuchs, 'Depression, Intercorporeality and Interaffectivity', 234.

will are not understood as characteristics of an isolated subject taking conscious decisions. They are embedded in intercorporeal relations. Second, personality and identity are not considered features of individual subjects. The relational character of bodily existence can only manifest itself in relational operations of becoming, not of being. So, body phenomenology agrees with neuropsychiatry in saying that a person's identity is a process of becoming, not a state of being. However, it disagrees with neuropsychiatry in not reducing the regime of touch to the practice of brain stimulation itself. Becoming is a relational category of the 'Leib', not an isolated biological, neurological or individual narrative.

Like any medical treatment of mental illness discussed as an isolated practice, the procedure of brain stimulation tends to some form of self-fulfilling prophecy. In theory, it reduces depression to a form of brain dysfunction and it only refers to factors confirming this view. It follows a logic of reset and reload, erasing bad signals and trying to build up new ones. The genealogy and ecological dynamics of depression and the ongoing treatment are left out – or they are dismissed as dimensions of failed attempts of previous treatments. The normative force of treatment resistancy, for example, severs all links of brain stimulation to an individual's history of failed attachment and desperate isolation. It generates a realm of a very abstract double bind effect by fuelling hopes and expectations without ever leaving the grounds of radical experimentation and unconcerned non-responsibility at any time.

If the requirement of ecologically embedded depression is taken seriously, this normative effect cannot be

dissolved by only pointing at conceptual transformations manifest in philosophical coherence. It can only be tackled by reflecting the painful and contradictory processes of touching and being touched within any 'shared space of attunement' pervaded by depression.⁴² Body phenomenology provides a coherent concept of the living body in order to leave room for a relational and social understanding of human existence that does not fall back into subjective, individualist, dualistic or highly normative accounts.

Helmuth Plessner's *Die Stufen des Organischen* (1928) was meant to address the conflicts between the natural sciences and philosophy, between empirical and non-empirical sciences in the beginning of the twentieth century. Plessner underlines the important mediation of ontological and empirical, of philosophical and biological concepts. In his view, phenomenology bridges the gap between different disciplines, discourses and ways of thinking. Following this thought, body phenomenology should not be misunderstood as a general rejection of psychiatric research and treatment. It rather seeks to reconcile theoretical models with our social reality by emphasising the tragic and eccentric positionality of human existence.

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⁴² Ibid., 233.

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