International Research Journal of Public and Environmental Health Vol.7 (4),pp. 133-139, August 2020
Available online at https://www.journalissues.org/IRJPEH/
https://doi.org/10.15739/irjpeh.20.019

ISSN 2360-8803

Review

Effects of modernity on depression

Received 23 April, 2020 | Revised 3 June, 2020 | Accepted 23 June, 2020 | Published 18 August, 2020

[1]Alan Suresh Vázquez Raposo*
[1]Luis Rey García Cortés
and
[1]Moisés Moreno Noguez

[1]Mexican Social Security Institute. Regional Delegation State of Mexico East. Head of Medical Benefits Services. Planning Coordination and Institutional Liaison. Medical Auxiliary Coordination of Health Research.

*Corresponding Author Email: alanraposocarax@gmail.com

The objective of this paper focuses on elucidating how modernity has transformed the status of depression according to its discursiveness. Depression exhibits specific symptoms that elementally can be a problem in the clinic if left undetermined, since a disorder cannot be tackled without the social axis in which it appears, where a symptom appears is where the relationship of a problem has to be made. Clinics need to enable the social and cultural field to account for the effects of modernity on psychological disorders.

Keywords: Depression, modernity, clinic, symptom, melancholy.

INTRODUCTION

Depression: Symptom and Definition

The aim of this article is to problematize depression in relation to modern discourse via culture, how this discourse affects the creation of subjectivities by modifying symptoms and the implications that the clinic faces in the terms of the problem. This will enable us to approach the field of social psychology, psychoanalysis and social medicine to establish an analysis in the understanding of depressive symptoms that are challenged by modern discourse.

It is possible to think of depression as a "dry halt" that is sustained by an ideal always destined for failure but that implies a transmutation of perceptions. The traditional definition dictates that “Depression is the result of complex interactions between social, psychological, and biological factors. Those who have been through adverse life circumstances (unemployment, mourning, psychological trauma) are more likely to experience depression. In turn, depression can generate more stress and dysfunction, and worsen the life situation of the affected person and, consequently, the depression itself” (World Health Organization, 2020). However, lack of clarity of the concept affects understanding of the problem.

Depression is the tragedy of coercion, the imposition of blame on oneself and the loss of decision or the impossibility of not choosing; the depressive patient frames a structure of bottomless emptiness that removes him from himself, that is, faced with the impossibility of filling that “bottomless” state- the inquisitive frenzy strives to slide the blame on himself, a way of making himself guilty of his inability to resolve the vacuum. Bertholet' (2012) statement is accurate; “Depression is a set of affections of the subject: sadness, inhibition, despondency, reluctance, crying crisis, anguish, frustration, isolation, pain, hopelessness, disappointment, and heartbreak. Affections are present and have a prominent place in the subject's experience".

Cruz (2012) when analyzing depression placed a list to aid identification of the symptoms, and said “the signs and symptoms of depression are clear and observable and knowing them will make it possible to know if a person

suffers from it or just going through a stage of distress in their life; these are:

- Obvious signs of sadness.
- Anhedonia (loss of pleasure or interest).
- Insomnia or hyperinsomnia.
- Disturbance of appetite and weight.
- Decreased energy and feeling of fatigue or lethargy.
- Cognitive impairment of concentration, short-term memory.
- Inability to make decisions.
- Social isolation.
- Decreased libido.
- Symptoms and general thoughts of guilt and / or shame.
- Frequent thoughts about death and suicide.
- Anxiety.
- Somatic complaints.
- Auditory and visual hallucinations, including paranoia.
- Hypersensitivity to rejection.
- Excessive risk-taking behavior.
- Ruminate and think things over.
- Hopelessness (loss of sense of life). ”

The pathology of depression is subscribed at the level of symptoms in loss and no replacement, in ignorance of what was lost and in the search for something unknown. The symptom is the description of what happened regarding this conflict that can only be represented in words, "the symptoms of neuroses are essentially substitute satisfactions for unfulfilled sexual desires" (Freud, 1992). It is necessary to mention that when referring to sexual desires, it is not a coital implication, but a psychic reality that is represented by the elements of pleasure and displeasure, the libido or psychic energy. Therefore, it is the specific representation of what happened in everyday experience that will reflect the patient's condition. The non-fulfillment of a dissatisfaction is taken to the extreme so that depression appears as an effect of what is not done. The symptom opens the path in the fabrication of the reality and perception of the patient because it is there in the symptom that the subject exposes something of himself. In the symptom, there is an instinctual satisfaction since there is an enjoyment before the ideal inscribed to a debt. The establishment of depression in the patient implies a discomfort in the thoughts, the body, the attitudes, this installation is a wound that does not close, it cannot be sutured with any method.

The depressed patient is perceived to be in anguish, receiving the blows of culture represented in different masks: society, discourses, institutions, unconscious, superego, desire, ideologies. Each mask can be an impulse to assign the suffering and distressing condition to the depressed patient. The patient has realized that the determined condition is more than just beyond it. The patient is subject to his ideal ruptures that make him guilty for not being able to access that statute. In this regard, Martínez (2018) carried out a study in which he concluded that “there is a significant correlation between psychosocial factors and variables of lifestyle, depression, anxiety and cognitive distortion, which shows that the participants studied would prevail in terms of present disturbances at a psychological level, also damaging different aspects of normal life, as well as in work, family and personal settings. However, it influences the performance of institutions and development in the social area. For this reason, depression is considered a habitual mental disorder that is determined by the existence of feelings of sadness, dissatisfaction, loss of interest or pleasure, in many cases feelings of guilt or lack of self-esteem. With this, sleep disorders of appetite can occur, feeling tired and attention deficit. ”

Now, the pathology of depression is subject to the discourses that its production enunciates. How can we think of depression linked to the ethical field?, López and Pérez (2003) stated that “nature not only draws our attention in melancholy unaware of the loss, but also decreases in self-esteem, that is, that impoverishment of the self, mainly moral, where the reproaches, the insults and the waiting for punishment give account of a despicable being”. Therefore, depression has a specific symptomatic character, related to ethics. The subject destroys all function of value for himself for being impotent before what he seeks. Guilt is the central axis of depression, the normative field is about effect and tension in the dimension of the patient's psyche, in Chapter VI Bleichmar (1978) refers to Psychogenesis of Depressive Pictures about a patient named Carola, where he commented that “Carola's depression is not the reactivation of a poorly developed grief, at least in the current meaning, that is, of a certain episode of painful loss. It is not depression about something in particular. It is a way of looking at oneself, the only one that knows.

The influence of modernity via culture is commendable, if we understand the processes by which modern discourse is articulated. Pavón (2017) stated that “the existence of the neoliberal subject is characterized by its relationship with what exceeds it, by its drive towards excess, by being outside its limits, which does not cease to provoke stress, depression, drug addiction, suicide, panic attacks and other typical symptoms of our time. This is how neoliberalism tends to degrade mental health and everything else that cannot be exploited, valued economically”.

Implications of Modernity in the manifestation of Depression

The current modern discourse that societies and institutions produce has adopted the aspirations of the subject within society, so that from a certain realization it is obliged to fulfill the duty to the subject, but this duty will be presented as opportunities to fulfill, such as longed for freedom. The subject has been dispossessed of what was never his but he always believed his own and has been sedated with the horizon of the promises. Thus said, Zizek (2012) assured that “typical patients who go to the analyst to solve their problems do not feel guilty for excess pleasure, for being carried away by pleasures against their sense of duty or moral or whatever, on the contrary, they feel guilty for not enjoying enough, they feel guilty for not being able to enjoy" (min. 12). These arguments set the

stage where the subjects / patients who come to the consultation spaces enunciate a certain symptom, which, based on the vision of their ideological apparatuses and their discursive transformations, support their world views, even when they are inappropriate for health.

Culture and patients constitute an indissoluble dialectic that is undoubtedly represented in the pathologies of a subject, the central reflection lies in re / thinking depression as a symptom of the subject itself but something else, as an effect of society itself, as a response to system failure, such a structure is suspended on the shores of the discursive interests of power, the relationship between culture and patient strained by power reflects the patient in depression as the axis to eradicate.

The possibility of thinking about modern times gives rise to redefining the symptoms that appear ingrained in the discord of everyday life. The material force with which we are challenged by culture places us in the definitive tragedy of substantial subtraction from life itself, subjectivity is subtracted by the invisible order that society stipulates the said order, said authority has modified in these times, has blurred the subject of his individuality to fulfill a greater purpose, the subject we knew has become an ideological subject of the.

Now, the capitalist discourse has changed dramatically because the classical materialistic subject that sought to abolish classes has been left behind, with the arrival of the free market and the expansion of the subject as a company (the micro-company to be managed) the bases for a subject are determined free (antagonistic concepts in themselves), the mandates of the arrival of the free market are justified in sentences such as "be yourself", "do what you like the most", "be the best", "realize yourself in life" .. The subject has lost the possibility of claiming himself, he has been overwhelmed by the invisibility of the mandates disguised as liberties. “Working is not just producing or selling the labor force. It entails doing it within a framework of social norms that define what is employment and what is not, what is a good job and what is not, etc. This framework of legal and social regulations in which labor activity is organized in practice turns the labor market into a social institution, which shows that the norm of employment as a rule of social insertion has changed profoundly in the last three decades. In addition, this fact means that transformations in the world of work have profound and structural effects on the production conditions of modern societies” (Porras, 2017).

Lipovetsky (2005) anticipated and directly exclaimed that “today's man is characterized by vulnerability. The generalization of depression should not be attributed to the psychological vicissitudes of each one or to the difficulties of current life, but to the desertion of the public, who cleared the ground until the emergence of the pure individual. In search of himself, Narcissus obsessed only by himself and, aśi, prone to fainting or sinking at any time in the face of adversity facing it with bare chest, without external force" (p. 46). However, the radicalization of depression these days, has revolved around happiness, the possibility of success, the impossibility of not being, the order of social ties to the mandates of the superego, the patient it rushes into the social order, the building of the symptom is grounded in the discourse that evokes the social.

In this way the mercantile, economic, political, culture and power processes require the patient to determine the height of his ideals in order to necessarily fulfill them and whoever is not appealing to direct his thought to current discourses falls flatly to the place of the criminal, to say, “The criminal designated as the enemy of all, which everyone has an interest in pursuing, falls outside the pact, disqualifies himself as a citizen, and emerges carrying himself as a wild fragment of nature; appears as the wicked, the monster, the mad perhaps, the sick and soon the "abnormal". It is in this way that one day will become the subject of a scientific objectification and of the "treatment" that is correlative to it” (Foucault, 2002). The reason why in power networks, the depressed patient becomes the subject that is persecuted to save him, is because he wants to take charge of his choices. Here, it would be interesting to place the figure of Bartleby - the main character of the work of Herman Melville (2008) "Bartleby" - who proves to be a political entity that breaks the project of subjectivation of the masses. Bartleby is the reflection of the decline of the narrator of the text, curiously, the text closes as follows "with messages of life, these letters rush towards death" to exclaim the failed position of the subject, the representation of the main character is inscribed from a clinical perspective as the possibility of accounting for what is unknown, the clinical background that this character opts for the combative overturn in the effigy of symptoms. In the end, the position of the text is the “bottomless” that insists on the representation of the depressive patient.

With this, it is possible to argue that depression is currently built by the inability to choose among so many options, among so many possibilities offered by the system. Choosing is a burden that the depressive patient does not bear since they know that there is a loss, that is to say, for the depressed patient every choice suggests losing something, that is unbearable for him. The patient's condition is then based on a series of choices that prevent him from holding to take charge of himself. "The social bond constitutes in this sense, a modality of treatment of jouissance, which will be determined from the form and function of the discourse in which the subject is inscribed" (Jiménez, 2014).

The need to carry out an analysis of depression today is that just as new forms of production, new ideologies, new ways of viewing the world are presented, symptoms transmute, they are the metamorphosis that insists on making itself known. The current depressive patient has mutated due to the imperatives that the economic, political, mercantile and consumer systems offer. The thing does not recover, the depressive is totally in the cultural web of the time, in a way it resists change to rip and visualize the failure of the system itself, culture or society. “Some cultural elements can influence the development and

appearance of depression, as is the case in the Jewish culture. In a study of 339 people (157 men and 182 women), a similar prevalence of depression was found for both sexes " (Zarragoitía, 2011). This supports the idea that the influence of contexts or society generates effects on health, specifically in the case of the development of depression.

The current-modern depressive patient is manifested in the mobility of the secret always said, the capitalist discourse encloses the shock of depression in the univocity that determines the patients as special, the subject has once again been unique in the no difference, the symptoms of the patients have spread to discursive conditions. It is no longer just the body, nor the words of the patient in the office, the symptom spreads or becomes better visualized to a gear that surpasses it. In this sense "little by little, an administrative and political space is articulated in a therapeutic space, tending to individualize bodies, diseases, symptoms, lives and deaths; it constitutes a real picture of juxtaposed and carefully distinct singularities. A medically useful space is born from discipline" (Foucault, 2002). The depressed loses the enigmas that make him visible, the state of the depressive is a discharge of negation, the path that the depressive makes in his conscious dimension is untimely and does not stop doing a "nothing", a prank on the outside. The depressive is describable and always impossible, unattainable, therefore it is required to make the depressive not depressive in its form, it is necessary to do qualification, fashion, number and treatment to remove a remnant of the difference.

Depression is not just a quality or a state of mind, it is the result of the overturning of the culture and the negation of the negation, each statute that occurs in the flow of time and that is solidified by history, frame the need to raise new ways of reflecting on psychic conditions, disorders, to say: diseases. "In accordance with what has been stated, we cannot say that the subject today suffers from a repression of the drives by civilization as in 1930. The ideal of renunciation that, at the beginning of the 20th century, gave rise to an unsatisfied desire has turned to an ideal of consumerism that took the place vacated by the failing of ideals, thus operating a tamponade of the cause of desire due to the invasion of technological products in the market. These changes have led to privileging a psychic suffering that manifests itself today in other forms, to the detriment of the suffering of the hysteria of Freud's time that translated an interpellation to the bourgeois order that passed through the body of women. Thus they slide on the horizon of our time: bulimias, anorexias, passages to the act, addictions in general, panic attacks, depressions, psychosomatic phenomena, and melancholizations. Given the failing of ideals, the names of the father appear that give the subject a false being, we can hear him in the clinic through presentations such as: "I am addicted", "I am a player", which indicate a position of apparent pacification and suturing of interrogations around subjective suffering. In this sense, there is a new regime of discourse in contemporary civilization that does not promote or even prevent the formulation of interrogations" (Aksenchuki, 2014).

The vertigo of neoliberal discourse implies taking into account the deployment that the depressive leaves, the depressive manifestation is explained differently today, appealing to a significant bodily, existential, social, anthropological, political, cultural and philosophical recurrence has to be raised in different shapes. The foundation of the symptoms concentrates the anonymity of the problem, it causes the effect of the story itself. Modern demand nullifies the subject, deprives him of it and gives rise to the psychic need to be and how to be. The depressive is subject to the discourse and the approaches that are said about him, therefore he agrees with Josué et al. (2006) in which "Depression is not only a medical problem, but in parallel it is part of a social phenomenon. Depressed patients have multiple risk factors that can lead to the morbid process, meaning risk to the probability that an individual has to develop a given disease throughout a pre-established period".

Heading to a comprehensive clinic

The clinical implication in the depressive subject would go in the question of the symptom and its implications with the environment of the patient, the depression is not reducible, the depression does not suggest an incessant similar repetition between one subject and another, the psychoanalytic clinic does not propose something definitive or seeks to close the field to the predictability of what happens, there are no totalities.

It is Foucault (2001) who leaves the way to rethink the medical clinic and above all the psychoanalytic clinic to have a new structure of thought, "To the exhaustive presence of the disease in its symptoms, the transparent transparency of the pathological being for the syntax of a descriptive language: fundamental isomorphism of the structure of the disease and of the verbal form that surrounds it. The descriptive act is, in its own right, a perception of being, and conversely, being does not show itself in symptomatic manifestations, therefore essential, without offering itself to the domain of a language that is the very word of things. In the medicine of the species, the nature of the disease and its description could not correspond without an intermediate moment that was, with its two dimensions, the "picture"; in the clinic, being seen and being spoken communicate smoothly in the manifest truth of the disease of which precisely the whole being is there. There is no disease except in the element of the visible, and therefore of the enunciable. " (p. 138). From this, the clinical perspective that gives the patient as a central point and what is properly said, that is, what is stated in the patient, constructs the field of his subjectivity integrated by social processes, groups and institutions. The premise of the clinic is not muzzled by a purely methodological statute since the complexity of the subject in his psychic reality cannot simply focus on a kind of technical repetition, but in so far as the clinic is a listening

and speech is given as Primary guarantor for treating neurotic disturbances to link the process by which the symptom speaks.

As Boschetti (2004) points out, “Doctors must find out what problems their patients have and must help them find viable solutions. When this is not the case, some cognitive behavioral therapy techniques can be used to counteract automatic negative thinking. The clinic's field of intervention envisions the possibility for the subject to take responsibility for what he knows about himself, for his symptom, and from this scope give rise to the subject himself and thus approach the processes of the social without generating a definitive closure.

Primary care is essential to determine the course of treatment for depression, according to de la Gándara (1997) "The high prevalence of mental disorders in the general population and in primary care (PC) and its serious social repercussions are known (to be) economic and sanitary. Therefore, the recognition, diagnosis and treatment of mental illness must be improved since the impact of a bad medical diagnosis is a problem not only for health, it is important to point out that the identification of the depressive disorder must be accurate.

For Pérez and García (2001), the clinical intervention of depression focuses on pharmacological treatment, psychological treatments (from which different types of therapy derive such as cognitive, cognitive-behavioral, behavioral, interpersonal psychotherapy, and psychoanalytic therapy is reserved). and brief therapy.), stating that “There are three psychological treatments that have been shown to be effective in depression. They are Behavioral Therapy, Cognitive Therapy and Interpersonal Psychotherapy. Of all of them it can be said that they are "well established" treatments. All of them consist of a structured program of the order of 12-16 sessions, with some additional ones, and have an application manual (sometimes including a patient manual). Likewise, all are susceptible to group application, and not only as an acute treatment, but also as a continuation and maintenance.

However, for Zarragoitía et al. (2018) “Depression is perhaps the most unrecognized, undiagnosed, and untreated of medical illnesses, and the direct and indirect costs are greater than any other illness, except cardiovascular. This is why some researchers have called it the great "silent epidemic." In primary care studies it is stated that it is underdiagnosed in 31%, although some go as far as 50%. It occurs between 5% -8% of the population, but in comorbidity with other medical and psychiatric diseases it can reach between 25% -30%. Currently, this disease ranks fourth among disabling diseases and it is estimated that by 2020 it will rank second. It is the leading cause of disability in mental disorders. ”

The World Health Organization (2004) assured that with regard to depression, early identification is essential to prevent it since it is known that even in high-income countries, almost 50% of those who suffer from depression are not identified. Early identification means more effective treatment and prevents disability or death by suicide. In most cases, depressive disorders can be effectively treated with cheap, common medications and simple psychosocial interventions. This can be accomplished in primary health care services by providing basic training and appropriate medicines.

The dissection of depression represents the center of analysis of melancholy itself, said so, the latter by representing an encryption of "what is lost" the patient blames or reproaches himself for the loss; if the social and psychic structure represent a direction in the patient, the disease appears as a brake on that direction, the gradual possibility that the patient acquires the character of "healthy" appears as long as the patient recovers the libidinal forces and the place in another "object".

Depression is the disease of a society that suffers under excess positivity. It reflects that humanity directs war against itself. ” (Han, 2012) from the patient, his own has been lost forever, depression arises, given the temporality the symptoms arise stated in the word or the body and reaffirmed in the social, the relief of the conflict becomes a implicit enjoyment of remembering what the patient has lost. That is to say, the patient does not want to forget what he lost, since insofar as he is his property, he looks for it insistently, the symptom is memory and the encounter between what is lost and the patient, if by speaking the brief silence of the depressive patient is killed.

In other words, in these interesting times the need to rethink psychic disorders focuses on how the locomotive accelerates without slowing down, on how times evolve, transform, mutate into discourses, practices and ways of thinking about any phenomenon, however the emphasis that is made to the symptom has to do with something that reigns and pushes even with changes, if modern societies request the search for happiness even when it costs their own lives, it must be carried out, the mandate of the repressive society is that there is no mandate, you can be whoever you want, you can choose what you want, you can do what you can and that is perfect, because in modern societies, subjecting subjectivity is no longer characteristic of repression and normativity, but rather of the freedom of the subject, Han (2012) says about this: “Neuronal diseases such as depression, attention deficit hyperactivity disorder (ADHD), borderline personality disorder (tlp) or the syndrome of occupational attrition (sdo) define the pathological panorama of the beginning of this century. These diseases are not infections, they are heart attacks caused not by the negativity of the other immunological, but by an excess of positivity. In this way, they subtract themselves from any immunological technique destined to repel the negativity of the strange, if we conceive that modern health proposals are linked to a specific mode of operation where there is no place to question sadness, since the imperative that shapes society is not to lose happiness.

The organization of the discourses allows us to reflect that clinical practice does not remit the orthodox production of the clinic, it is necessary to change the reins of thought in its functionality and criticism, the clinic needs

to rethink the social conditions that call for modifying the ways of interpreting certain symptom since the latter is the configurator of the link between disease and clinical intervention, giving rise to listening to the symptom implies understanding the processes of emergence of the symptom itself and as such of the same society that produces it. Han (2012) will say "In reality, what sickens is not excess responsibility and initiative, but the imperative of performance, as a new mandate of the late modern labor society." in this sense, the proposal is aimed at rearticulating the ways of rethinking phenomena, diseases and their repercussions, generating other clinical strategies that give rise to inter and transdisciplinary reflections that promote a decrease in the prevalence of the disease depressant.

The link between the social and the disease cannot be denied, thus, the collective importance of working for the eradication of depressive disorder is necessary, since it involves different works, it is even stated that the family as the primary entity of the social-cultural face primary care is of the utmost consideration and significance because "It must be borne in mind that the causes of anxiety and depression, both as symptoms and disorders; they are multifactorial. Family-related factors could act as causal factors in the case of reactive symptoms, but as triggering or maintaining factors in the case of anxious and depressive disorders (which have a high biological predisposition). The impact on each family may be different and be associated with other psychosocial factors. It is important to achieve a collaborative therapeutic relationship that generates a realistic feeling of control in the family and favors the mobilization of the system's capacities to promote improvement. This idea allows the system to show openness and consider that there are more efficient ways of operating than they have up to now. " (Vargas, 2014)

The recommendations suggest bordering on a new form in clinical practice, primary care becomes essential, there are different ways of approaching, understanding and interpreting phenomena related to mental health, the field of excision does not generate exact certainty, therefore that it is always possible to carry out more works that develop an interdisciplinary understanding of the problems to be solved like depression. However, there are recommendations to better observe the phenomena, in the case of depression the Andalusian Health Service through the Ministry of Health with García et al. (2011) issues recommendations that may be useful in the clinical consultation to identify a patient with possible symptoms of depression, comment that "when evaluating a person who may have depression, make a complete evaluation that is not based simply on a count of the symptoms. Note the degree of functional impairment and / or associated disability and the duration of the episode. Consider, in addition to evaluating symptoms and associated functional disability, how the following factors may have affected a person's development, course, and severity of depression:

- History of depression and mental health or physical comorbid disorders.
- Any history of mood swelling (to determine if depression may be part of bipolar disorder).
- Any previous experience of response to treatments.
- The quality of interpersonal relationships.
- Living conditions and social isolation. "

Everyday life is important in the manifestation, development and prevalence of a disease, all the importance of the contextual development of a human being, "Unemployment, risks in childhood, job insecurity, urban marginality, Income, inequalities in access to the health system or some of the effects of globalization (economic immigration, for example) are, according to the World Health Organization, social determinants of the health status of a population on which it is possible to and you must intervene. The same is true of culture. Obviously the uses and customs, the common rules that man has been generating to develop and live in society affect the issues that we have defined as the causes of the causes of the disease. " (Ugarte, 2009), the importance of the socio-cultural aspect of economic processes is not undeniable and clearly determines the production of patients with depression. It is important to resort to multiple disciplines to contain or reduce the problem.

REFERENCES

Aksenchuki R (2014). "Cultural unrest at the intersection of modernity / postmodernity". Wandering UNAM. 9 (15):1 – 7.

Alcaide I (2010). "Mourning and Melancholy, Complement of Narcissism". GEPU Psychology Magazine. eleven); pp. 25 - 31

Bertholet R (2012). "Depression, a reading from psychoanalysis". IV International Congress of Research and Professional Practice in Psychology XIX Research Conference VIII Meeting of Researchers in Psychology of MERCOSUR. Faculty of Psychology - University of Buenos Aires, Buenos Aires.

Bleichmar H (1978) "Depression: a psychoanalytic study". Buenos Aires, Argentina: New Vision Editions.

Boschetti B (2004) "Depression and its management in the field of family medicine" Archivos en Medicina Familiar, 6 (3): 61-63.

Cruz G (2012). "From Sadness to Depression" Electronic J. Psychol. Iztacala, 15 (4):1310-1325.

de la Gándara J (1997). "Depression and anxiety management in primary care". Primary Care, 20 (7):389-394

Foucault, M. (2001) "The birth of the clinic. Mexico". D.F .: Siglo XXI Editores

Foucault, M. (2002) "Watch and Punish". México, D.F .: Siglo XXI Editores

Freud S (1992). "Complete Works Volume XX". Buenos Aires, Argentina: Amorrortu Editores

García B, Nogueras E, Muñoz F (2011). "Treatment of depression in Primary Care". Group for the Study of depression in Primary Care. Andalusian Health Service.

Health counseling.
Han B (2012). "The fatigue society". Barcelona, Spain: Herder Editorial.
Jiménez C (2014). "A critique of a notion from psychoanalysis (master's thesis)". National university of Colombia. Available in:http://bdigital.unal.edu.co/49642/15/32937544.2015.pdf
Josué L, Tores V, Urrutia E, Moreno R, Font I, Cardona M (2006). "Psychosocial factors of depression". Cuban Journal of Military Medicine, 35 (3): 1-7.
Lipovetsky G (2005). "The era of emptiness". Barcelona, Spain: Editorial Anagrama.
López L, Pérez A (2003). "The hidden face of sadness." Journal of the Spanish Neuropsychiatric Association, 23 (87):53-65.
Martínez D (2018). "Psychosocial factors in prevalence in depression, anxiety, cognitive distortion and lifestyle habits". Scientific Psychology Magazine online. Available at: https://www.psicologiacientifica.com/factores-psicosociales-depresion-ansiedad-distorsion-cognitiva-habitos-de-vida/
Pavón D (2017). "Subjectivity and psychology in neoliberal capitalism". Political Psychology, 14 (40):589-607.
Pérez M, García J (2001). "Effective psychological treatments for depression". Psicothema, 13 (3):493-510.
Porras N (2017). "Analysis of the relationship between mental health and human discomfort at work". Equity & Development, 29:161-178.
Ugarte A (2009). "A Socio-Cultural Model of Health Action". Quality of Life Magazine, 1 (3):165-180.
Vargas H (2014). "Family types and anxiety and depression". Herediana Medical Magazine, 25: 57-59.
World Health Organization. (2004). "Invest in Mental Health". Available at: https://www.who.int/mental_health/advocacy/en/spanish_final.pdf
World Health Organization. (2020, January 30). "Depression". Available at: https://www.who.int/es/news-room/fact-sheets/detail/depression
Zarragoitía I (2011). "Depression. Generalities and Particularities". Havana, Cuba: Editorial Ciencias Médicas.
Zarragoitía I, de la Osa M, Agudín S, Casañas M (2018). "Depression: Challenges and Conflicts in the XXI Century" in Interpsiquis XIX Virtual International Congress of Psychiatry, Psychology and Mental Health Nursing. Congress held online internationally. Available at: https://psiquiatria.com/congresos/pdf/1-1-2018-13-pon4[1].pdf
Zizek S (2012). "The perverse guide to ideology." Zizek, S. (Script) and Fiennes, S (Director). Documentary film. United Kingdom: Production Companies: Co-production United Kingdom-Ireland; P Guide LTD / Blinder Films / Bord Scannán Na Héireann / The Irish Film Board / Film4 / British Film Institute Film Fund / Rooks Nest Entertainment