A Phenomenologically Inspired Framework of the Experience of Depression Described in First-person Testimonies

Possibility, Ability, and Being with Others in Depression

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Table of Contents

Preface

Nowadays we think we know what depression is, it has been consistently present in our society – be it the result of psychological trauma and adverse events, the demanding and overwhelming nature of everyday life, or a disease of the brain that alters what we feel, what we think, and ultimately who we are. Indeed, the condition has occupied the forefront of public awareness and scientific research across various disciplines for many decades now, so that by now we are often mislead into thinking that we have understood and explained it, at least to some extent. Diagnostic manuals in psychiatry specify its symptoms and signs into neat distinct categories, antidepressants promise its alleviation and the return to normal life by 'fixing' aberrant neurochemistry. But they miss one thing – what it really feels like to experience and live with depression for those afflicted with the condition. I still very distinctly remember starting to read a first-person account of depression for the first time, Andrew Solomon's (2001) renowned "The Noonday Demon" quite some time ago. I thought I knew at least to some extent what depression is – it is a mental illness, characterized by low mood, absence of interest and pleasure, feelings of guilt and shame – and it can be treated with the help of medication, which targets the underlying serotonin imbalance. But what this memoir described was not merely an illness characterized by symptoms and associated with changes in brain chemistry. It described a sudden assault on everything one had ever known and held dear. It described an existence in darkness, without any meaning, purpose, or direction. It described a pervasive and all-encompassing loss that one could not make sense of. Everything was different in depression – one could not work, love, imagine, think, hope, be with others. This was a predicament of immense suffering that was not only intolerable but also seemed permanent and ever-lasting. I was struck by how little I knew about depression, by how little everything I knew about it captured what Andrew Solomon described in his autobiographical account. And philosophy in general, and phenomenology in particular, as I had gotten to know them in Osnabrück offered themselves as the best means to provide me with what I was missing to attempt to understand and explain the experience of depression described in first-person testimonies. Particularly the research project "Emotional Experience in Depression: A philosophical Study" headed by Prof. Dr. Achim Stephan and Prof. Dr. Matthew Ratcliffe was the perfect setting for this.

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Introduction

> Depression obliterates the tangible. It removes us to its own landscape, remote as the Yukon from the quotidian world where the great majority – including depressives in remission – live and love and work and plan. Those concepts – live, love, work, plan – scarcely apply here. Depression robs whatever present-day pleasure we're accustomed to deriving from them, and the future, to the depressed person, looks like nothing other than an endless loop of now. Nothing will help. Just drawing breath after odious, laborious, stale breath begins to seem pointless. (Smith 1999, 21)

Depression is a disorder of affect, which is estimated to affect 300 million people worldwide and was recently declared as the leading cause of disability in the world (World Health Organization, 2017). It is diagnosed on the basis of the observation and report of particular symptoms that are defined in diagnostic manuals such as the International Classification of Diseases currently in its tenth edition (ICD 10), the Diagnostic and Statistical Manual of Mental Disorder currently in its fifth edition (DSM V).[1]

According to the DSM IV TR, unipolar or major depression[2] is diagnosed in the presence of at least one major depressive episode (DSM IV TR, 369). The diagnosis of a major depressive episode requires the presence of five or more of the following symptoms:

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[1] Throughout this work, I consistently refer to diagnostic criteria for depression and further mental disorders (e.g. in Chapter 1, Appendix 3, and Appendix 5) as specified by the DSM-IV-TR (2000) as these were the criteria in use in medical diagnosis at the time of production of the majority of testimonies I researched. Moreover, specifically regarding depression, the diagnostic criteria have not been revised substantially in the new edition. One notable change should be explicitly mentioned here, though – the exclusion of the so-called 'bereavement criterion' from DSM V (2013, 160-161), which also instigated a lot of rigorous debate both in psychiatry and clinical psychology (e.g. Lamb, Pies, and Zisook (2010); Friedman (2012); Wakefield and First (2012); see also Zachar, First, and Kendler (2017) for an overview of the debate and a historical account for excluding bereavement from the diagnosis of depression) and in the wider public (e.g. among others in "The New York Times", the editorial "Good Grief" and in "The Guardian" the critical commentary "Grief is Good News for Pharmaceutical Companies"). According to the DSM IV TR (2000, 356), the diagnosis of depression should not be administered to individuals who meet the criteria for a depressive episode if this happens shortly after they have experienced the loss of a loved one. Depression and (intense) grief are usually both associated with feelings of sadness, altered sleep patterns, loss of interest, feelings of guilt, etc., which motivate the exclusion of cases of bereavement as the presence of the diagnostic criteria is the result of an (emotional) response, which is neither abnormal nor dysfunctional. The DSM V does not acknowledge this exclusion anymore as cases of (intense) bereavement can commonly precipitate the onset of a major depressive episode. The discussion of the reliability and validity of DSM V criteria of depression exceeds the scope of this work. Its particular relevance in this context pertains to potential over-diagnosis and will be briefly discussed later in this chapter.

[2] It can be distinguished between two major forms of depression – unipolar and bipolar (also known as bipolar disorder). While both are affective disorders, the former is characterized by the presence of major depressive episodes only while the latter also includes manic episodes. Unipolar or major depression, moreover can have different forms with respect to severity (e.g. mild, moderate, severe), duration (e.g. recurrent or chronic), onset (e.g. post-partum). Nevertheless, all of them include major depressive episodes as their most characteristic feature. Subsequently, I use the term 'depression' throughout this work to refer to all forms of unipolar depression as these do not significantly differ with respect to the experience (of major depressive episodes) associated with them. Although bipolar depression is characterized by manic episodes as well, only of handful of the authors of the studied testimonies reported of being diagnosed with bipolar disorder and in their testimonies described the experience almost exclusively of major depressive episodes. Whenever manic episodes were described in the testimonies, these descriptions were either explicitly introduced as capturing

(1) depressed mood
(2) markedly diminished interest or pleasure in all, or almost all, activities
(3) significant weight loss or weight gain without dieting
(4) insomnia or hypersomnia
(5) psychomotor agitation or retardation
(6) fatigue or loss of energy
(7) feelings of worthlessness or excessive or inappropriate guilt
(8) diminished ability to think or concentrate or make decisions
(9) recurrent thoughts of death, suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

The symptoms should be present nearly every day and cause clinically significant distress or impairments in important areas of functioning. Moreover, at least one of the symptoms should be either (1) depressed mood or (2) loss of interest and pleasure in activities (DSM IV TR, 356). These diagnostic criteria have been criticized on numerous grounds, some of which I am going to address later. Although this manner of diagnosing mental illness is fairly recent (the DSM I was published in 1952), depression has been consistently identified as one of the psychiatric conditions with longest historical traditions, which also are still at least to some extend implicated in the present diagnostic criteria. Thus, before proceeding to address the shortcomings of the DSM-classificatory and diagnostic approach, I am going to present a short overview of the history of depression.

1. Depression: Past and Present

Besides being one of the most frequently diagnosed and experienced psychiatric disorders, depression, it has been noted (e.g. Horwitz, Wakefield, and Lorenzo-Luaces 2016; Radden 2009, 5-16), has a long historical tradition and has been consistently associated with a set of similar symptoms. The changes in affect revolving around the characteristic depressed or low mood, sadness, despair, hopelessness, fear, despondency, and dejection have been consistently considered symptoms of depression from Hippocratic times till the present[3] (Horwitz et al. 2016, 3). The first identifiable descriptions of melancholia produced by

these episodes, or it was clear from the experiences reported in them that they were occurring within a manic episode only.

[3] Jennifer Radden (2003) also similarly observes that ancient descriptions of depression share a focus on states of sadness, fear, and despondency with present ones but warns against equating present-day depression with melancholic states of the past specifically with respect to its theoretical implications for diagnosis, classification, and treatment.

Hippocrates in the fifth century defined the condition as characterized by "fear or sadness that last a long time" (Hippocrates 1923-1931, Vol. IV, 185 as in Horwitz el al. 2016, 3) accompanied by "aversion to food, despondency, sleeplessness, irritability, restlessness" (Hippocrates 1923-1931, Vol. IV, 263 as in Horwitz el al. 2016, 3). These, moreover, should last an unusually long time to be indicative of an illness. Melancholia was considered to result from an excess of black bile that itself could be caused by a wide range of factors such as "diet, lifestyles, living conditions, and atmospheric elements" (Horwitz et al. 2016, 3). Melancholia, in Hippocratic times, thus, was a condition of abnormal sadness, fear, and despondency that resulted from a humoral imbalance localized in the complex relationship between individuals and their surroundings. Its nature of a disordered or pathological reaction was based on its excessive duration with respect to the circumstances triggering it.

One of the most influential and richest contributions to the discourse on depression is Robert Burton's (1621) "The Anatomy of Melancholy", which also was inspired by the Hippocratic tradition. He also focused on the presence of feelings of sadness and fear that appeared without an apparent cause and elaborated on the various manifestations of responses to loss across individuals (Horwitz et al. 2016, 5-7). While his work was undoubtedly a central contribution to the discourse on depression, it did not introduce a novel understanding of the condition. Starting in the seventeenth century with the introduction of new scientific methodology, melancholia became a condition of the nervous system and the brain with a "uniform presentation in each individual" (Horwitz et al. 2016, 8). Here, also different forms of melancholia were distinguished based on their manifestations – one associated with sadness, fear, hopelessness, and another, neurotic melancholia that was more akin to the cluster of diseases of nerves (Horwitz et al. 2016, 8). These were two different conditions rather than states along a melancholic continuum and accordingly were associated with different treatments – while those suffering from nervous depression were treated mainly by general medical professionals or such specializing in the diseases of the nerves on an out-patient basis, melancholic patients were treated by psychiatrists as in-patients (Horwitz et al. 2016, 8).

Emil Kraepelin, the founder of modern psychiatry, focused on the study of the melancholic type and started establishing our present classificatory and diagnostic system by distinguishing first between depression and mania and dementia praecox (schizophrenia). Thereby, he also preserved the distinction between pathological or abnormal and normal affective responses with respect to their context (Horwitz et al. 2016, 9-10). Sigmund Freud, in contrast, was concerned mainly with the neurotic form of melancholia and focused on the distinction between grief, which could also be severe and long-lasting, but not pathological

or deviant in any sense, and melancholia. Generally, melancholic conditions were seen as resulting from a brain affliction or dysfunction, while neurotic disorders were the result of psychosocial factors, especially the loss of a loved object (Horwitz et al. 2016, 10). The distinction between grief and melancholia was preserved until recently.

The first two editions of the Diagnostic and Statistical Manual of Diseases (DSM I, 1952 and DSM II, 1968; American Psychiatric Association) generally preserved Kraepelin's distinction between melancholic and psychotic states and viewed neurotic depression as the manifestation of underlying anxiety disorders (Horwitz et al. 2016, 11-12). The third edition of the manual (DSM III, 1980), though, introduced a radically new formulation of depression that was retained also in the subsequent editions and abolished distinctions between unipolar forms that had melancholic and neurotic traits (Horwitz et al. 2016, 15-16). It still remained to some extent context sensitive as it excluded cases of bereavement from the diagnosis of depression. The introduction of this new definition of depression and the respective criteria "facilitated communication and understanding among the research community and provided diagnostic criteria that clinicians and researchers from a variety of theoretical persuasions could use. [And created] a reliable way of measuring depression" (Horwitz et al. 2016, 16). But it also was associated with major deficiencies. For instance, defining and diagnosing depression on the basis of these criteria, in particular by excluding only cases of bereavement, it obscured to a large extend the boundary between non-pathological but yet severe and prolonged responses to major losses of other sorts as well resulting in extreme cases in the pathologization of sadness and the over-diagnosis of depression (e.g. Horwitz and Wakefield 2007, 6-14).

2. Depression and Psychiatric Classification

Psychiatric classification, in particular that starting with the DSM III (1980), has been criticized on numerous other grounds as well. Here, I am going to address those that pertain to its focus on the nature of the diagnostic criteria resulting from their operationalized definition in particular[4]. It has frequently been pointed out that although the DSM attempts to remain atheoretical, many of its central terms are "either loaded with metaphysical assumptions […] or are tainted by reference to hypothetical extra-clinical, sub-personal processes" (Parnas and Zahavi 2002, 140). Moreover, it also does not include any account of human subjectivity and in consequence deemphasizes the patient's experience by

[4] See also Cooper (2004) for a discussion of its conceptual shortcomings; Regier, First, Marshall, and Narrow (2002) for a general historical overview of the development of psychiatric classification, its strengths, and limitations, and Thornton (2007, Chapter 5) for a detailed discussion of the validity of psychiatric classification.

attempting to focus on observable, behavioural manifestations (Parnas and Zahavi 2002, 140). Focusing on behavioural manifestations itself is also not grounded in any considerations about the relationship between experience, modes of experience and content and how it is expressed in human behaviour (Parnas and Zahavi 2002, 140). Thus, it has been frequently argued that the neglect of subjective experience in psychiatry is the result of the "pervasive lack of a suitable theoretical psychopathological framework to address human *experience*" (Parnas and Zahavi 2002, 140; emphasis in the original).

The attempt to remain atheoretical and the subsequent operationalization of diagnostic terms are the result of a major conceptual shift, which started with the DSM III. Consciousness and subjectivity are considered objects of study, and respectively "conscious events (such as delusions or auditory hallucinations) [are] well delimited, atomic entities that could easily be captured and quantified" (Parnas, Sass, and Zahavi 2012, 272). Under the influence of logical positivism, operationalized definitions of various experiential phenomena were derived. Operational definitions tell us how to operate in order to empirically check a particular concept, but this is not possible for the majority of phenomena considered symptomatic of mental illness such as delusions, hallucinations, identity disturbances, etc. that cannot be associated with any observable atomic facts (Parnas, Sass, and Zahavi 2012, 272-273). These phenomena are commonly presented and described in very diverse contextualized ways that escape such operational definitions. Subsequently, psychiatric classification became concerned with the assessment of objective signs and symptoms of various conditions and consistently attempts to convert (aspects of) first-personal experience into "specific categories of symptoms and signs that are defined in third-person terms" (Parnas et al. 2012, 270). This focus, it has been suggested, can be replaced by the an underlying phenomenological or phenomenologically-inspired theoretic foundation that can not only inform psychiatric classification but also provide the suitable basis for the study of changes in subjectivity and consciousness in their entirety.

These limitations of operationalized diagnostic criteria to many become very vivid when encountering first-person reports of mental illness. Taking a look at any first-person report of depression, one is struck by radical turn the author's existence has taken – rather than describing distinct altered or aberrant states and processes, her whole subjectivity has been transformed. And this transformation, moreover, carries specific meaning and significance for her. She is not merely sad, disinterested and anxious, rather everything and anything around her carries a sense of loss, indifference, and threat. She does not merely fail to enjoy her former hobbies, these have become an overwhelming burden. She fails to lead a life of meaning and purpose, all her endeavours, strivings, and projects have been rendered

pointless, futile, or have become beyond her means and powers. Thus, what has transformed for the individual suffering from depression is the structure and quality of all her subjective experiences and this, for many, has happened to a point where they are left with painful self-alienation, incoherence, and disintegration that themselves are integral to the experience of depression. And this undoubtedly does not amount to clinically significant changes in various states and processes but to a different way of being.

3. Phenomenology and Psychopathology

Phenomenology can aid the study of psychopathology in a wide variety of ways and traditionally it has focused on examining the essential features of experience that can serve to inform a valid classification of pathological conditions as, for example, in Karl Jaspers' (1959/1997) "General Psychopathology". By first and foremost providing the suitable and appropriate theoretical groundwork for the study of consciousness and subjectivity, for instance, it can aid in the identification of both the phenomena to be studied and categorized and their potential reduction to underlying changes in biological structures. Phenomenological psychopathology, moreover, examine the changes in the pre-reflective background rather than focusing on the identification of objective and observable signs and symptoms, which among other merits, can improve the validity of psychiatric diagnosis.[5] Adopting the theoretical insights and methodology developed by phenomenological approaches also allows for the consideration, explanation, and understanding of the various phenomena associated with mental illnesses in relation to the individual subject and her consciousness within which they emerge instead of the currently common focus on the identification, assessment, and study of these as isolated distinct occurrences (Fuchs 2010, 548). Diagnostic entities, or categories are, then, "certain *typical modes of human experience and existence*, reflected in their invariant phenomenological structures" (Fuchs 2010, 548; emphasis in the original). Thereby, phenomenology, moreover, can also discover and examine relations between what are commonly considered disparate and unrelated phenomena and psychiatric conditions and categories.

Some of the essential aspects of human subjectivity that have consistently been identified as particularly vulnerable to disturbances, especially in cases of mental illness are embodiment, temporality, and intersubjectivity (e.g. van den Berg 1972/2013, 5-18; Parnas and Zahavi 2002, 145-155; Fuchs 2010, 551-566). Phenomenological accounts traditionally

[5] For example, Doerr-Zegers, Irarrázaval, Mundt, and Palette (2017) propose that a phenomenologically oriented diagnostic approach to depression, which is motivated by the central role of disturbances of embodiment, can be used to avoid over-diagnosis of major depression.

distinguish between two modes of bodily experience – a tacit, pre-reflective one, in which the body is the medium of conscious experience and interaction (so-called living body or Leib) and a reflective one, in which the body becomes the object of experience. In the former mode, the body "constitutes the zero-point that permits my perceptual view on the world, while it is itself not perceived; it operates in every action and interaction with others, without requiring explicit attention" (Fuchs 2010, 551). In the latter mode, it becomes the object of experience, commonly through its failure to perform particular tasks. Then, instead of being implicit and conspicuous, it moves to the foreground of experience particularly in terms of how it impedes on our strivings. This, transforms our subjective perspective and tasks begin to appear effortful, insurmountable, etc. Disturbances of any of the modes, it has been suggested, are common to psychopathological conditions such as schizophrenia, depression, body dysmorphic disorder, and anorexia nervosa (Fuchs 2010, 552-558; Fuchs 2013; Fuchs and Schlimme 2009). In depression, for instance, the corporealization of the lived body precludes one's active strivings and appetitive behaviours (Fuchs 2005, 99-100), while in body dysmorphic disorder one becomes conscious of the object body as exposed to the gazes of others, which is commonly associated with experiences of shame and embarrassment (Fuchs 2010, 556; Fuchs 2002, 234-236)

Similarly, we can distinguish between implicit or pre-reflective temporality and explicit or reflective temporality. The former is not an object of conscious experience, but rather one of its essential features. Synthesis of the just-past moments, the present, and the moments to come endows consciousness with an implicit temporal dimension so that whenever we undergo any subjective experiences these are endowed with a sense of continuity and duration (Fuchs 2010, 558). In explicit temporality, in contrast, one becomes aware of one's past, present, and future, for example in autobiographical recollection (Fuchs 2010, 558-559). Disturbances in both implicit and explicit temporality are associated with several psychopathological conditions. In major depression and manic depression, for instance, there is, respectively, a retardation and acceleration of experienced temporal flow, which affect basic motivational drives (Fuchs 2010, 559; see also Fuchs 2001). In schizophrenia disturbances of the basic temporal structure of implicit time can be used to explain grave disturbances of agency such as delusions of control and thought disorder (Fuchs 2010, 559-560). The severe disturbance of the narrative self and the failure to integrate multiple autobiographical episodes into a stable, coherent, and continuous self-experience and -concept in borderline personality disorder can be explained by the disruption of explicit temporality (Fuchs 2010, 560-561). The present is experienced as lacking the structure and orientation that originate from the synthesis of past, present, and future so that the individual

suffering from borderline personality disorder feels disconnected from past episodes and cannot anticipate any continuity in the future. Consequently, she can identify only with that which she is currently experiencing.

The disturbances in one's being and interacting with others are common to almost all psychopathological conditions. These have most commonly been viewed as resulting from the disturbed or impaired development of particular mentalizing capacities, e.g. mind reading, which precludes one's access to others' mental states by means of theorizing about these or simulating them. According to phenomenology, in contrast, "intersubjectivity is primarily based on a pre-reflective, immediate relationship of self and other in an emergent bi-personal field" (Fuchs 2010, 562). The disturbances in experiencing and interacting with others, as for instance in schizophrenia, autism, and depression can be explained in terms of failures to enter or establish a shared bi-personal field that occur of different levels of intersubjectivity rather than in terms of deficits in theorizing or mentalizing. At the level of primary intersubjectivity, one gains a basic understanding of others and their actions through the participation in common practices. Already at this initial state of intersubjective experience and interaction, the actions of others are encountered as expressive of one's intentions in the context of embodied and empathic interaction. At the level of secondary intersubjectivity, one develops abilities such as joint attention and gaze following, which make it possible to go beyond the particular embodied interaction and refer to a general context. We come to encounter others as intentional agents and their actions as pragmatically meaningful. Moreover, in patterned interactions in particular, we become aware of being perceived by others as intentional agents within a common social space. The common social space also starts assuming a symbolic structure, which culminates in the development of language abilities and verbal communication (Fuchs 2010, 562-563; see also Gallagher and Zahavi 2002, 208-217 for a detailed overview of the levels of intersubjectivity). The disturbances of intersubjectivity occur at various forms in different psychopathological conditions. For instance, autism, which is still traditionally considered to involve a severe deficit in theorizing about others' mental states, can be explained in terms of disturbances of primary embodied intersubjectivity. These, moreover can also account for a range of impairments in social interactions that are present before the acquisition of the so-called Theory of Mind that enables mind-reading (Fuchs 2010, 563-564; Fuchs 2015; Gallagher 2004). In schizophrenia disturbances of secondary intersubjectivity disrupt the shift between a central first-person and decentered third-person observational perspective so that the patient cannot distinguish between the perspectives of self and other and consequently fails to integrate these in self-awareness and experience. This can result in experiences of thought

broadcasting, which reflect a failure of self-awareness in terms of a first-personal embodied experience that is now replaced by a disembodied view of oneself from the outside (Fuchs 2010, 565-566; Fuchs 2015; Gallagher 2004).

Phenomenological or phenomenologically inspired approaches to psychopathology by considering the essential structures of human subjectivity and experience in its entirety can also remain sensitive to how patients make sense of the various disturbances they are subjected to and attempt to (re-)establish a sense of coherence. The wide-ranging and encompassing changes in subjectivity in disorders like depression and schizophrenia, disrupt patterns of meaning and coherence and in many cases even make it impossible to lead the life one used to prior to the onset of the illness. Mental illness is not merely a conglomeration of seemingly unconnected distinct experiential and behavioural phenomena that are dysfunctional and cause significant distress or harm to the patient, but rather an all-encompassing, pervasive transformation of one's subjectivity that can be incapacitating and debilitating especially in terms of its wide scope – not only one's moods change in depression, also what one feels and is able to do differs radically, one does not just feel less interested, rather one cannot even imagine being interested in something, one does not simply lose faith that one will improve, but rather is not able to foresee anything else than doom and gloom in the future. One, in other words, exists in a radically different way that can be explained and understood only if we consider conscious experience and subjectivity in their entirety and also how the changes they undergo impact one and one's life, what meaning and significance they carry for those experiencing them.

Acknowledging the devastating effect on one's existence also involves remaining sensitive and accommodating the subjective suffering that those afflicted with mental illness experience. Suffering, most importantly, greatly exceeds the experience of incapacitation or distress related to various changes in subjectivity and encompasses also the profound self- and other-alienation and disruption of the pursued trajectory of one's everyday existence. As mentioned above, the changes in all aspects of subjectivity have grave effects on one's life, which render all former active pursuits of any socially, culturally, and personally significant projects and endeavours impossible, incoherent, and meaningless. One, so to say, loses his grip on life, particularly on that life that was both expressive and constitutive of one as the person, the unique individual that one is. One feels left at the mercy of something one cannot control, which is powerful and overwhelming that it controls every aspect of existence. And this loss effaces one, one loses everything that used to be essential, unique, identificatory in any way. And suffers for losing it and attempts to regain a grip on a meaningful existence, establish order from the chaos of mental illness, understand what is happening and why.

Suffering is an essential component of the experience of mental illness, particularly in terms of the self-alienation and loss of control over one's existence, of one's habitual or common way of leading a life.

4. Outline of the Dissertation

In this work, I am going to propose that the experience characteristic of depression is an amalgamation of alterations in three main structures in the experiential background, which endow our subjectivity with particular form and quality – the pre-reflective experience of possibility, of agency and ability, and of intersubjectivity. It might be argued that I thereby depart significantly from phenomenological accounts of psychopathology, which focus on embodiment, temporality, and intersubjectivity as discussed above. While this is indeed the case, this departure is motivated by a specific aim, that of explaining the *lived experience* of depression in general, which encompasses the range of more or less specific experiential phenomena, their meaning and significance for those experiencing these, but also how they transform existence into a depressive mode of being. The latter, somewhat extended focus, includes sensitivity to particularly those changes in subjectivity, which are experienced and identified as relating to a predicament of suffering and torment, which is almost invariably emphasized in first-person testimonies of depression. Experiencing and living with depression are two inseparable aspects that are fused together in the depressive mode of being[6]. Therefore, phenomenology as the study of lived experience can aid us in understanding what it feels like to be depressed and live with depression. So, the search I embark on starts off by identifying the *major themes* resurfacing in first-person reports, which present us with the most basic aspects of the depressive mode of being specifically in view of their detrimental and devastating impacts on one's habitual or taken for granted existence. These reflect not only significant changes in experience but also especially those that have shattered and disturbed what is most essential and valued by one. These major themes, I suggest, are the *main structural aspects of depressive experience* and already incorporate the ones

[6] While in a former examination of the so-called 'depressive comportment' (Jacobs, Stephan, Paskaleva-Yankova, and Wilutzky 2014) the main focus was on the identification and study of alterations in existential feelings or background orientations, here I aim at examining also how particular background orientations are formed in cases of disturbances in more fundamental background structures. Moreover, here, I also sketch a proposal of how changes in the existential background can be differently manifested in reflective experience under the influence of different patterns of individual, social, and cultural significance with a specific attention to socially stigmatized instances. Kerrin Jacobs (2013, 2), moreover has also provided a detailed and insightful analysis of what she terms 'the depressive situation', which is "is characterized by such structural changes in evaluative processes, which contribute to characteristic experiences and modes of enaction that differ significantly from non-depressive ones". The specific focus here falls on evaluative processes and their radical alteration in depression. My examination of the experience of depression or the depressive mode of being is of a broader scope by attempting to identify, examine and understand wider-scope changes, which inevitably also include changes in evaluative processes of this sort.

that occupy the central stage in phenomenology, namely embodiment, temporality, and intersubjectivity.

What first-person accounts of depression describe is that the depressive mode of being, which replaces formerly meaningful existence, is characterized by radical changes in what *is possible*, what one *is able to do*, and how one *relates to others*. These changes render existence meaningless and pointless, prevent one from pursuing one's strivings and endeavours, and confine one to a world of loneliness and isolation that can be manifested, explained, and understood in various ways by those afflicted with depression. In developing this phenomenologically inspired proposal, I also attempt to touch on some issues that are central to understanding what being afflicted with depression is like that are commonly not in the focus of phenomenology such as social stigmatization, oppression, and their impacts on the own personhood and personal identity. Nevertheless, these are very frequently identified as integral to experiencing and living with depression and, I am going to suggest, are still in need of detailed study and illumination in order to understand depressive experience in its entirety.

In this endeavour, first-person testimonies of varying degree of narrativity, I am going to argue, are the most suitable and appropriate source of material for understanding the experience of depression. The first chapter of this dissertation is going to be dedicated to introducing the main source of testimonies of depression I studied – a collection of anonymous accounts of depressive experience produced in response to an online survey. In doing this, I am going to elaborate on some potential restrictions and problems associated with this material, namely that of the presence of additional mental illnesses that can present us with descriptions of experiences not associated with depression and how the present study controlled for it. Then, I am going to proceed to a detailed discussion of the specific methodology deployed for studying the anonymous testimonies of depression and the considerations that motivated this choice. I am also going to introduce an overview of the classification of experiental phenomena the study of first-person testimonies resulted in. The experience of depression is characterized by a wide variety of different experiential phenomena that are manifestations of changes in the pre-reflective sense of *possibility*, of *agency and ability*, and of *intersubjectivity*. While these are commonly pre-reflectively experienced and most of the time for most of us establish a stable background of being embedded in a world shared with others, their radical changes in depression introduce different background orientations or ways of being (Ratcliffe 2005; 2008) that amount to a radically different existence.

The second chapter is dedicated to arguing for the central role of narratives in studying and understanding the experience of mental illness and in coming to terms with it. By first examining the major tenets of narrative theories of the self and experience, I am going to highlight the particular characteristics of self-narratives that make them essential to both establishing meaning and coherence in mental illness and to the study of the lived experience of depression in particular. These, I am going to suggest, are to be found in their perspectival nature (Goldie 2011; 2012, Chapter 2) that endows them with explanatory, revelatory, and expressive powers that aid in understanding and explaining what it is like to be in a radically different mode of being.

Chapter 3 is dedicated to the examination of the alterations in the experience of possibility. I am going to suggest that individuals suffering from depression fail to encounter individual possibilities, specifically such that move them to actively engage with the world. This disturbs their active embeddedness in the world in several ways. It transforms them into passive observers of the pace of life and disrupts their common or habitual engagements with the world. Thereby, moreover, the essence of our common anticipation of the future is disrupted so that one is confined to the present moment of intolerable suffering. The lack of active engagement presents the future as devoid of (positive) prospects and essentially lacking a structure. These changes establish, respectively, background orientations of threat and insecurity and loss of hope and meaning. Furthermore, the failure to anticipate relief places one in a predicament of ever-lasting intolerable suffering, which presents death (by suicide) as the only possible relief.

In Chapter 4, I proceed to discussing the changes in the experience of agency. Testimonies of depression frequently include descriptions of a radically altered or even lost (experience of) agency that their authors describe in terms of (feelings of) inability. In doing this they report of two broad kinds of abilities that have been lost or diminished – (1) those necessary for the performance of commonly effortless and automatically carried out routine activities and (2) general capacities that one deploys for more complex, non-routine activities. The (experienced) loss of these prevents individuals suffering from depression from the active pursuit of a wide range of practical endeavours and ultimately is detrimental to their well-being. The former kind of abilities, presents us with skills that enable us to engage in the everyday routine activities, which structure our lives. While at least some of these are still performed in depression, how they are encountered and carried out differs radically – rather than automatically engaging in these without the need of deliberation or the experience of effort, depressed individuals experience these as effortful, burdensome, and demanding. They are often performed on the basis of their normative significance alone. Skills (e.g.

Merleau-Ponty 1945/2002, Dreyfus undated), I suggest incorporate a pre-reflective experience of normative significance, which when lost can be replaced by practical reasoning motivated by continued identification with specific practical identities (Korsgaard 2009; 2014). The loss of skills is commonly described in bodily terms and, thus, can be understood as resulting from disorders of embodiment, namely the corporealization of the lived body (Fuchs 2001, 2005).

The loss of capacities also radically affects performance. While it also makes it difficult to carry out a range of various activities, it is experienced and described in terms of its impacts on the quality or level of performance. Individuals suffering from depression frequently refer to failing to function, making mistakes, performing poorly, etc. in many contexts. These descriptions suggest that capacities, unlike skills, are associated with an evaluative aspect of agency, namely of the own performance with respect to, for instance socially and culturally shared standards. Both instances of (experiences of) loss of abilities culminate in a loss of the sense of agency that can culminate in the discontinuation and abandonment of one's common active engagements with the world and disturb meaningful existence by transforming it into a mode of passive being.

In Chapter 5, I discuss the final major theme addressed in testimonies of depression – that of (social) isolation and loss of relatedness to others. Intersubjectivity occupies a front-row seat in phenomenological analyses and it has been consistently argued that it is plays a constitutive and developmental role for the experience of reality, self-experience, and, naturally, social interactions with others. Depression is only rarely associated with disturbances of reality such as hallucinations or delusions as in cases of psychosis. Nevertheless, I suggest that it is characterized by a specific failure to share reality with others, namely by failing to adopt a shared second-person perspective, which is essential to experiences of sharing a common world with other subjects and relating to them. The depressive mode of ever-lasting suffering, loss of meaning and purpose of existence, hopelessness, and inability radically differs from that of others and thereby establishes an unbridgeable gap that makes it impossible to sustain the shared second-person perspective required for participatory sense-making and establishing the basis for social interactions. Against this background, others are encountered as radically different and not understanding one. The breakdown of the shared second-person perspective, moreover, alters how one experiences oneself as well. It confines one to the solitary position of a disengaged observer and entity of observation and replaces implicit and explicit first-personal reflection with the foreign perspective of the observer of a disembedded and unrelated entity. In particular in

combination with disturbances in agency, this establishes background orientations of depressive shame and guilt that further alienate one from others.

The social alienation characteristic of depression comes also in the form of interpersonal disembeddedness, which impacts one's engagement and participation in the world of persons by posing restrictions on one's personhood and (moral) agency. While for some this might be merely a by-product or a secondary phenomenon resulting from social and cultural contexts, testimonies by individuals suffering from depression consistently describe it in particular with respect to its detrimental and devastating effects on sustaining a meaningful person-life. Here, I propose that we can understand social isolation specifically in terms of the impact of so-called oppressive master narratives (Lindemann Nelson 2014, 109-117) that embody and propagate socially stigmatized conceptions of depression. Adopting these narratives, commonly results in the failure to recognize and appropriately respond to individuals suffering with depression. Consequently, they can be excluded from a range of social practices and also withdraw from such. Most importantly, being confronted with failures of recognition and response, they are likely to experience shame, embarrassment, or even guilt with respect to their illness. While one might already find oneself in background orientations of depressive shame and guilt, I propose that socially stigmatized conceptions of depression further compound and emphasize these.

In the final chapter of this dissertation, I focus specifically on the presently dominant conceptions of depression particularly in view of their effect on the how the changes background orientations are expressed and manifested. In doing this, I engage with the study of the differences in understanding and experiencing depression in two different cultural groups as reflected in the responses provided to the anonymous survey administered in two different countries – Great Britain and Bulgaria. While in both samples of testimonies the same two broad kinds of conceptions were reported, namely that depression is a pathological psychological reaction to adverse life events and that it is an illness caused by aberrant neurochemistry, the variants these subsume differ with respect to the stigmatizing assumptions. While both cultural groups associated mainly the former conception with negative evaluations of those afflicted with depression, these are more pronounced in Bulgarian society. Depression is frequently seen as indicative of personal shortcoming and weakness and is to at least some within the volitional and voluntary control. This added burden of responsibility for being ill emphasizes the manifestations of shame and guilt.

1. Studying the Experience of Depression

The experience of mental illness is complex and frequently resists description. It has nonetheless become the subject of and motivated the creation of multiple autobiographical accounts over time. Moreover, testimonies of the experience of depression can also be elicited in other formats as well such as surveys and interviews. In this dissertation, I focused on two formats of testimonies of depression – anonymous responses to an online survey and published autobiographical accounts, or memoirs. In this chapter, I am going to present the particular motivations and aims that drove my analysis of the experience of depression described in these. First, I am going to present the main source of testimonies central to developing a classification of experiential phenomena, the Durham Depression Questionnaire (DDQ). Then, I am going to discuss in detail the particular methodology deployed for studying the testimonies of depression and the reasons for it. And finally, I am going to present an overview of the classification of experiential phenomena, which will be the main subject of the chapters to follow.

1. The Durham Depression Questionnaire

Testimonies of the experience of depression can come in various forms such as book-length autobiographical accounts, anonymous first-person reports gathered by medical health professionals in the course of assessment and treatment of depression, historical documents recording descriptions of living with and experiencing depression, mental-health online forums, and responses to questionnaires designed to elicit descriptions of the experience of depression. Unlike published autobiographical accounts, those that remain anonymously authored, it is important to mention here, are more likely to include desrciptions of what are commonly considered socially inacceptable affective states, thoughts, and behaviours such as for instance anger, hostility, and irritability, (social) anxiety, and the respective tendencies towards withdrawal and avoidance of social situations specifically in view of these. Moreover, the shield of anonymity might make those subjected to the social stigmatization of mental illness in general feel protected so that they are more likely to share their experience. With the recent developments and advances in technology, the anonymous sharing of testimonies has become even more wide-spread and convenient. Large numbers of mental health and depression forums offer their users the possibility for describing and sharing their experience of and with their illness whereby this can be done from different locations such as their homes, etc. In my research of the experience of depression as described in first-person

testimonies, I focus on two kinds of first-person reports, anonymous descriptions of experience produced in responses to an online questionnaire, the Durham Depression Questionnaire, and published autobiographical accounts of suffering from and living with depression. The study of the anonymous testimonies was the main source for developing a detailed classification of the experiential phenomena constituting depression. These phenomena were, moreover, also consistently reported in autobiographies of depression as well.

The Durham Depression Questionnaire was created in 2011 as part of the joint AHRC (the UK's Arts and Humanities Research Council)- and DFG (German Research Foundation)-funded project "Emotional Experience of Depression: A Philosophical Study" run by researchers at Durham University UK and the University of Osnabrück, Germany. Its original version in English (DDQ UK)[7] was made available online by the UK mental health charity SANE on their homepage. It is designed to elicit testimonies describing various aspects of the experience of depression in response to open questions. The survey consists of an information sheet, consent form, and two sections of questions (the questionnaire can be found in Appendix 1 "Overview of the Durham Depression Questionnaire (DDQ UK)"). The participant information sheet provides an overview of the study, its motivation and aims, the development of the questionnaire, and information about confidentiality and the options to proceed when participating in the survey. Section A encompasses ten questions that inquire about the following general (background) details: age, gender, country of residence, diagnosis of depression, year of diagnosis, details of diagnosis, treatment for depression, the presence of other psychiatric diagnoses, details about other diagnoses, and whether one is depressed at the time of completing the questionnaire. Section B inquires in detail about various aspects of the experience of depression in thirteen questions (responses to Q1B-Q8B were in the focus of this dissertation), which range from descriptions changes in moods, emotions, and feelings (Q1B), changes in how the world (Q2B), others (Q3B), the own body (Q4B), and time is experienced (Q6B), how one's performance of everyday activities (Q5B) and thinking changes (Q7B), how one thinks of life (Q8B). Furthermore, respondents could also provide details on the effects of medication (Q9B), how they conceived of and understood their condition, what causes they attributed it to (Q11B), what aspects they found difficult to communicate to other people (Q10B), what they have consulted in their attempts to understand depression (Q12B), and indicate further important aspects of experiencing

[7] Throughout this work, I am going to use the 'DDQ UK' and 'DDQ BG' when referring to, discussion, and introducing passages and responses submitted to, respectively, the British and the Bulgarian version of the DDQ.

and living with depression that are not covered by this questionnaire (Q13B). All questions in Section B could be answered in the participants' own words in free text. The respondents could write as much or as little as they desired in their responses and some of the answers they provided were limited to a few words while others were substantially longer. It was also possible to terminate working on the questionnaire altogether or only temporarily: in the latter case, the respondents could continue completing the survey at a later time by logging in and resuming answering the remaining questions. In 2012, the DDQ was translated to Bulgarian (DDQ BG) and administered online as well. This version will be discussed later in the chapter.

1.1. Testimonies of Depression Submitted in Responses to the DDQ UK: Overview, Background Information, and Sampling Criteria

A total of 148 responses were submitted in response to the DDQ UK. The majority of respondents (120) were female (25 were male; one respondent indicated a confused gender; one indicated being gender queer; and one did not indicate gender), which is also in line with the recorded general higher prevalence of depression in women. The respondents' age ranged from 16 years to 76 years. They indicated in various detail and specificity the different depression diagnosis they had received such, for instance the commonly indicated unspecific diagnosis 'depression', to more specific ones such 'major', 'clinical', 'severe', 'mild', 'moderate', 'recurrent', 'chronic' depression. Among the diagnosis of depressive disorders, there were such of post-natal, dysthymia, cyclothymia, and seasonal mood disorder (see Appendix 2 "Background information DDQ UK" for an overview of the respondents' age, gender, and details about their diagnosis of depression and further psychiatric conditions). Several participants indicated being either diagnosed with a bipolar disorder or being currently under observation to determine the diagnosis of such and in their responses to the questions in Section B described their experience during depressive episodes and at only a few instances explicitly compared it to that during manic phases. Throughout this work, I will adopt the term 'depression' to refer to all instances of depressive disorders reported by the participants and authors of memoirs.

Many of the respondents to the DDQ UK indicated the presence of additional psychiatric diagnoses as well (85 respondents indicated having not being diagnosed with further psychopathological conditions; 60 reported of being diagnosed with at least one further psychopathological condition). These range from other affective disorders such as phobias and generalized anxiety disorder, through eating disorders to personality disorders in some cases. The individual additional psychiatric diagnoses were examined in a preliminary

study of the submitted responses in order to establish criteria for the sample of testimonies to be analysed here so that it includes descriptions of experiential phenomena associated with depression rather than with further psychopathological conditions or non-pathological mood states (See Appendix 3 "Overview of Sampling Criteria DDQ UK" for an overview of the criteria for the choice of testimonies to be studied and the symptoms of additional psychopathological conditions, which they were based on).

The term 'depression' is deployed to refer to a wide range of phenomenal states that exceed pathological conditions of major or clinical depression such as (long-lasting) episodes of intense sadness and low mood, emotional distress in general, hopelessness and despair, etc. While these are also of profound importance, my focus here is the study of the experience of pathological cases of depression rather than those of non-pathological, albeit unpleasant and distressing emotional torment. Therefore, to focus on the study of the experience of depression as a mental illness, the analysis and interpretation of the testimonies from the DDQ was restricted to those whose authors indicated having received a medical diagnosis of depression (Sampling criterion 1 (SC1)). Furthermore, many of the additional psychiatric diagnoses reported in response to Q8A and Q9A[8] are associated with experiences that are in some cases similar to depressive experience to at least some respect (e.g. episodes of specific anxiety or fear in the case of phobias, altered perception and experience of the own body in eating disorders) or radically different (e.g. experiences of derealisation, delusions, and hallucinations that are associated with psychosis and schizophrenia but only rarely with depression). In order to avoid confounding both instances with depressive experiences, further restrictions based on the reported additional psychiatric diagnoses (Sampling criterion 2 (SC2)) were introduced.

Based on the SC1, only the testimonies provided by respondents who had received a medical diagnosis of depression were considered for further analysis. From the submitted responses, the authors of twelve testimonies indicated not having received an official medical diagnosis of depression. Thus, the remaining 136 responses to the DDQ UK were studied in view of the additional psychiatric disgnoses their autjors reported.

The sampling criteria based on the presence of additional psychiatric diagnoses (SC 2) formed two main groups. The first groups, SC2.1, encompassed additional diagnoses of disorders involving grave disturbance of the experience of reality, changes in personality, and affect, most commonly borderline personality disorder. Borderline personality disorder and

[8] *Q8A: Have you been diagnosed with any other psychiatric condition; Q9A: If you answered yes to the previous question, please provide brief details of what was diagnosed and when.*

personality disorders in general can be frequently associated with marked and rapid changes in affect, shifts in how they view others and relate to them, and radical alterations in self-image (DSM IV TR 526, 706). Also diagnoses such as psychotic or dissociative disorders and episodes can present problems for the study of depression-specific experience by presenting us with descriotions of experiential phenomena that are not equivocally associated ith depression or not characteristic of it. Consequently, after the exclusion of fourteen testimonies whose authors reported of an additional diagnosis of a personality or dissocitive disorder, a total of 122 testimonies for further examination of the individual responses to the question in Section B in view of additional psychiatric diagnoses.

The symptomatic changes in affect, thinking, and action for further conditions that are not closely associated with changes in underlying personality traits and structures or the intact experience of reality can also be problematic in the study of the experience of depression. Further affective and eating disorders, for instance, are associated, respectively, with changes in affective and bodily experience. In an attempt to identify depression-specific experiences, descriptions of experiential phenomena that could be related to these disorders were excluded as well (SC2.2). For this purpose, the responses to the questions in Section B provided by the participants were studied in view of the individual additional psychiatric diagnoses that can be associated with depression-like experiences and phenomena uncharacteristic of depression. Based on these criteria, the sample of testimonies to be studied included the following responses to individual questions from Section B of the DDQ UK authored by 122 respondents: 99 responses to Q1B, 107 responses to Q2B, 110 responses to Q3B, 105 responses to Q4B, 112 responses to Q5B, 109 responses toQ6B, 110 responses to Q7B, 107 responses toQ8B, 107 responses to Q9B, 107 responses to Q10B, and 106 responses to Q11B.[9]

1.2. Testimonies of Depression Submitted in Response to the DDQ BG: Overview, Background Information, and Sampling Criteria

The DDQ was translated to Bulgarian (see Appendix 4 "Responses to the DDQ BG" for the original version of the responses in Bulgarian and my English translation of these) and was available online with the help of the mental health organization "Adaptation" (амбулатория за психично здраве "Адаптация") that provided a platform for the link to the survey. Additionally, a link to the survey was also made available in an anonymous online forum for mental health dedicated to depression at www.puls.bg. A total of fifteen responses

[9] The numbers of participants who answered the individual questions in Section B varies also because some of these were not answered.

were submitted. Here, as well, there were more female respondents (twelve) than male respondents (only three). The youngest respondent was 17-years old and the oldest 51-years old, with the majority being in their early to mid-30s and early 40s. This rather young population can be mainly associated with the format of the study, as for some older individuals looking for information on mental health online might not be so common as they either are not used to using the Internet for this purpose (information specifically about health and mental health in particular) or be unwilling to participate even in anonymous surveys, especially those available online as the result of a general social stigmatization. A further factor for the small number of responses can be the general lack of awareness of interdisciplinary research of mental health, which is considered to be within the domain of clinical psychology and psychiatry.

From those who participated in the survey, only one respondent reported of not having being diagnosed with depression by a medical professional and their testimony was not studied here (SC1; for an overview of the sampling criteria and the responses that were not included in the sample to be studied, see Appendix 5 "Overview of Sampling Criteria DDQ BG"). In general, similarly to the background information provided in responses to the DDQ UK, the diagnosis of depression is frequently accompanied by a specification referring to its intensity (e.g. moderate or mild) and its recurrent or chronic nature. In one case, the process of diagnosis is described as offering several instances of affective disorders, which is, as also indicated by the responses to the DDQ common in medical practice. Some of the respondents to the DDQ BG indicated the presence of clinical anxiety or panic attacks as part of their depression rather than an additional diagnosis of a further affective disorder. The majority of the participants did not have additional psychiatric diagnosis. The testimonies produced by those who indicated the presence of an additional psychiatric diagnosis were examined analogously to the responses to the DDQ UK introduced in the previous sub-section so that the sample of testimonies to be studied included the following responses toquestions in Section B authored by 13 respondents (one respondents did not answer any questions from Section B): twelve (12) responses to Q1B, thirteen (13) responses to Q2B, eleven (11) responses to Q3B, thirteen (13) responses to Q4B, thirteen (13) responses to Q5B, twelve (12) responses to Q6B, thirteen (13) responses to Q7B, twelve (12) responses to Q8B, thirteen (13) responses to Q10B, and thirteen (13) responses to Q11B.

In general, the responses to the DDQ BG did not portray a radically different experiential profile than those described in the testimonies obtained with the help of the DDQ UK. They, nonetheless, revealed a difference in how depression is viewed and

understood in the two different cultural groups particularly with respect to the degree of social stigmatization of the condition and those suffering from it. The experience of depression and any mental illness in general is embedded and respective shaped by a variety of cultural influences. In order to explicate the subtle differences between the two samples of testimonies, in Chapter 6, I am going to focus on an examination of the respective conceptions and understanding of depression in particular as these embody the vast network of social and cultural beliefs and assumptions about illness, identity, etc. and the socially and culturally shared meaning of both specific affective experiences, thoughts, and behaviours in general and manifestations of illness in particular.

2. Methodology for Studying the Experience of Depression

The large number of anonymous testimonies produced in response to the DDQ UK were adopted as the primary sample of descriptions of the experience of depression to be studied and were continuously compared to the published autobiographical accounts that were deployed in this research project as well (Brampton 2008; Crafton 2009; Danquah 1998; Hatfield 2008; Lewis 2002; Plath 1963; Smith 1999; Solomon 2001; Thompson 1995; Styron 1990; Wurtzel 1994). Both formats of testimonies present us with numerous descriptions of a wide range of various phenomena spanning emotions, feelings, moods, cognitive styles, specific thoughts, behavioural and action tendencies, and bodily feelings and sensations. In order to understand how these constitute a radically different mode of being or existence and establish the general experiential character of depression, their analysis did not include a narrow focus restricted to specific types of states that were reported (e.g. only affective states, only cognitive states and processes, only bodily experiences) but rather attempts to provide a comprehensive framework, which integrates these in particular in view of the changes in underlying background structures as these are experienced and described by individuals suffering from depression. These aspirations motivated the development of a broad multi-level classification or categorisation of the phenomena described in the responses to the DDQ UK, which was compared and applied to the Bulgarian testimonies and to the sample of published depression memoirs. The last, unlike the majority of the anonymous testimonies, intertwine descriptions of depressive experience with recollections of the past, specifically of episodes relevant to the illness, include fewer descriptions of socially unacceptable emotions (e.g. anger, irritability especially with other people, guilt and shame), and only rarely describe experiences of temporal flow in particular. When discussing the alterations in the existential background in the next chapters, I am going to also explicitly refer to the respective descriptions of experience in memoirs as well.

The particular methodology that was adopted in studying the testimonies of depression was driven by two main concerns – on the one hand, I wished and attempted for this study to preserve and reflect the centrality of first-person reports and descriptions of depression in being and feeling depressed, and on the other, I set out to engage in a *phenomenologically* inspired or oriented study of depression, which determines: what is to be studied, namely the phenomena that constitute what it feels like to be depressed and the life of the individual afflicted with depression; how it is to be studied; and the theoretical background that is utilized to explain and understand the experience of depression. The combination of these concerns or motivations sets the framework of methodological considerations in the following way: (1) close attention to the identification of various phenomena that are described in first-person testimonies of depression regardless of their functional nature (e.g. affective phenomena, cognitive phenomena, behaviours and actions, bodily feelings); (2) this identification should also consider how they are described by the authors because finely nuanced differences in description can be indicative of differences in experiential profile, underlying structural changes, or the impact and meaning of these phenomena in the larger socio-cultural context of experiencing and living with depression; (3) the examination of testimonies of depressive experience is aimed at illuminating how changes in the pre-reflective experiential background give rise to the reflective phenomena described in them. Starting off on this particular endeavor to develop a *phenomenologically inspired framework of the experience of depression as it is described in first-person testimonies* is already at least to some extent theoretically informed, which places restrictions on what is to be studied and what theoretical considerations will be deployed for its analysis and interpretation. Based on these particular aspirations and in view of the aforementioned considerations and restrictions these imply, I attempted to develop and deploy a methodology that best suits my aim and motivation and the specific type of testimonies that are the core of my dissertation, namely anonymous testimonies and memoirs of depression. Consequently, a combination of phenomenological methodology and theoretical background and grounded-theory inspired initial analysis was adhered to.

Originating from sociology, the family of different grounded theory methods "offers a way of constructing sociological reality" (Charmaz 1990, 1162). Using the grounded theory methodology, the researcher constructs a *theory* from the available data by creating theoretical categories and analyzing the relationships between categories (Charmaz 1990, 1162). For instance, the grounded theory methodology developed by Kathy Charmaz (1990, 1162) starts with the "data from the lived experience of the research participants" with the aim of closely attending to how they construct their worlds. Correspondingly to this commitment, the

grounded theorist does not begin with a pre-formulated theoretical hypothesis. Rather the categories emerging from the data "explain and conceptualize (1) the data, (2) common sense understandings of these data, and, likely, (3) other theoretical interpretations" (Charmaz 1990, 1162). Thereby, the resulting theory is *grounded* in the data. Moreover, the emerging categories and concepts from the data are further deployed to mold the data collection process. Essential to this methodology is that it initially lacks any theoretical commitments – the researcher approaches the data without any pre-conceived categories and hypothesis.

While grounded theory offers at first glance a suitable methodological approach for studying the lived experience of depression, I found this problematic specifically given the nature of the materials to be deployed for its study (narrative testimonies) and my research interest and question. First of all, the testimonies I examined were in a way static – these are texts produced either in response to a particular survey with open questions or published autobiographical accounts. This did not allow for a modification of adjustment of the interview process upon examination of a part of the testimonies. It could be argued that upon an examination of some of the testimonies, a selective focus on what and exactly which descriptions of the testimonies were to be further studied. While this might refine and restrict the research question to, for example, "What are the relationships between the most salient and frequently described affective experience in depression?", it would also lead to neglecting a large number of further phenomena, which those afflicted with depression undergo during depressive episodes and identify as constitutive of what depression feels like for them. For instance, this would exclude the examination of (commonly not affectively charged) feelings of inability and incapacity, the changes in temporal experience in its different variants, etc. Second, while I, in line with grounded theory did not approach the data with a pre-formulated hypothesis that had to be confirmed or disconfirmed by it, I did have a particular research question couched in a specific theoretical tradition, namely "What is the phenomenal profile of depression as described in first-person testimonies of the condition?", which aims at studying the phenomenon of depression from a particular perspective, namely that of phenomenology, which itself is accompanied with a methodology and conceptual apparatus of its own. So, while I did not pre-conceive of categories of experiences before studying the testimonies, some basic theoretical considerations were already in place – that the phenomena described are reflective instances of experiential phenomena, which span affective states such as moods, emotions, and feelings, bodily experiences, cognitive states, and action patterns or behaviours. These then, were to be studied within the larger framework of phenomenology in particular so as to identify and examine in detail both how they differ from non-pathological experience and how they are related to changes in the

experiential background. This, already at the onset of the inquiry, introduces some conceptual considerations unlike cases of grounded theory research. And finally, a yet further characteristic of applying grounded theory methods to the study of the experience of depression is that it would result in a theory of the experience of depression. I find this problematic, in particular, in view of the large variability of both experiential states and their individual phenomenal character. A theory, strictly speaking, is a scientific construction, achieved by postulating abstract entities or constructs, which might not be observable. These are organized in a coherent structure by laws and regularities that focus on causal relations among the entities and the phenomenon or process the theory addresses. Theories in general, moreover, enable the explanation and prediction of the phenomenon in question. Consequently, a theory of the experience of depression would have to explain and predict how it develops, what forms it takes in particular cases. Upon the examination of numerous accounts of depression, I am hesitant to engage in such an endeavour and highly skeptical that a theory of what it feels like to be depressed is possible at all – the experience of depression is not only immensely complex, in the sense that it encompasses a large multitude of various reflectively experienced phenomena (which actually are what clinicians are presented with), but also can vary immensely depending on its contextualization in social, personal, cultural, political, and even economical settings.

In view of the aim to understand the experience of depression, phenomenological research methods provide us with an apt and suitable framework. Phenomenology „attempts to gain insightful descriptions of the way we experience the world pre-reflectively, without taxonomizing, classifying, or abstracting it. [...] it offers us the possibility of plausible insights that bring us in more direct contact with the world“ (van Manen 1990, 9). Thus, following the general orientation of the phenomenological research methodology, there is no need for abstraction from the first-person experience of illness by focusing on the construction or the emergence of abstract concepts, which explain it in attempting to answer the research question “What is the experience of depression?”. The resulting product of a phenomenological analysis of the experience of depression is, then, “a thematic description of the pre-given “essences” and structures of lived experience” (Starks and Trinidad 2007, 1373).

Thus, within the general framework of phenomenological inquiry and sharing a lack of pre-formulated hypothesis and attention to identifying the phenomena to be studied from the data, with grounded theory, I first identified a multitude of reflective experiences

described in the sample of testimonies. Consider for example the following passages from the DDQ UK[10]:

> When I am depressed the main emotion that I feel is *loneliness*. I feel like I have no one I can turn to, and this *isolation* makes me feel trapped. […] I feel lost and completely separate from the world, and it feels like *no one has ever experienced what I'm going through* before. (R292UK, Q1B; emphases addedd)[11]

> I could be surrounded by friends, which I was in reality, but still feel ridiculously *lonely* and like *no one cared about me at all*. (R22UK, Q2B; emphases added)[12]

> Started when I was very young. Didn't understand it. Never mentioned it to anyone. Believed myself to be anti social and just 'different'. When I felt bad at this time of my life *I was very withdrawn, couldn't handle social situations, didn't want to talk to anyone*, when I did talk to people I was smiley and positive. (R161UK, Q1B; emphases added)

First, each sentence received one or more labels on the basis of the experiential phenomena described in it. Then, each passage and the respective labels it received were examined to determine commonalities between the labels and the experiences across testimonies. In the first passage, the experience of loneliness is framed in terms of how other people do not understand what one is going through and how one is feeling. The second respondent similarly feels lonely and isolated but rather in terms of how her close ones do not appear emotionally invested in her well-being. For the third respondent the experiences of loneliness and isolation from others are framed rather in terms of her failure or inability to (successfully) engage in such. Consequently, on the basis of this examination, these experiences were formalized as so-called codes[13], namely: (a) *others do not understand*, (b) *others do not care*, and (c) *inability to* socialize.

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[10] The individual responses to the DDQ are going to be anonymously introduced when referring to them throughout this work. In doing this, the anonymity of the respondents will be preserved by referring to them with the numerical identifier they received upon participating in the survey (for instance respondent 15 is going to be referred to as R15, followed by the abbreviation 'UK' or 'BG' to indicate respectively whether it was obtained by the British or the Bulgarian version of the survey respectively). Moreover, the question the respective passage was produced in response to is also going to be indicated in the following form: Q1B stands for question one from Section B.

[11] Q1B: *Describe your emotions and moods during those periods when you are depressed. In what ways are they different from when you are not depressed?*

[12] Q2B: *Does the world look different when you're depressed? If so, how?*

[13] The minimal unit of coding was individual sentences and the coding of testimonies was performed by using MAXQDA software. In the cases, in which individual sentences from the testimonies described more than one reflective experience, all of the respective codes were administered to it. And in cases in which several consequtive sentences described one and the same phenomenon, or one phenomenon was described in several sentences, the whole passage was administered the code rather than each individual sentence. The final version of the classification of experiential phenomena that is presented in Table 1 is the result of multiple phases of coding, each of which included revising and developing the classification and the coding system in the manner described above. Moreover, at various stages of the development of the classification of described phenomena, the anonymous testimonies were independently coded by several coders to insure reliability and validity of the codes and their administration. The coders (Jes Buster Madsen, Natalia Koperska, Nadine Haufe, Maria Carolina Lopez Rivero, Maximilian Wächter, and Ernesto Lopez Motecinos) performed this task as part of an

The close attention to fine nuances in (the descriptions of) reflective experiences resulted in the identification of a large number of such, which, some could argue, are not disparate phenomena but rather merely aspects of one and the same experience and the object of my study should be the latter, more general or wider-scope phenomena rather than the individual aspects. While this concern is valid in its own right, here, I aim at, first, identifying reflective phenomena as they are individuated and described by those suffering from depression, and then addressing each and every one of these within the framework of phenomenology. The multitude of reflective manifestations of this sort is, ultimately, what diagnostic criteria and similar operationalized notions are based on. Consider, for instance, the following response from the DDQ UK:

> When I'm depressed life never seems worth living. I can never think about how my life is different from when I'm not depessed. I think that my life will never change and that I will always be depressed. Thinking about the future makes my depression even worse because I can't bear to think of being depressed my whole life. I forget what my life is like when I'm not depressed and feel that my life and future is pointless. (R75UK, Q8B)[14]

Wanting to identify reflective experiences as these are felt and reported by the one undergoing them, in this particular case, I identified in the first sentence the experience of life as meaningless or pointless; the second, third, and fourth sentence refer to experiencing the present moment of suffering as eternal and ever-lasting, whereby the focus is on the lack of prospects for improvement or change and not on the meaning or value of life; and the last sentence describes again feelings of meaningless and pointlessness of existence as the first one does. Based on the specific aspects emphasized, I view these as distinct reflective experiences, rather than one wider-scoped experience of life as not worth living because of its unbearable quality and, accordingly, formulate three separate codes: the first and last reflective experiences are captured by the code *life is pointless*; while the second by the code *suffering will last forever*. While in this particular constellation reported here, some might argue that they are not separate experiences, I wish to examine them as such also because thereby each and every reflective phenomenon characteristic of mental illness can be related to changes in subjectivity in its own right. Thereby, if one were to undertake a systematic revision of, for example, operationalized criteria in line with the phenomenological tradition, this can provide a comprehensive and systematic basis of how various reflective experiences are related to changes in the pre-reflective experiential background. This, moreover, can also allow for a larger-scale comparative assessment of symptoms or experiences and underlying

interdisciplinary course in the context of their master's studies in Cognitive Science at the University of Osnabrück.

[14] Q8B: *In what ways, if any, does depression make you think differently about life compared to when you are not depressed?*

changes in the structures of consciousness across different mental illnesses and the study of impacts of social and cultural factors on experience and symptoms. While the experiences of life as pointless and meaningless and of the the present moment of suffering as lasting forever are indeed similar, they are not overlapping in the sense of, for instance, the latter being subsumed by the former. Rather, the subtle nuances that I wish to capture here can be understood as representative of commonalities of changes in the underlying pre-reflective experiential background. These, though, can be present individually and in a combination in cases of depression. It is not always the case that one might experience existence and life as meaningless and pointless because of the suffering one is undergoing at the moment. Likewise, undergoing immense suffering and emotional torment, which seems permanent is not always necessarily accompanied by experiences of life as meaningless and pointless. In other words, motivated by the varied descriptions of a large number of feelings, emotions, moods, action tendencies, thoughts, etc. in testimonies of depression, I wish this study to reflect this variety and heterogeneity without generalizing or reducing it.

This analysis resulted in the formulation of a number of codes, which capture individual, i.e. not overlapping or identical, reflective experiences. The reflective phenomnena were then clustered on the basis of the qualitative similarities they share, as in the example of experiences of loneliness introduced earlier in this section. Thereby, they can be understood as manifestations of more or less specific background orientations or existential feelings (Ratcliffe 2008, 2015) in line with the phenomenological theoretical tradition. And categories themselves are organized in three over-arching themes that were addressed by the majority (106) of the respondents to the DDQ UK[15] and can be understood within phenomenological theories of subjectivity as background structures of experience, namely the sense of *possibility*, of *agency and ability*, and of *intersubjectivity*. Thus, this study of testimonies of the experience of depression resulted in a three-fold classification of reflective phenomena, background or existential orientations, and pre-reflective structures of experience, which I am going to discuss in detail in Chapter 3, 4, and 5.[16] But before proceeding to this, in the section to follow, I am going to introduce some of the frequently described background orientations and reflective experiences in order to illustrate how codes

[15] Only sixteen respondents did not address all three themes in their testimonies, whereby eleven of them did not answer all questions in Section B.

[16] When engaging in these detailed discussions, I am going to introduce examples from the anonymous testimonies submitted in response to the DDQ UK, which describe various reflective expriences and the background orientations they are manifestations of. In doing this, I am going to indicate how many respondents described finding themselves in each of the background orientations (indicated by their description of at least one or more of its manifestations) and how many respondents refer to each of the reflective manifestations. Whenever I introduce the ratio of descriptions of background orientations and reflective manifestations, it is derived from the final sample of 122 testimonies produced in response to the DDQ UK and 13 testimonies produced in response to the DDQ BG.

and categories were derived from the testimonies (a detailed overview of all codes, their definitions, and examples of passages describing the experiences each of them captures can be found in Appendix 6 "Classification of the Experiential Phenomena Described in First-person Testimonies of Depression"). In doing this, I am also going to present the particular theoretical background, which motivated the creation of this classification, namely the notions of background orientations and structures of experience.

Loss of Possibility	Loss of Ability and Agency	Loss of Intersubjectivity
Disconnectedness	**Disturbed skillful engagement**	Loss of fundamental intersubjectivity
Disconnectedness and disengagement	**The failing body**	**Loneliness**
Numbing of the senses	**The resistant body**	*Others do not care*
Emotional numbness	*Lack of vital powers*	*Others do not understand*
	Heavy body	*Avoiding others*
Loss of hope	*The unreliable body*	*Craving contact*
Loss of point and purpose	**The ailing body**	*Inability to socialize*
Life is pointless	*Physical ailments*	**The disembedded self**
Activities are pointless	**Effortful routine**	**Shame**
Low mood	*Körper and effort*	*Feeling useless, worthless, a failure*
Emotional instability	*Chores have to be done*	*Avoiding socialization because I am worthless*
Sadness	*Postponing routine tasks*	*Others do not like me*
Crying		*Self-hate and disgust*
Lack of pleasure	**Incapacitation**	**Guilt**
Hopelessness	*I cannot function*	*Feeling a burden*
Suffering will last forever	*Unable to deal with life*	*Guilt and self-blame*
Lack of significant future	*Diminished performance*	*Fixating on the past*
Inability to induce change		*I do not deserve living*
Lack of security	Loss of agency and temporal experience	**Hostility towards others**
Sense of impending doom	*Time is irrelevant*	*Impatience and irritability*
Hostile world	*Everything takes forever*	*Perceptual hypersensitivity*
Withdrawing from an insecure world	*Running out of time*	*Anger*
Cognitive manifestations of the loss of hope		Interpersonal disconnectedness
Irrationality		*Others reacting to depression*
Downward spiral		*Master narratives of depression*
		Withdrawal due to stigma
Temporal experience		*Others are patronising*
Time drags		*Pretence*
Stuck to the present		
Waiting for alleviation		
Bodily experience		
Being weighted down		
Changes in appetite		
Being suicidal		
Death as an escape		
No relief from suffering		
I am failing at life		

Table 1: A classification of the experience of depression described in first-person testimonies: categories in **bold** are background orientations of various specificity, which in some cases (e.g. **disturbed skillful engagement**) subsume several more specific such. The (sub-) categories in *italics* are reflective phenomena described in testimonies of depression (and used as codes in the analysis of the testimonies).

3. Classification of the Experiential Phenomena Described in First-person Testimonies of Depression

One of the phenomena associated with depression and frequently described in first-person accounts is the experience of disconnectedness from the world, which can be present in different variants with respect to aspects of pre-reflective relatedness we are commonly not aware of such as distance, intensity of perception, and general affective excitability. In some cases, disconnectedness can be experienced in feeling as a distant observer of life, of being behind a barrier or a glass wall, or encapsulated in a bubble:

> When I'm depressed it is like I have become separated from the rest of the world (R20UK, Q1B)
>
> It is as if there is a barrier between you and the rest of the world, and perhaps there is, but it is sometimes a visible manifestation of the feeling inside (R118UK, Q2B)

These passages, then, present us with experiences of *disconnectedness and disengagement* as their focus is on feelings of separation and peculiar passive contemplation. But disconnectedness from the world can also become apparent in terms of the changing intensity of perception – when we perceive something from a distance, it might appear less bright or colourful, less noisy, etc. Accordingly, the code *numbing of the senses* was administered to descriptions like this:

> I see things on a grey scale when depressed – colours don't really register and my hearing seems dulled too. (R237UK, Q2B)

The absence of affective experience, or e*motional numbness,* is another manifestation of a background of disconnectedness. Commonly described as failng to feel anything or experiencing a painful and disturbing absence fo affect, this phenomenon can also be captured in metaphors such as feeling dead, empty, flat, black, or grey:

> Either feeling totally numb and experiencing a total 'nothingness' or feeling absolutely devastated when there was nothing to explain it at all. (R22UK, Q1B)
>
> I have no feeling's inside except feeling sorry for myself and feel totally dead inside. (R28UK, Q1B)

Descriptions of experiences of hopelessness are also frequently present in testimonies of depression. These also can take different forms on the basis of the particular emphasis of specific characteristics or aspects of how and why one feels hopeless. For instance, some refer mainly to the experienced *lack of significant future.* Descriptions of such experiences emphasize the lack of future possibilities for meaningful engagement with the world, a failure to anticipate a future, or merely feeling hopeless and not being able to entertain specific hopes:

> You can't see far into the future so you can't see aspirations or dreams. Everything I ever wanted to do with my life before seemed impossible now. I also would think that I would never get out, that I'd be depressed forever. (R22UK, Q8B)
>
> there is the feeling that your life "contracts" – you stop seeing it as an expansive project and it all zeroes in on feelings of despair and wanting to escape. (R61UK, Q8B)
>
> Also I feel like there is no positive future for me (R105UK, Q7B)[17]

One can feel hopeless also in terms of the lack of prospects for alleviation of the enormous and intense suffering one is currently undergoing. Descriptions, which emphasize the ever-lasting nature of the present predicament of pain and distress are captured by the code *suffering will last forever*, which, unlike instances of descriptions of feeling as if one lacks a significant future, are centrally about the permanent and everlasting nature of present suffering:

> I think that my life will never change and that I will always be depressed. Thinking about the future makes my depression even worse because I can't bear to think of being depressed my whole life. (R75UK, Q8B)
>
> Life will never end, or change. Everything is negative. I lose my imagination, in particular, being able to imagine any different state other than depression. Life is a chore. (R169UK, Q8B)

The lack of prospects for a (significant) future can also be directly related to oneself, unlike the two instances described above. In such cases, the lack of hope centers around the own *inability to induce* change, i.e., attributes the lack of future prospects to the own self and its characteristics:

> When I am depressed I feel as if there is no future for me.
>
> […] I hate everything about myself and wish I could change but I know that I never would be able to. (R16UK, Q1B)

Testimonies of depression also frequently include reports of the failure of their authors to perform a wide range of activities in everyday life – these appear more effortful, demanding, difficult, and even overwhelming. What is at the core of these experiences, as I am going to suggest in Chapter 4, is a (sense of) loss of agency in terms of a diminishment or even complete loss of the abilities and capacities required for performing a large number of different activities. For example, to many respondents to the DDQ UK, even the simplest everyday routine activities seem like a challenge as described in these passages:

> Start to feel constantly tired, body almost feels heavy and even the slightest activity becomes a great burden to complete. (R331UK, Q4B)[18]

[17] Q7B: *How, if at all, does depression affect your ability to think?*
[18] Q4B: *How does your body feel when you're depressed?*

> Making tea takes so much effort I have to go back to sleep to recover as soon as I've drunk it. (R89UK, Q5B)[19]

While both passages depict the experience of being overwhelmed by the requirements of everyday activities, they nevertheless present us with different phenomena: the author of the first one encounters even routine and formerly not demanding acitivites as burdensome specifically in terms of her diminished energy or vital potential and for the author of the second one, the simple activity of making tea has become so physically exhausting that she needs to recover from it. Accordingly, passages as the first one, focusing on expeiences of diminished vitality, energy, tiredness or exhaustion are captured by the code *lack of vital powers* and descriptions that emphasize the increased physical effort associated with the performance of routine simple activities, like the second one, motivate the creation of the code *Körper and effort*.

But one might also feel incapacitated to perform in the manner one used to prior to the onset of a depressive episode as, for instance, described here:

> I have no motivation at all, I do not want to get out of bed, do any household chores, go out of the house, or meet anyone. (R154UK, Q1B)

> I find it hard to concentrate […] I find decision making hard over even simple things. My memory is poor and I sometimes find it difficult to find the right words to express myself. (R186UK, Q7B)

> At its worst, you don't want to do anything, or can't do anything even. […] You just get by doing the minimum to survive. Eat, sleep and work of possible. (R361UK, Q5B)

Unlike the instances introduced previously, which explicitly refer to the physically demanding nature of simple tasks, these passages highlight the experience of increasing difficulty to perform up to particular (usually socially shared) standards of 'normal' functioning in view of one's decreasing capacities that can be of rather general or specific nature, such as, respectively, motivation and decision-making or concentration and memory. Thus, instances of this sort present us with other kinds of being unable to act, namely of a failure of functioning and are reflected by a separate code, *I cannot function*.

Further frequently reported reflective experiences are of shame. These also come in different variants, which share qualitative similarities. Consider, for instance, the following passages:

> I'll never be of any use, I'm a failure and my life is too so I just want to give up. (R192UK, Q8B)

> It seems like they don't like me. I think people are just being nice to me out fo guilt or obligation. I take offence at random comments and see these as

[19] Q5B: *How does depression affect your ability to perform routine tasks and other everyday activities?*

> purposeful digs at me because I am inadequate and they're annoyed with me. (R166UK, Q3B)[20]

The former excerpt depicts experiences of shame first and foremost in terms of altered self-awareness, which presents the own self primarily, if not solely, in view of its negative characteristics. The latter, though, focuses on another aspect of the experience of shame, that of being negatively evaluated by others. These descriptions, thus, both present us with instances of feeling ashamed, which come in two variants – one of *feeling useless, worthless, a failure* and of others as not approving of or liking one (*others do not like me*).

Experiences of loneliness and social isolation or disconnectedness are also abundant in reports of the the experience of depression. In many cases, these come in the form of encountering others as not caring or emotionally invested in one's well-being, whereby one might feel abandoned or neglected:

> Even though family often checks to see how I am doing, I feel as if they don't care. I feel separated from them. I may even feel like they never ask how I am doing. (R323UK, Q3B)

But others can be experienced as distant and unrelatable also in terms of a failure to share commonalities with one, understand them, or sympathize with them:

> Everyone seems so annoyingly normal, happy, able to cope, unaware of the turmoil that is filling my room, my head, my life, my world. (R253UK, Q3B)

And still other passages in testimonies of depression refer to experiencing alienation and a failure to relate and connect to other people that results from a socially stigmatized conception of the disorder, which can culminate in negative judgements and avoidance, as for example, here:

> Their attitude varies from apparent indifference, irritation and anger, pretending nothing is amiss, you've brought it on yourself, the brisk 'pull yourself together' or 'you have so much, you shouldn't be depressed'. […] In the main, only those who have experienced depression seem supportive. (R137UK, Q3B)

While all these instances capture feeling lonely and isolated, they present us with different experiential phenomena and are, thus, operationalized as separate codes, namely *others do not care, others do not like me*, and master narratives of depression.

The instances captured by the last code, it can be argued, do not present us with the same kind of experiential phenomena as, for example, descriptions of the first two variants of loneliness. It is indeed the case that the last passage focuses on how others engage or interact with one specifically in view of one's condition and are the result of particular socio-cultural context surrounding mental illness in general and depression in particular.

[20] Q3B: *Do other people, including family and friends, seem different to you when you're depressed? If so, how?*

Nevertheless, descriptions of the experience of social alienation consistently feature in testimonies of depressive experience and should be examined in their own right. Such are experiences and phenomena that result from the fracturing of the interpersonal bond, which is itself related to the social stigmatization of mental illness in general and depression in particular. Descriptions of others as failing to recognize one's suffering, of avoiding, or patronizing one, which I understand as part of the disturbances of sharing a common world with others, thus, are also included in the classification of the experiential phenomena, although they are not reflective manifestations of an underlying background orientation but rather the result of sociocultural factors.

As introduced earlier and depicted in Table 1 the various reflective experiences, like the ones introduced above, are clustered in background orientations (represented in the table in bold). Background orientations or existential feelings[21], it has been suggested by Matthew Ratcliffe (2005; 2008; 2015), are pre-reflective and pre-intentional feelings that provide us with a sense of how we find ourselves in the world as:

> [t]o find oneself in a world is to have a sense of the various ways in which things could be encountered: as perceptually or practically accessible, as somehow significant, as available to others, and so forth. And changes in the overall style of experience, in existential feeling, are shifts in the kinds of possibility one is receptive to (Ratcliffe 2015, 51).[22]

They, similarly to the Heideggerian mood or attunement[23], are "presupposed by the intelligibility of intentionally directed experiences, thoughts, and activities" (Ratcliffe 2015, 56) and establish the basis of being intentionally directed at something by positioning us in

[21] Throughout this work, I use the term 'background orientation' when referring to the existential background of experience. I choose to deploy this term rather than the more common 'existential feeling(s)' for several reasons: (1) it emphasizes the encompassing and comprehensive character of existential feelings as introduced by Ratcliffe (2008) in contrast to the term 'feelings', which, in my understanding, highlights the bodily-experiential aspect of the phenomenon; (2) feelings, moreover, are often associated with very specific, circumscribed instances (often reflected also in our linguistic intuitions – feeling lost, tired, etc.) of reflectively experienced or foregorunded phenomena that we can differentiate among (feeling lost vs. feeling confused, muddled, etc.), which might misleadingly suggest that the background of experience is also expected to be clearly distinctive, with particular scope, or come in distinct instances; (3) the connotation of 'orientation' as on the one hand a direction, stream, or flow, which captures the difficulty in getting a grip on these experiences, and on the other its encompassing character – as the orientation determines which aspects of e.g. a specific entity we experience visually, existential feelings constitute spaces of experiential possibility.

[22] Matthew Ratcliffe (e.g. 2005, 2008, 2015) adopts a broad conception of possibility, on which it refers to the multitude of various experiences one can undergo in specific situations. For instance, if I find myself in a world, which appears threatening and hostile, I am more likely to experience feelings of anxiety, insecurity, etc. When discussing the changes in the experience of possibility in depression in Chapter 3 "Loss of possibility", I deploy a narrower notion of possibility that encompasses the patterns of engagements with the world possible for us based on deeply ingrained and tacit social and cultural practices, individual bodily characteristics, particular pragmatic contexts, etc. For example, for someone who drives, a car offers the possibility to get from A to B and is experienced as something that can be driven by this person. To someone who does not drive, it offers the possibility to be taken with it from A to B by someone else, etc. As this examples evidences what I mean with 'possibility' is a pattern of interactions or active engagements with the world rather than spaces of experiential possibility (that I suggest are in Ratcliffe's focus).

[23] For a detailed discussion of the differences between Heideggerian moods and existential feelings see Ratcliffe 2008, 2015.

the world. Existential feelings, unlike particular emotions, are not about anything in particular; rather they reflect, among other things, one major aspect of how we experience the world, namely in terms of what is possible. For instance, only in a world in which threat is possible, one can be afraid of a particular situation or entity. When subjected to a radical shift of possibility, one, thus, finds oneself in a world that is imbued with gravely changed patterns of significance – finding oneself in a world permeated by threat, the most dominant pattern of significance is that of being in danger and subsequently entities that formerly did not carry this particular significance can now be associated with feelings of anxiety or fear. Radical changes in existential feelings constitute a markedly different way of being and it has been argued that the experience of different psychopathological conditions can be understood in terms of these (e.g. Benson, Gibson, and Brand 2014; Jacobs et al. 2014; Fuchs 2013; Ratcliffe 2008 Chapter 5, 6, and 7; Ratcliffe 2015; Slaby, Paskaleva, and Stephan 2013).

Existential feeling or deep emotion[24] is "experienced as an all-encompassing state of being" (Ratcliffe 2010, 609). Focusing on a background orientation of guilt or 'deep guilt' in depression, Ratcliffe (2010, 614) suggests that:

> It is a transformation in how one finds oneself in the world, in what is usually taken for granted as a backdrop for the various ways in which things can be experienced. Deep guilt involves a loss of the conditions of intelligibility for certain kinds of intentional state, and this is what gives it its depth. There is no hope, no practical significance, no pleasure, and there cannot be. When you feel guilty about something, you can still contemplate feeling otherwise, and you do not feel guilty about plenty of other things. But, in the case of deep guilt, no alternatives to guilt present themselves.

Background orientations or deep emotions, thereby, are not an accumulation of qualitatively similar intentional states, bodily feelings, and evaluative judgements. Rather, these reflective intentional states that exhibit similarity in content and quality presuppose a general underlying background receptivity to particular types of significance. For example, instances of feeling disengaged and disconnected and failing to respond emotionally to occurrences and events in the world share a common pattern of significance – that of being peculiarly distant and disengaged from the world, others, and one's own life. Accordingly, the reflective experiences captured by the codes *disconnectedness and disengagement* and *emotional numbness* discussed above can be understood as manifestations of a background orientation of disconnectedness.

[24] Ratcliffe (2010), in a comprehensive examination of deep guilt in depression, illuminates the relationship of manifestation or expression of existential feelings or background orientations. Although he (Ratcliffe 2010) prefers the term 'deep emotions' or 'deep guilt' in this particular discussion, it can be replaced by 'existential feeling' or 'background orientation'. 'Deep emotions', in particular 'deep guilt', emphasizes the different instances of (affective) experiences that include intentional states, bodily feelings, etc.

Similarly, commonly reported instances of feeling as if lacking a significant future and as if the present moment of suffering will last forever have in common the general failure to anticipate a positive change of the present predicament, or in other words, to hope for a change for the better. Accordingly, these experiences can be understood as manifestations of a background orientation of hopelessness.

Background orientations or existential feelings, it has been argued, are "[…] centrally about having a sense of possibility" (Ratcliffe 2012, 28). The sense of possibility, thus, can be understood as one of the main structural determinants of our sense of being in the world – by disclosing the world in terms of possible ways to engage with it, it establishes one of the aspects of finding oneself in the world, that of how entities are significant to us.

But the experience of being in the world is not a static perception of one's spatiotemporal location. Rather, it is characterized by a sense of how we can actively engage with the world by means of various endeavours and projects. Background orientations, thereby, also encompass a sense of what we are able to do, of how we can interact with the world as well. Moreover, they also provide us a background sense of sharedness of reality, which makes interactions with others and a sense of inhabiting a common world possible. And these three aspects are also the main themes addressed by the authors of testimonies of depressive experience who describe how they find themselves in the world mainly in terms of the changes in what is *possible*, in the experience of their *abilities*, and of belonging to a *shared* world. Thus, the three-fold framework of depressive experience in Table 1 centres around changes in the experience of possibility, agency, and intersubjectivity[25], which establish various background orientations that are manifested in emotions, moods, thoughts, bodily sensations, action tendencies, and behaviours.[26]

[25] The experience of possibility, agency, and intersubjectivity are not the only background structures of experience. Further or different structures of experience can be identified in particular with respect to specific research interests. Here, the main focus is the study of the experience of depression that is commonly described in terms of alienation and disconnectedness from a shared world. But when studying the subjective experience of schizophrenia, for instance, the disturbances in the experience of shared reality might motivate different conceptions of structures of experience and uncover other distinct changes in these. In general, though, uncovering the background changes underlying the experience of various mental illnesses can illuminate both commonalities and difference and potentially modify psychiatric classification.

[26] It has been suggested that another way to cluster or classify the changes in experience in depression is with respect to what the underlying existential feelings relate to in particular (Jacobs et al. 2014) – the experience of the world, the own body, and others. Unlike this classification, the one suggested here focuses on the one hand on the overarching themes as described in first-person accounts that similarly to existential feelings we rarely if ever reflect on. On the other hand, it attempts to capture the structure of the foregrounded experience of embeddeness in a shared world without centring on the objects of reflective intentional experience in particular. Possibility, agency, and intersubjectivity cannot be conceived as objects of reflective experience, rather they *structure* or *organize* one's experience of specific intentional objects themselves. For instance, by experiencing the world as devoid of possibilities, the particular significance each and every object has changes dramatically. Analogously, the loss of agency in terms of feeling unable to function in everyday life make even the simplest and most basic routine activities appear demanding, effortful, and beyond one and respectively one feels overwhelmed and incapacitated by an increasingly demanding and challenging world. And the loss of an

For instance, the experienced loss of possibility, which is going to be the subject of Chapter 3, places one, among others, in orientations of disconnectedness and disengagement, pointlessness, and suicidality. What all these ways of finding oneself in the world have in common is the loss of something we commonly take for granted, namely that of a wide variety of (active) engagements with the world and practical endeavours as being possible for one. For some of the respondents to the DDQ UK, the loss of possibility establishes a way of being that is characterized by a detached observation of the world, others, and the course of life (**disconnectedness**) as in this passage:

> […] feeling that I am on the outside looking in […] (R128UK, Q1B)

Failing to experience things as possible can also establish a general background of meaninglessness, pointlessness, and lack of purpose of one's existence (**loss of point and purpose**) that can come to the foreground of experience in the feeling that

> [l]ife seems completely pointless when depressed. Depression is the worst feeling in the world and when you're absorbed in its depths you just don't even want to be there, anything to stop the numbness and pain. You can't see far into the future so you can't see aspirations or dreams. Everything I ever wanted to do with my life before seemed impossible now. (R22UK, Q8B)

And in particularly severe cases, to many, the utter lack of possibilities transforms life into an intolerable mode of suffering and lack of prospects, which presents death as the only way to put an end to it (**death as a relief**):

> […] I feel like there is no positive future for me so this can lead to me thinking suicidal thoughts. (R105UK, Q7B)

The loss of agency and ability in depression, which I am going to discuss in Chapter 4, also radically transforms one's experience and disturbs one's active engagements with the world. It establishes, among others, background orientations of disturbed bodily experience (**the resistant body**), of increasing effort associated with the performance of routine activities (**effortful routine**), and of general incapacitation (**incapacitation**) as described in these passages:

> […] In many instances it is not the overwhelming belief that doing a task is pointless it is the effort involved that prevents me. I have no energy, my limbs ache, to stand for any length of time is uncomfortable and the effort required even to get out of bed and dress is beyond me. […] (R154UK, Q5B)

> It affects it severely. The amount I feel able to do is directly related to how depressed I am. Overall, I am unable to run a household and rely very heavily on my mother, especially with things like paperwork, finances and organisation. […] (R212UK, Q5B)

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intersubjective perspective makes not only others appear distant and alienated, but also constitutes a different form of self-awareness. By focusing on these structures, we can arrive at a comprehensive and encompassing overview of reflective experiences that share *structural* and *qualitative* similarities rather than specific (intentional) objects.

Both cases present us with instances of particular ways of finding oneself in the world, which are characterized by the pre-reflective experience of loss of ability and disturbed agency. As in the case of loss of possibilities, these changes in the pre-reflective sense of ability and agency establish different background orientations and impact the experience of temporal flow as described in these reports of different foregrounded reflective experiences of deceleration of temporal flow:

> […] things also seem to take forever to do, even the kettle boiling takes forever and makes me angry and upset. (R237UK, Q6B)[27]

The failure to feel related to and engage with other people is the last major theme addressed in testimonies of depressive experience. In Chapter 5, I am going to present how changes in this central aspect of human experience place one in orientations of intersubjective disconnectedness such as loneliness, shame, and guilt. Failing ot share a common perspective with others confines one to a solitary existence (**loneliness**) – they do not understand one, do not care about her, and she is not enticed to engage in interactions with them as described in these passages:

> […] It's like I can be surrounded by my friends, and yet I feel like I'm still alone. […] (R51UK, Q2B)
>
> Don't feel like doing anything, don't answer the phone to friends as I find chit chat so boring, it's usually all about their problems and they never ask how I am feeling. (R349UK, Q5B)

This failure of intersubjective relatedness also confines one to being both the observer of others and the object of their observation, which radically transforms one's self-awareness and establishes orientations of **shame** and **guilt** that make other ways of relating ot others not possible:

> Partner – I feel like he hates me, doesn't love me enough, like I'm a pain in the ass to live with. I feel like a burden. (R97UK, Q3B)
>
> Feel I am not worthy of my friends or my job. (R343UK, Q8B)

The background orientations established by disturbances in the experience of possibility, agency, and intersubjectivity can be rather general and diffuse or more localized and specific depending on the specificity of the foregrounded aspects of experience.[28] Consider for

[27] Q6B: *When you are depressed, does time seem different to you? If so, how?*

[28] It has been suggested (Stephan 2012; Jacobs et al. 2014) that we can distinguish between elementary and non-elementary existential feelings or background orientations with respect to the fundamentality of the background experience they constitute. Elementary existential feelings "[…] provide us with a sense of reality: of ourselves, our actions, other persons and objects, and the surrounding world as such" (Stephan 2012, 158). They rarely undergo substantial changes in the absence of psychopathological conditions (Stephan 2012). Non-elementary existential feelings "[…] comprise feelings that concern one's own vital state (such as feeling healthy and strong, versus feeling exhausted and weak), or that reflect one's position within social environments (such as feeling welcomed and familiar, versus feeling disrespected and rejected), or that manifest one's standing towards the world in general (such as feeling at home or as a participant in the tide of events, versus feeling disconnected, like a stranger or not at home in this world)" (Stephan 2012, 158). General and specific background orientations

instance the experience of inhabiting a *shared* world that is the backdrop of experience, thought, and action for us most of the time. Against this background, the world and the individual entities in it are disclosed as present for others as well, others are encountered as conscious, intentional, minded beings who have a somewhat similar subjective experience of the world, and we feel related to them in a basic or fundamental sense of sharing a subjective perspective on the world that might yet in some respects vary among individuals. This background sense of shared but yet somewhat individual subjective perspective on reality is commonly taken for granted and enables communication and active engagement in joint projects. But in some cases, the background experience of intersubjectivity can be radically disturbed and establishes a general background orientation of alienation from others that becomes the backdrop of more specific ways of being in the world. For instance, instead of being seamlessly integrated in intersubjective interactions, one might feel as a distant observer of others or feel observed by them, which in particular when combined with a sense of declining abilities and diminished performance can establish a more specific background orientation of shame manifested in reflective feelings of diminished self-worth and tendencies towards avoiding others. But the loss of the sense of shared yet individual subjectivity can present others also as having an essentially different perspective on the world, which establishes a further specific background orientation of intersubjective alienation, namely loneliness. It, in turn, can be manifested in reflective experiences of being not understood or cared for by others as they fail to relate to one's subjective perspective. The radical disturbance of intersubjectivity thereby establishes a *general orientation* of loss of intersubjective relatedness, which includes two *more specific orientations* of shame and loneliness.[29] Specific background orientations, thus, can be understood as more concrete ways of being with respect to the *particular aspects* of finding oneself in the world that come to the foreground of experience and are manifested in affective experience, thought, and action. Accordingly, while the specific orientations of shame and loneliness in the examples

as I understand them stand in a somewhat different relation – specific background orientations are more concrete instances of general orientations, which bring individual specific aspects of how one finds oneself in the world to the foreground of experience when subjected to alterations. For instance, the general orientation of loss of relatedness to a world shared with others encompasses more specific backgrounds of loneliness, hostility, shame, and guilt. Each of these is manifested in various reflective phenomena – the first is expressed in feelings of, for instance, not being understood by others; the second in instances of anger and irritability in particular with respect to intersubjective interactions; the existential background of shame is manifested in feelings of diminished self-worth, self-hate, and disgust; and guilt in tendencies towards self-blame and rumination and experiencing oneself as harming or burdening others.

[29] This, of course, does not imply that whenever we experience shame or guilt (or any of the reflective phenomena that are going to be discussed), we find ourselves in particular (altered) background orientations. These emotions or emotional episodes are undoubtedly warranted in particular situations. My concern here is to understand how the individual experiences one is subjected to in depression are structured and many of these also have their non-pathological instances in everyday life.

above are both instances of intersubjective disconnectedness, each of them is a distinct way of being disconnected from an intersubjectively shared world. In the former, one fails to relate to others (or rather one can relate to others only in one particular way) by feeling ashamed and attempting to withdraw or conceal a deficient or a flawed self, while in the latter one encounters others as not understanding in virtue of the discrepancies in subjective perspectives. Thus, they also comprise qualitatively distinct but yet structurally common ways of being in the world.

Depression, it is important to note here, is a rather heterogeneous condition, which is characterized by a large variety of reflective experiences and a multitude of changes in the existential background. The categories and subcategories suggested and elaborated here are not intended as a comprehensive list that presents us with (potential) necessary and sufficient conditions, which have to be met to administer a diagnosis of depression. Quite on the contrary, the following categorisation of reported changes of experience in depression is an attempt at examining the changes in structures of experience, the background orientations they tend to bring about, and the variety of their foregrounded manifestations in affective experience, thinking, and acting. Thereby, my aim is to provide an overview of how background changes operate in depression and can be manifested in a multitude of experiences, cognitive states and processes, and behaviours, which individuals suffering from the condition describe. Moreover, long-term or recurring mental and physical illnesses are complex phenomena and go along with interpretative processes, which themselves also impact reflective experience. Thereby, social, cultural, personal interpretations and patterns of meaning associated with the experience of illness exert an influence on the manifestations of changes in background orientations. The classification proposed here, thus, offers a framework of the typologies of being that can be used to inform psychiatric classification and diagnosis particularly by relating the multitude of reflectively experienced phenomena that are commonly the basis for creating (operationalized) diagnostic criteria to changes in the experiential background. This, moreover, is here informed by phenomenological theories, which are aimed at developing a systematic account of human subjectivity.

4. Conclusion

Testimonies of depression provide us with a detailed picture of a radically altered way of being in the world or existence. The world of the depressed fails to offer her the habitual or common possibilities for active engagement, there are no prospects for a (significant or better) future, which obliterates any sense of hope with respect to what is to come. One also feels profoundly and severely disabled – what was formerly effortless, easy, and automatically

performed is now challenging, requires enormous strain and effort. One feels ashamed of one's (alleged) failures, ruminates on the past, and berates oneself for burdening others or harming them. Meaningful relatedness and belonging are not possible anymore – the depressed individual feels alienated, disconnected, and estranged from others who seem to her to inhabit a markedly different world. In order to systematically study these experiences, I have embarked on a phenomenological study of first-person descriptions of depressive experience that is aimed at uncovering the changes in both background and foreground aspects of experience. Starting at the expeiential foreground, I, first, identified a multitude of different reflective phenomena reported in testimonies of depression. These reflective phenomena were then organized in clusters or categories, which can be conceived as background orientations that themselves are established by changes in some of the major structures of subjectivity, namely the pre-reflective sense of possibility, of ability, and of intersubjectivity. This organization or classification of reflective phenomena and beckground orientations is ultimately aimed at providing a phenomenological framework of the experience of depression that can both serve as the basis for revision of operationalized definitions of experience and illuminates the complex and dynamic relationships between the pre-reflective background of experience and the reflective of foregrounded manifesttaions of changes it undergoes in depression. This framework was derived by deploying methods from grounded theory (Charmaz 1990) and phenomenological analysis (van Manen 1990) that award a central role to reports of first-person experience and provide the broad theoretical foundation to analyse it.

2. Narratives and Mental Illness

First-person testimonies of mental illness most commonly come in the form of a narrative that can come in different formats: some can be produced in response to specific questions, as in the case of the testimonies produced in response to the DDQ, others can be book-length autobiographical accounts, and third can be stories that are not produced for an audience but rather as an attempt to organize and understand the incomprehensible suffering one is subjected to. First-person narratives have traditionally enjoyed the attention of many disciplines particularly in terms of their role in (self-)understanding and self-experience. They organize the (relevant) events of one's life in a temporal and causal sequence, which is characterized by the main features of a story – a beginning, a middle, and an end. But there, undoubtedly, is more to them than the mere sequencing of various events in the form of a story to be told to others. Most importantly, they are also characterized by meaningfulness and coherence that establish, according to narrative theorists, the stability, coherence, and integration of our sense of who we are. Thereby, autobiographical narratives essentially present their readers or audiences with one's individual perspective, with the thematic structure of how one understands oneself, what one values, and how one leads one's life. Before proceeding to the examination of first-person testimonies of depression, in this chapter, I am going to suggest, in line with some of the leading narrative theories in philosophy in particular, that they are essential to having a coherent and unified self-experience and self-understanding. Most importantly, and of the utmost relevance to the current work, narrative accounts of mental illness in general and depression in particular, can help bridge the painfully experienced discrepancy of self-identity that many individuals suffering from the condition report of. Moreover, by offering the possibility to include different perspectives that belong to the same individual, they allow for the communication and organization of radical and encompassing changes in experience, thought, and action (Goldie 2011; 2012; 2012a), which is the focus of my research here. In arguing for the importance of narratives for self-experience, I am going to first, set out some preliminary considerations about the role of language and the linguistic interpretation of (affective) experience. Then, I am going to provide a brief overview of some of the most widely popularized and influential accounts of the narrative self. I am also going to focus in detail on some of the characteristics of autobiographical narratives that can be considered central specifically in terms of their role in the construction of a coherent and unified self-experience

in mental illness. And lastly, I am going to address some criticisms of narrative theories of the self that argue against the constitutive role of narratives in self-experience (Strawson 2004). I am going to suggest that while narratives might not be constitutive of all variants or instances of self-experience, they are essential for restoring our common sense of being unified and coherent *persons* as for instance in cases of mental illness. Then, I am going to present and address a particular worry about the use of published autobiographical accounts to study the experience of depression mainly resulting from some specific requirements peculiar to the genre of autopathography. In doing this, I am going to argue that some of these are also to be found in anonymous testimonies of the experience of depression and are the result of its embeddedness in social and cultural context. I am also going to discuss some similarities and differences between published autobiographical accounts and anonymous testimonies specifically in view of their degree of narrativity and the linguistic devices such as metaphors in the two formats.

1. Interpretation: From Experience to Narrative

Central to a narrative understanding of the self and existence is the notion of interpretation, which establishes, transforms, and integrates the patterns of meaning and significance that imbue the world for each of us. As famously argued by Charles Taylor, we are "self-interpreting animals" (Taylor 1985) who make sense of their affective experience by means of interpretation and articulation. Here, I am going to review his account of self-interpretation and experience and emphasize its centrality for a narrative account of the self and self-experience.

According to Charles Taylor (1985, 47), our interpretations of ourselves and our experience do not establish a subjective view of reality that can be separated from an objective physical world but rather are constitutive of what we are and thus central to our existence and self-understanding. Arguing for the irreducibility of affective experience, he conceives of emotions as involving ascriptions of import, whereby "some of these imports are subject-referring" (Taylor 1985, 59). When we experience shame, for example, we perceive a particular situation or an event as having a specific import, which is based on how the event or situation in question relates to some of our subject-specific goals, purposes, and strivings, in this case dignity. Thus, to bear with this example, to feel ashamed is to experience the subject relevant import of a particular situation, to perceive the situation as having this import that is itself determined by our strivings qua being a subject. Subject-referring imports, thereby, provide us with a sense of what it is to be a subject. Moreover, this reflexive

sense of what it is like to be a subject incorporates a sense of what it is like to be a human, of what matters to us as human subjects (Taylor 1985, 60).

We become aware of imports, thus, through feeling. To bear with the aforementioned example of experiencing shame, in the act of reflecting on our experience and the respective situation, we come to articulate the particular imports, which are involved in feeling ashamed. When experiencing shame, we become aware of a situation as shameful for us qua being humans with particular aspirations and goals. Shame becomes shame in virtue of the shameful situation that it is embedded in, of the (articulated) import that makes the situation appear shameful so that, consequently, interpreting the situation as shameful is constitutive of our feeling ashamed. Certain feelings, thereby, involve a level of articulation as "the sense of things they incorporate requires the application of certain terms" (Taylor 1985, 63). Accordingly, shame requires the articulation of the situation, event, or act, which harms our dignity and makes these shameful. And particularly in cases when we feel, for instance, shame without being able to articulate what makes a particular situation shameful, further articulation of the imports of the specific situation may change, dissipate or transform our feeling. Our feelings, thus, are bound with articulation:

> Our subject-referring feelings have to incorporate a certain degree of articulation in order to open us to the imports involved. [...]
>
> But these feelings attribute imports, indeed they open us to the domain of what it is to be human. And because they are articulated they purport to give a characterization of these imports, and hence to offer insight into this domain. One might say, they ascribe a form to what matters to us (Taylor 1985, 64).

The ongoing process of articulation and interpretation we are constantly involved in opens us to further articulations as what we are experiencing is a function of what we have already articulated, which opens us up for further imports.

Language plays a central crucial role in the process of self-interpretation. By acquiring and refining the vocabulary in the process of articulation, our experiences and how we understand ourselves changes (Abbey 2014, 59-60). Thus, by articulating the implicit level of what moves and affects us, we define ourselves as humans, which are moved and affected by those imports and become explicitly aware of what matters to us. Our identity, thereby, is constituted (at least partly) by how we interpret ourselves[30]. It has been suggested that we can distinguish between two levels in self-interpretations: an implicit level of "reactions, motivations, and actions" and an explicit level of "linguistic articulations" (Laitinen 2002, 60)

[30] It is important to note here that self-interpretation or how we understand who we are is not based only and exclusively on self-reflective processes. How others conceive of us and relate to us also plays a role in our understanding of who we are. A detailed discussion of the role of other persons in our self-understanding, exemplified by instances of stigmatization of depression, will be discussed in Chapter 5 "Loss of Intersubjectivity and Social Isolation: Loneliness, Shame, and Guilt".

that enter into a threefold dialectic. At the level of implicit functioning, our identity is constructed through our orientations that may not become explicit. We can also explicate the sense of who we are by articulating our implicit orientations. Here, there can be conflicting and rival answers to the question who we are and some of these might be less accurate than others and they all can be re-evaluated and weighted against each other (Laitinen 2002, 60-61). The third phase is "the appropriation of the explications, or the internalisation of the expressions" (Laitinen 2002, 60-61). These then become routine with time and turn into habits and become part of the implicit background (Laitinen 2002, 61).

When attempting to answer the question about who we are, we most commonly construct stories, in which we articulate our implicit orientations. This reflexive activity of interpreting what matters to us makes explicit the guiding themes or principles of life. Thus, for instance, in cases of mental illness, in which the condition disrupts the continuity of one's life as one has known it, narratives can explicate the prior orientations and how they have been transformed or disturbed. The unity of one's life as a whole is thereby made explicit and can, in such cases of interruption or disturbance, be breached with the help of reflection and interpretation.

In narratives, in particular autobiographical ones, the events of the narrator's life are also situated in a temporal perspective of thematic relatedness – she is essentially engaged in creating an account of how she has become the person she is now and where she is going (Laitinen 2002, 63). Our movement towards or away from the things we value, thereby, becomes the subject of our self-narrative (Laitinen 2002, 63). Narratives are, consequently, essentially about what we value, what has import for us that is reflected in our affective experience and active engagements with the world, about what provides us with a sense of control over the direction in which our lives are headed. By explicating both what has import to us and how we lead our lives, we situate ourselves in the larger framework of life and agency. Accordingly, especially in the cases when we have been rendered unable or ineffective in controlling the direction of our lives or find ourselves astray from our implicit orientation not as the result of our resolution or self-reflection but rather by being disabled to act in accordance with our implicit orientations, self-interpretation and articulation can help us re-establish a grip on these. In this process, we come to reflect on what used to move us or still moves us but may encounter resistance from realms external to the individual that cannot be subjected to her control.

Consider, for example, some cases of depression, in which those afflicted with the condition find themselves unable to experience affection and engage in interactions with their loved ones. While the loving father used to anticipate his son's football game with

excitement, now it is a chore, a demanding event he has to visit and which will be a torture for him. This is experienced as in stark contrast with who he used to be – rather than enthusiastically and excitedly cheering for his son on the field, he now lacks any motivation and desire to go there. This brings about a sense of discontinuity of the underlying implicit orientation of valuing time spent with one's children and supporting them, which has been rendered ineffective by a radical loss or transformation of the imports that go along with it. And by reflecting on this, by articulating what used to be the case and how things have changed, the father can come to the realization that either he has been rendered ineffective and inefficacious with respect to his underlying orientation or the imports associated with this orientation have shifted or been transformed. But in this case specifically, the change was not occasioned by an agentive act of reflection and identification. Rather, it seems that all he used to value and care about has now lost its significance without any resolve on his part. He, consequently, might feel as a different person as well. And this disturbance of continuity of who one experiences and understands oneself to be itself occasions the interpretation and re-interpretation of present and past patterns of import through reflection and articulation. So, he might in response to this attempt to bridge the gap between the loving, engaged father and the lonely, overwhelmed, and disinterested person by creating the story of how he came to be the latter.

2. Narratives and the Self

According to the main proponents of hermeneutical narrative views (e.g. Charles Taylor, Alasdair MacIntyre, Paul Ricoeuer), our actions and existence can be made sense of only in terms of narrative accounts, which provide us with causal-historical sequence of events, mental states, and experiences. Thereby, in narratives, for instance, our various actions can be characterized and made sense of with respect to our intentions, judgments, and evaluations and the larger framework of social and cultural meaning and significance (Schechtman 2011, 396). On these views, moreover, narratives are also the only and ultimate way to the good life – the human life is a quest for the good that can only be accomplished in narrative terms by means of normative evaluations.

Selves can be seen as inherently narrative in non-hermeneutic accounts as well. As Schechtman (2011, 396) points out, Dennett's view of the self as the center of narrative gravity is also extremely popular and influential. According to him (Dennett 1992 as in Schechtman 2011, 396-397), the self is an abstraction, a character that we create when narrating about our lives. On this view, moreover, unlike on hermeneutical views, narrativity is not related to the quest for the good. Rather, what we do is construct fictional protagonist

as opposed to genuine existing selves that lead and make sense of their life and also engage in normative evaluations exclusively in narrative terms (Schechtman 2011, 398).

Schechtman's narrative self-constitution view (Schechtman 1996, as in Schechtman 2011, 398), similarly to Dennett's does not formulate a strong link between agency and (narrative) selfhood. Rather, according to her (Schechtman 1996, as in Schechtman 2011, 398), "we constitute ourselves as selves by understanding our lives as narrative in form and living accordingly". Respectively, our experiences are interpreted and experienced as particular types of experiences in virtue of being parts of a specific story. As Schechtman (2011, 398) points out, one and the same event can be experienced in radically different ways depending on the general background story, the causal-historical account of the events in one's life, against which it is interpreted. And what is crucial to selfhood is "keeping track of this background and responding accordingly" (Schechtman 2011, 398). Accordingly, unlike in Dennett's account, the self is not a fictional entity but a real existing one that is constituted by narrativity but unlike hermeneutical accounts, there is no emphasis on the ethical dimensions of narrativity and a strong link between agency and selfhood.

Further widely acknowledged view of the self and life as inherently narrative is presented by Jerome Bruner (2004). He adopts a broadly constructivist perspective and argues that the cognitive achievement of narrating the story of one's life is an act of world making (Bruner 2004; Hyvärinen 2008). According to him, narratives are cognitive achievements that organize and structure our perceptions and experiences of the world (Bruner 2004). Life and narrative, moreover, have a "mutual relationship of imitation" (Hyvärinen 2008, 264), whereby narratives imitate the structure of life as it is lived and led by the individual (self) and life itself learns something from the stories that we tell. What we term 'life' then is essentially constructed by different modes of thinking that are based on, for instance, genres, types of texts and the characters in them, etc. Recounting one's life, thus, is an act of interpretation, a cognitive achievement that also includes revision of past events and experience in autobiographical narration (Bruner 2004; Hyvärinen 2008, 265). On such a constructivist conception of life as a narrative, it is impossible to distinguish reality from our interpretations of it as all our experiences are already constructed by interpretation and revision of the past.

It is important to note here that according to Bruner (2004; Hyvärinen 2008, 267) our autobiographical accounts are at least party determined and shaped by various social and cultural influences, so that they are individual instances of conventional stories present in different social and cultural groups (Bruner 2004; Hyvärinen 2008, 267). From an early age, we enter into narrative practices and subsequently also start telling the stories of our lives by

borrowing both general frameworks and structures that organize our understanding and self-understanding and particular principles and instances so that "eventually the culturally shaped cognitive and linguistic processes that guide the self-telling of life narratives achieve the power to structure perceptual experience, to organize memory, to segment and purpose-build the very "events" of a life. In the end, we become the autobiographical narratives by which we "tell about" our lives" (Bruner 2004, 694) and thus individual embodiments of cultural significance and understanding.[31]

Elaborating on his understanding of narratives as constitutive of the construction of self and life, Bruner (1991) understands these as characterised by ten major features: (1) diachronicity, (2) particularity, (3) intentional state entailment, (4) hermeneutic composability, (5) canonicity and breach, (6) referentiality, (7) genericness (8) normativeness, (9) context sensitivity and negotiability, and (10) narrative accrual that I am going to briefly examine here.

Being essentially interpretations of events unfolding over time, narratives capture time as lived by the narrator (1). They might not follow the original course of the events but rather diachronically organize them over time with respect to the significance and meaning of the events that occurred at particular times (Bruner 1991, 6). Although narratives are about particular events, they are generally tokens of types of stories that are socially and culturally shared (2) such as bully gets his punishment, boy and girl get romantically involved, etc. (Bruner 1991, 6), which are filled in with specific particular happenings. These types of stories shape how we experience various occurrences, how we understand and organize them and provide us with a pattern of structuring and anticipating what is to come as part of a particular event. Depicting agents and how they engage with the world, narratives also describe the relevant intentional states of their characters (3). But these, Bruner suggests are not sufficient for providing a causal account of the depicted event as "[...] some measure of agency is always present in narrative, and agency presupposes choice—some element of "freedom"" (Bruner

[31] It is important to note here that the narrative construction of the self does not happen in isolation from the general social environment. Rather, our self-narratives are at least to some respect also authored by how others understand and engage with us (e.g. Lindeman Nelson 2001, 81-88). The socially shared understandings and conceptions of different social groups, for instance, can in some cases fail to acknowledge aspects of how we understand and experience ourselves and engage us in processes of oppression and failure of recognition of (moral) agency in particular. Here, both individual self-narratives and the specific master narratives that are shared in social communities can be the main vehicles of both oppression and failure of recognition and resistance to such. And this is probably most apparent in instances of socially shared culture-specific conceptions of individuals or groups of individuals that are characterized by a general negative attitude. A particular instance that I am going to focus on is the stigmatized perception of mental illness in general and depression in particular that is described in first-person testimonies (see Chapter 5 "Loss of Intersubjectivity: Loneliness, Shame, Guilt, and Social Isolation" and Chapter 6 "Social and Cultural Influences on the Experience of Depression Described in First-person Testimonies").

1991, 7). Thus, they are rather interpretations of events rather than exclusively veridical causal accounts[32].

The events and the actions of the protagonists in a narrative are shaped in terms of a putative plot so that parts and wholes rely on each other for the construction of a particular story (4). Thus, to express a particular meaning, the whole has to be constituted in a particular way by specific parts, so that it is to be interpreted as this particular kind of a story with this specific meaning on the side of those who create and receive it. This is essentially an interpretative activity, which, as Bruner (1991) claims is best exemplified by narratives because of their special and peculiar nature and not merely resulting from ambiguities in them.

Although narratives present us with sequences of events, not every sequence of events constitutes a narrative. For instance, as pointed out by Bruner (1991, 11), canonical scripts about how to behave in certain situations depict a sequence of related events but by far are no stories. A story worth telling, rather, is one about how such canonical scripts, which are the background of stories, have been breached (5). As narratives are our main interpretational devices, we tend to intentionally and deliberately resort to them when the habitual has been disturbed and what happens does not make sense anymore. Thus, although the breaches of the canonical are also highly conventional (Bruner 1991, 12), they are still prompting interpretation and worth telling (to others and oneself). Narratives, thereby, are about the human plights, which breach the canonical and disturb existence.

As already mentioned, Bruner's central claim is that the stories we create are constitutive of life, in particular life as we experience and lead it. Thus, they are not mere representations of a reality that exists independently of its subjects but rather, in virtue of their interpretative and constructive nature, constitute what is real for their narrators (6). Thereby, they also establish a pattern of meaningful relatedness and interaction with the world as it is encountered and interpreted.

[32] It is important to note here, that this claim appears to challenge some widely accepted characteristics of narratives, namely that they are essentially accounts of the causal and temporal sequence of events (e.g. Currie 2010). While I largely sympathise with Bruner's focus on the interpretative nature of narratives, I take him here to claim that they are not to be read as veridical causal accounts, in particular with respect to the actions of characters they depict but rather the narrator's interpretation of these (or an invitation for an interpretation of these extended to the audience). This, though does not imply that they do not depict the causal sequence, be it the actual, objective, or veridical one or someone's interpretation of it as they do revolve around a causal sequence of events and states. For instance, if I am to tell you the story of why I was late for work for today, it would revolve around how me taking a too long shower because I believed it was still 07:00 and not 08:00 as I had forgotten to properly set the time on my kitchen clock, which then made me miss my train, etc. Thereby, my story will essentially revolve around what I interpret as the cause of me being late rather than a merely accidental sequence of events that ended with me being late. So, my interpretation will identify my forgetfulness as the cause of me being late although, for instance, the kitchen clock might have been showing the wrong time because of a malfunction (although I had set it to the proper time).

Narratives famously belong to various genres such as comedy, tragedy, etc. (7) that offer various possibilities for presenting the different human plights (Bruner 1991, 14-15). The introduction of new literary genres throughout the ages, respectively, has shaped "[…] our modes of thought" (Bruner 1991, 15) by not only depicting particular social ontology but also by inviting us to specific styles of epistemology (Bruner 1991, 15). Thereby in introducing new ways of representing reality, they also change how we construct (subjective) reality and shape how we experience the world and ourselves. Narratives, moreover, are normative (8) as they are breaches of the conventional. But as the conventional shifts with time, what constitutes a breach in it changes. Subsequently, Bruner (1991, 15-16) suggests that its normativeness "is not historically or culturally terminal" (Bruner 1991, 16) as what it is concerned with and its form change through the ages. The normativeness of narrative, according to him, resides rather in how it sets the norm for our experience, understanding, and construction of reality.

When encountering and interpreting narratives, we bring in background knowledge about the narrator's intentions, which establishes a context for their interpretation and the negotiation of conflicting narratives (9). Possessing socially shared culturally specific beliefs, assumptions, and knowledge, the reader or audience, thus approaches narratives within both a specific interpretative framework and with certain expectations. Thereby, the interpretation of the narrative does not occur in the absence of doubt, disbelief and only on the basis of what the text depicts. Moreover, this context sensitivity of narratives allows for the negotiation of conflicting or opposing narratives, which further establishes the coherence of culture (Bruner 1991, 17-18). Narratives, thus, through their sensitivity to context and openness to negotiability can constitute the basis for a coherent interpretation and construction of a shared reality.

We are constantly engaged in the creation of numerous narratives – we tell our partner how our working day went, we tell our colleagues what we were up to over the weekend, we talk to friends about work, etc. The multiplicity of narratives that we are constantly creating accrue to coherent accounts of lives, which revolves around a self continuously persistent through time (9). At a larger scale, the narratives told within a community accrue to form traditions, practices and culminate in the establishment of culture and history, which diachronically integrate the past, present, and future. By accruing in coherent wholes, narratives establish a comprehensive and coherent interpretative framework, which persists over time and moreover establishes a sense of belonging and shared existence within a community.

Narratives, thus, broadly speaking, are culturally bound interpretations of reality and the self that constitute one's (sense of) self and the life of a self. By presenting us with possible ways of being a self and leading the life of a self, they structure and organize how we experience reality and ourselves. Moreover, by being the major artefact for the reflection and articulation of underlying implicit orientations and the imports they incorporate, narratives are essential to human flourishing, continuity, and coherence. Autobiographical narratives provide us with a specific kind of reflective self-understanding that is characterized by the explication of implicit coherence of individual meaningful existence. On the one hand, they constitute one of the main avenues to self-understanding and self-determination (Taylor 1985) and on the other they provide us with 'modes of thinking about reality' that are socially and culturally embedded (Bruner 1991, 2004). Respectively, they are also tools that are apt and appropriate for the re-establishment and re-integration of disturbed continuity such and coherence of life and the self as in cases of mental illness. In order to understand what has befallen one, why one's life is disintegrating, and to find and restore lost meaning and purpose, many of those suffering with them can resort to the help of narrative accounts. These, though, do not necessarily have to be explicit accounts that are related to an audience, readership, etc. such as published memoirs, anonymous testimonies, or illness narratives related to medical professionals, friends and family, etc. They can also be merely 'thought through' in narrative terms as suggested by Peter Goldie's (2012) insightful examination of narratives. In his account, he also emphasizes the perspectival nature of narratives, which I consider central to their role in cases of mental illness in particular. Here, I am going to review some of his considerations and arguments in particular in their relevance to the study of mental illness.

2.1. Narrative Perspectives

A crucial aspect of narratives, which is central to understanding their role in self-experience is highlighted by Peter Goldie (2012). Like the majority of narrative theorists, a narrative, according to him, is

> […] more than just a bare annal or chronicle or list of a sequence of events, but a representation of those events which is shaped, organized, and coloured, presenting those events, and the people involved in them, *from a certain perspective or perspectives*, and thereby giving narrative structure—coherence, meaningfulness, and evaluative and emotional import—to what is related (Goldie 2012, 2; emphasis added).

Most importantly, on this account, the various events depicted in a narrative are represented from a particular perspective or perspectives, which shape, organize, and colour these into a

narrative characterized by coherence, meaningfulness, and evaluative and emotional import (Goldie 2012, 8). Narratives, thus, are representations of specific sequences of events that can capture the perspectives, for instance that of a narrator and those of the characters in it, which present us with the respective interpretations of these events. And each perspective can establish a pattern of meaningfulness and coherence within its respective interpretative framework. The coherence and meaningfulness of narratives are, according to Goldie (2012, 8) realized by a process of emplotment that consists of the following four parts: (1) raw material for emplotment, (2) process of emplotment itself, (3) the outcome of emplotment (the story or narrative), and (4) possible effects of the narrative or story on thinker, listener, etc.

The raw material for the emplotment (1) contains descriptions of events, actors, actions, etc. that may come in a varying degree of richness. Determining the richness of these descriptions is part of the process of emplotment and can vary. The process of emplotment (2) mediates between the raw material and the narrative itself (Goldie 2012, 10). It is an agentive act, which organizes the raw material into a coherent whole. The various elements of the raw material such as agents, objects, events, and the like are then brought together and arranged in a meaningful structure. Although emplotment requires agency, it is not a consciously intended act. In the process of emplotment, the raw material is shaped, organized, and coloured (Goldie 2012, 11). The selection of the raw material with the appropriate degree of richness and shaping it in a way appropriate to the narrative happens in the process of shaping. The raw material is also organized into a narrative, which has a beginning, middle, and end. Moreover, optionally one can also colour the narrative by bestowing evaluative and emotional import to the description of the events. It is important to note here that the process of emplotment is

> […] a tentative, groping procedure: one might begin with an idea of how the narrative should be shaped, and, once one has developed it somewhat, one might be able to see saliencies that one could not see before, and then find it appropriate to go back and reshape the narrative in this new light. More than that, the tâtonnement typically involves a groping search for the appropriate evaluative and emotional import of what is narrated. All these go together: it is not as though there is, first, a completed narrative, and then, second, an evaluation and emotional response to the narrative; rather, the evaluation and emotional response themselves infuse the narrative, shaping and colouring it (Goldie 2012, 11).

Thus, similarly to the claim that we are constantly involved in self-interpretation (Taylor 1985), Goldie emphasizes the constantly changing and dynamic nature of narrative and its accompanying self-understanding. Narratives, told or thought through, are the result of processes of constant evaluation and re-evaluation of sequences of events, which play a

crucial role in how we understand and experience the world and ourselves. Through processes of colouring, moreover, they provide us with an individual perspective of meaningful situatedness, which establishes how we find ourselves in the world and relate to it.

The manner in which the events depicted in a narrative are shaped, organized and coloured is related to the narrator's perspective. Being endowed with sentience, intentionality, and importantly self-reflexivity, humans have a personal perspective, which can be first-, second-, or third-personal plural or singular perspective. Being aware that we have a perspective and being able to conceptualize having a perspective, we are also aware that others have a perspective as well. Personal perspectives, moreover, are also evaluative. And it is through one's personal perspective that the processes of emplotment create narratives by shaping, organizing, and colouring their raw material.

The outcome of the process of emplotment, the narrative (3), is characterized by coherence, meaningfulness, and evaluative and emotional import. A coherent narrative "[...] reveals, through the process of emplotment, connections between the related events, and it does so in a way that a mere list, or annal, or chronicle, does not" (Goldie 2012, 14). In addition to varying degrees of coherence, a narrative can also be meaningful in two ways – by revealing how the thoughts, actions, and feelings of those internal to the narrative made sense from their perspective and how the narrator's external perspective was related to thinking through or articulating the narrative in this particular way (Goldie 2012, 17).

In establishing internal meaningfulness, one often has to make use of the psychological states of the characters in a narrative that can be revealed in different ways. These might be either explicitly stated in the narrative or merely demonstrated by the narrator. But when establishing internal meaningfulness, we often go beyond the appeal to the character's psychological states (Goldie 2012, 19). Sometimes, we can provide a "desirability characterization for an action" (Anscombe as in Goldie 2012, 19), which, for instance fills in the relevant motive that is not explicitly mentioned but rather implied in the narrative and then subsequently all other relevant psychological states. Internal meaningfulness can be established also by the appeal to a character trait that is expressed in a particular action, which again provides us with a general motive for it and lets us fill in the further relevant states. By revealing external factors that can have an impact on someone's mind, a narrative can also be internally meaningful. By mentioning that someone is under the influence of drugs, for instance, we can make sense of their bizarre behaviour when bumping into them in a club. These three ways are combined in a fourth type of internal meaningfulness, which exceeds their sum. As proposed by Goldie (2012, 20):

> Narratives often provide explanations of why someone had a particular motive, or why someone has a particular character or personality trait, or why someone was drunk, depressed, or angry. And the explanations that we get are narrative-historical explanations: they locate the motive, the trait, the undue influence on thinking, within a wider nexus, in a way that enables us to understand more deeply why someone did the thing that they did through appeal to aspects of their personal history or circumstances.

Thereby, narratives include also the perspective of the character or character's internal to the story – how they are situated in the world, what they value, what matters to them, and offer not only an explanation of why someone acted the way they did but an insight into how they perceive and experience the world. The internal perspective of the characters in a narrative, thus, establishes its internal coherence and meaningfulness not as that for the narrator, but essentially to those who are or were involved in the events described in the narrative at the time they occurred. The internal perspective or perspectives, then, establishes coherence and meaningfulness with respect to the pattern import for those internal to the story itself.

2.2. Perspectives in Autobiographical Narratives

While in non-autobiographical narratives the external and the internal perspective or perspectives belong to different subjects, the narrator and the character or characters of the story, in self-narratives they are attributable to the same subject. This, though, does not imply that in these cases the two perspectives overlap. Rather they can be essentially different and it has been suggested that they are intricately interwoven and in constant dynamic interaction (e.g. Goldie 2011; 2012). While, as reviewed earlier, the internal perspective presents us with the meaning of the depicted events for the character, the external conveys their significance for the narrator (at the time of thinking through or narrating). Thus, when creating autobiographical narratives, the internal and external perspective can establish two frameworks of meaningfulness and coherence – at the level of the internal perspective and at the level of the external perspective. Thereby, the narrative presents us with the meaning and significance of the depicted events at the time the character experienced these at the level of the internal perspective and how they are related to the narrator, who though is the same person as the character.

Commonly, there are gaps between the external and the internal perspective in an autobiographical narrative. In some cases, a particular comic incident from our past we are narrating about can still be comic in the present. In other cases, we may have a different emotional response to a past event. While I was enraged by the rather blunt and unhelpful customer service I received last night when trying to set up my new internet connection, now I might find my response to it by rudely hanging up shameful. Thereby, the external

perspective of me as the narrator exhibits a different pattern of evaluative import from that of me as the character of the narrative and presents us with an "evaluative ironic gap" (Goldie 2012, 38-39). There might also be an epistemic ironic gap as well – I might be aware of additional facts and details now as compared to the time of the incident that can present the situation as having different import now as I narrate about it or think through it in narrative terms. Moreover, I can also have a different emotional response to the past event – while I was enraged by the unhelpful customer service, I might now even not be affected by it and feel indifferent or mildly annoyed by their lack of cooperation. Thus, the patterns of emotional import for the character of the autobiographical narrative can differ from those for the narrator as well. The latter might be, then, related to a retrospective emotion, which I did not have at the time of the described event but experience only when remembering it. These discrepancies can be communicated by the narrative, which presents us with both the internal meaningfulness of the incident as it was experienced yesterday, and as it is interpreted today by me who now is in possession of additional relevant information, evaluates her own behaviour differently, and even has a different affective response to the particular occurrence. And, most importantly, by bridging the gaps between the external and the internal perspective, an autobiographical narrative can incorporate various events that are evaluated and responded to differently by the same subject in a meaningful and coherent whole.

The above mentioned evaluative, epistemic, and emotional gap between the external and the internal perspectives in an autobiographical narrative can be bridged by free indirect style as suggested by Goldie:

> [With] free indirect style, we see things through the character's eyes and language, but also through the author's eyes and language too. We inhabit omniscience and partiality at once. A gap opens between author and character, and the bridge – which is free indirect style itself – between them simultaneously closes that gap and draws attention to its distance. (Wood 2008, 11 as in Goldie 2011, 129)

Thus, what free indirect style does is intertwine the internal perspective of the character and the external of the narrator by introducing at the same time how the character experienced and evaluated the depicted events and how the author does it. The two are intertwined into a seamlessly integrated whole, which does not extinguish any of the perspectives but rather fuses these together. The audience or reader, then, gain insight into the internal meaningfulness for the character and the external for the narrator who has chosen to relate these events in this particular way. And most importantly, when thinking about the own past in this way, we can express "how what happened to us is 'infected' by the irony of our position: by what we now know, and by how we now evaluate and feel about what happened"

(Goldie 2011, 130) not in two separate parts but in one unitary piece. The external perspective can be thought of as my present perspective, that of me as I how find myself in the world, and am in possession of particular information, etc. From this perspective, then, I can evaluate and emotionally respond to events that happened to me in the past but without losing the perspective I had on them when I experienced them. Thereby, I can integrate these sometimes radically disparate affective and evaluative responses and express, explain, and understand how I, the narrator, now stand to both what happened then and to how I experienced it then. Thereby, I moreover, integrate my experience of the remembered events by responding to them emotionally and evaluatively now and re-interpreting and articulating their import.

Acknowledging the central role of narrative perspectives and understanding these in this way, I am going to suggest, makes autobiographical narratives central to one's self-experience and self-understanding in particular in cases of mental illness, which can be associated with radical shifts in how one finds herself in the world that are accompanied by marked changes in how one affectively responds to it as well that commonly are the basis for feelings of self-disintegration and loss of coherence and continuity. Being associated with radical changes in affective experience, thinking, and action, depression radically alters also how we experience and understand ourselves and, in many cases, disrupts the lives we used to live. And an external perspective (for instance during non-depressive periods or recovery or remission), which organizes, colours, and shapes the events in one's past and present can offer a possibility for explaining and understanding changes in experience, thinking, and behaviour during depressive episodes and can aid in regaining a sense of self-integration and self-coherence. Thereby, the internal perspective, which establishes the meaningfulness and coherence of experience at the time of experiencing these events, is not extinguished or replaced by an external one. Rather, the internal and external perspectives are simultaneously contrasted and intertwined in an internally and externally coherent narrative. And in doing this, the gaps between them are bridged by means of affectively and evaluatively responding not only to the described events from an external perspective but also to one's internal perspective as well. Before proceeding the detailed discussion of how bridging the gaps between the internal and external perspectives in autobiographical narratives aids the sense of self-coherence and self-integration, I am going to examine one of the most influential anti-narrativist account (Strawson 2004). I am going to suggest that it addresses several problems of a narrative understanding of the self, which are central to understanding experiencing and living with mental illness.

3. Episodic Selves and Narrative Persons

The dominant focus on the importance of narratives for personal identity, self-understanding, and well-being has not remained unchallenged. In what is probably the most influential criticism of narrative theories, Galen Strawson (2004) argues that the emphasis on the major role of narrativity in human life and experience is misguided and even potentially detrimental. He identifies two narrativity theses – a psychological and an ethical Narrativity thesis, whereby 'Narrativity' denotes "a specifically psychological property or outlook" (Strawson 2004, 428). According to the former, "[...] human beings typically see or live or experience their lives as a narrative or story of some sort, or at least as a collection of stories" (Strawson 2004, 428). This empirical, descriptive thesis about human nature is, as argued by Strawson, often coupled with the ethical narrativity thesis that is evaluative. According to it "[…] experiencing or conceiving one's life as a narrative is a good thing; a richly Narrative outlook is essential to a well-lived life, to true or full personhood" (Strawson 2004, 428). His argumentation against both is first and foremost based on a further distinction he introduces between the experience of oneself as a human being as a whole and the experience of oneself as an inner entity of some sort, whereby he is concerned mainly with the latter one (Strawson 2004, 429-430).

Moreover, the diachronic nature of self-experience, which is at the core of narrative theories in general, here, is contrasted with an episodic form of self-experience. In diachronic self-experience "one naturally figures oneself, considered as a self, as something that was there in the (further) past and will be there in the (further) future" while in its episodic form "one does not figure oneself, considered as a self, as something that was there in the (further) past and will be there in the (further) future" (Strawson 2004, 430). In the latter form, one does not have the sense that the self one is now was there in the past and will be there in the future, while one can still have a sense of being the same human being that has this particular past and can have a specific future. Here, it is important to note, the distinction is drawn between the self as an isolated entity present in current self-experience and the experience of oneself as a human being or a person who persists over time. While Strawson (2004) is concerned with the former and argues that it does not require narrative form of any sort, my concern lies with the latter (also in line with Goldie 2012; 2012a) and I agree with him that there is certain form of self-experience, which does not require narrativity, namely that of being a present self, which he terms 'self*'.

Strawson's argumentation against the central role of Narrativity in self*-experience starts off by trying to demonstrate that what we commonly term the 'self' is not a stable entity continuous and coherent through time but rather a succession of "many short-lived

selves" (Strawson 1999, 100). While these short-lived selves (which I suggest to term 'present selves' or in line with Strawson (1999; 2004) selves*) might not be narrative (constructions), I am going to suggest that our self-understanding and experience as *persons*, which is also what is in the core of autobiographies be they implicit or explicit, has a narrative structure. And that, moreover, building on Strawson's (1999; 2004) account, selves* are seen as coherently and meaningfully integrated in the life of a person at an implicit level, which when breached can be restored by autobiographical narratives.

As suggested by Strawson (1999; 2004), we can be aware of ourselves in an episodic mode, as present selves or selves*, which are, though integrated into our self-experience as persons or human beings. This sense of integration of selves* in personal self-experience is commonly implicit and not necessarily narrative, it is a background sense of our present mental presence as an integrative part of a unified and coherent person. For instance, I might experience myself* now as not the same entity me* at the age of 16, but experience both my present self* and my 16-year old self* as integrated in the person I am now who is remembering particular event that happened when I was 16-years old. But this sense of implicit continuity might be shattered or contested in many cases and this might prompt a need for an explicit integration of different present selves into a coherent person as a whole. Such cases require the deployment of explicit and thought through or publicly related narratives for the re-establishment of the sense of implicit continuity coherence, and meaningfulness. But let us first examine Strawson's (1999; 2012) understanding of the selves* that do not depend on Narrativity.

Developing his account of the episodic self, Strawson (1999) first adopts a phenomenological standpoint and focuses on the sense of the self as "the sense that people have of themselves as being, specifically, a mental presence; a mental someone; a single mental thing that is a conscious subject of experience" (Strawson 1997, p. 407 as in Strawson 1999, 104). Thus, the sense of self is not the experience of ourselves as human beings or persons but as the immediate presence of a mental entity that is an experiential subject. In self-experience, the self is "figured as [1] a *subject of experience* […], [2] a *thing* […], [3] a *mental* thing […], [4] a thing that is *single* at any time, and during any unified or hiatus-free period of experience, [5] a *persisting* thing, a thing that continues to exist across hiatuses in experience, [6] an *agent*, [7] as something that has a certain character or *personality*" (Strwason 1999, 106, emphases in the original). Thus, the self present in self-experience at any instance in time, the me*, or the present self, is not experienced as the self*, which underwent certain experiences in the past that happened to me as a person although it is somehow part of the me as a person or a whole human being as Strawson suggests (2004, 434). Thus, we can

understand the self*, the present self, or the me* that is experienced as an individuated mental presence at any point in time as a part or a segment of the person as a whole who is integrated, unified, and coherent over time. Although this view understands the self* as an episodic presence, it also includes a kind of implicit continuity or integration of selves*, present selves, or multiple me*s in the form of the experience of oneself as a person. While we might not be constantly experiencing ourselves first and foremost or explicitly as persons, this is the experience that is fundamental to a sense of coherence and continuity over the course of one's life. And, here, I agree with Goldie (2012, 128-132; 2012a, 1066-1068) who focuses on life stories of persons and self-experience of being a person rather than of (narrative) selves. These, moreover, are what autobiographical accounts are about – rather than narrating about a stable self*, which establishes our continuity over time, in our first-person accounts, we are concerned with the question how we have come to be the *persons* we are now, how the multiple transformations of sometimes very disparate and distinct mental presences have a bearing on our experience that we are one person-entity. Thus, being an episodic self* or experiencing oneself as an individuated mental presence at any time is not at odds with this understanding of narratives. Moreover, self-experience as developed by Strawson (1999; 2004) itself includes an aspect of implicit integration and coherence within person-experience. This, though, can be shattered or contested in many cases and narratives can restore the implicit sense of self* as integrated in one's self-experience as a person[33].

3.1. Present Selves and Implicit Person-integration

The self*, is implicitly embedded in the life of the person, it is like a self-state or a distinct but still meaningfully integrated temporal slice of the person as a whole. And indeed, we might experience ourselves in this implicit manner most of the time, mainly in cases, in which our implicit orientations do not transform or alter radically, especially not in the absence of personal agency (for example, our implicit orientations can change, as discussed at the beginning of this chapter in processes of interpretation and Laitinen (2002, 60)) we can have an implicit sense of who we are as our orientations can remain in many cases implicit[34]. But

[33] Whenever I use the term 'self-experience', 'self-coherence', etc. it refers to the experience of oneself as continuously present and coherently integrated person rather than a self. Adopting Strawson's (2004) terminology, I use 'self*', 'selves*', 'me*', 'self*-experience' when referring to the experience we have of ourselves as present selves at any point in time that are implicitly integrated in our self-experience as persons or human beings.

[34] Strawson (1999) explicitly excludes affective experience when discussing his account of episodic selves and here it could be objected that the continuity and stability of implicit orientations cannot be combined with Srawson's understanding of the episodic nature of the self. While implicit orientations include also affective elements, they can be understood broadly as the basis of all affect and cognition. If implicit orientations are encompassed, for instance, by what Matthew Ratcliffe (2005; 2008) has termed existential feelings or feelings

this is not always the case. Sometimes we find ourselves* moved in radically different ways, which also present our current selves* as not related in any way to the person-history or autobiography. And this, at least for some, if not for all, can be a predicament of suffering, distress, and need for a coherent and meaningful integration, which calls for a narrative perspective on one's life that bridges the past and future of a person to the present self*. Consider, for instance this description of radical alteration of implicit orientations that is associated with an experience of oneself as a self* that is not coherently and meaningfully integrated in self-experience as a person:

> Then one day, I woke up and I was not myself. I was an old self reborn, or a different self who surfaced and took over me. It happened every so often. Just like that. I would be given no warning signs. There would be no slow decent, no time to prepare. Suddenly, everything made me cry, my legs wouldn't move, I couldn't get work done, I forgot the point of showering, it was hard to open a jar of jelly. Suddenly.
>
> It was a glorious spring morning, sunny and dry and breezy, and I was sitting on the couch, staring out the window, an open book in my lap. I could not concentrate enough to follow the thread of even two sentences. My head hung to one side, impossibly heavy, my hand rested on the page, like some sad, ugly creature- a frog on a lily pad. I had no idea how long I had been there. The dogs swarmed around me and nosed me – my arms, my neck – curious, cautious, as though I were a dead animal they had discovered in the woods. I felt dead to myself. (Abramson 2005, 168)
>
> I can't leave my own bedroom. Me, who used to fly across the world and get on a plane without a moment's thought. […] I am fiercely independent. I am fierce. Or so people tell me. Used to tell me. I never used to be so afraid. When I was one of his editors, I used to stand up against Rupert Murdoch, arguing with him. I used to be so brave. I used to be somebody.
>
> I am still somebody.
>
> Aren't I?
>
> But who?
>
> I am somebody who can't leave her bedroom, somebody who can't walk across a road to buy a newspaper. (Brampton 2008, 34-35)

What Deb Abramson and Sally Brampton describe here is essentially a lack of implicit self-integration and coherence during depressive episodes. The present, depressive self*, in these cases, is not experienced as coherently integrated in one's personal self-experience but is rather strangely dissociated and not grounded in the trajectory of one's life. And this lack of coherence and integration is painfully experienced – both authors feel lost, incoherent, and

of being, they are broadly construed as embodied and enactive senses of what is possible and thereby constitute the background of all affect, cognition, and action. Implicit orientations, thus, can be the agentive, affective, and cognitive strands of the sense of possibility that give a direction to all our active strivings and responses in feeling and thinking, they are all that can possibly move us to act.

suffer greatly. They both wonder "Who am I now?", "How have I come to be like this?", "Is this the real me?", etc.

Some might argue that the lack of implicit coherence and integration here is related specifically to the experiential profile of depression as it is characterized by changes in experience, thinking, and action that are overwhelmingly painful and distressing. But this is not the case, as it can be experienced by some in particular during recovery from depression as well. For instance, at least some of those who have suffered from long-term depression that often had an early-age onset, might experience recovery (in particular one that results from medication) as unsettling and as disrupting the implicit integration of their multiple selves* into a depressive person or personality. Lauren Slater, in her account of her recovery from depression and obsessive symptoms describes experiences of this kind, for example in this passage:

> Not only had Prozac—thank all the good gods in the world—removed the disabling obsessive symptoms; it seemed, as well, to have tweaked the deeper proclivities of my personality. Who was I? Where was I? Everything seemed less relevant—my sacred menus, my gustatory habits, the narratives that had had so much meaning for me. Diminished. And in their place? Ice cream. (Slater 1998, 29)

> Having lived with chronic depression, a high-pitched anxiety, and a host of other psychiatric symptoms since my earliest years, I had made for myself an illness identity, a story of the self that had illness as its main motive. I did not sleep well because I was ill. I cut myself because I was ill. Illness, for me, had been the explanatory model on which my being was based. Since I had spent much time in mental hospitals, illness had also been something I had learned, like a skill, like spelling. […] And now, gone. I had tipped over, stepped over the border into health. (Slater, 1998; 50-51)

And when experiencing this painful and distressing disturbance of implicit integration of multiple selves* into our self-experience as persons, we can resort to autobiographical narratives, which can restore it. So, rather than postulating the existence of narrative selves*, I propose that our self-experience as persons, particularly in cases of loss of self*-integration and coherence, can be mended by narratives. Thus, rather than speaking of the narrative self*, we can speak of a narrative person. Moreover, this understanding does not commit us to an ethical narrativity thesis – rather than arguing that narrativity is essential to human flourishing, we can on this reading recognize its potentially therapeutic effects in those cases, which are associated with distress and suffering related to the loss of implicit self*-integration and coherence of self-experience as a person.

3.2. Self*-reintegration and Person Narratives

The understanding of the relationship between narratives and self-experience I started developing above views narratives as essential for the experience of oneself as a (unified and coherent) person leading a particular person-life in particular in cases of distressing, unsettling, and painful disturbance of implicit self*-integration, rather than as such for self*-experience, specifically of the type objected by Strawson (2004). Although we can commonly experience ourselves as selves* or distinct mental presences that are not narratively constructed or constituted, this 'episodic' self*-experience is associated with a sense of implicit self-continuity in terms of being a coherent and unified person that essentially is the integration of multiple selves* in the past, present, and future. And while this implicit sense of integration, unity, and coherence of selves* in the context of personal self-experience might not necessarily be narrative, in cases of disruption can be associated with distress, discomfort, and suffering and be restored with the help of autobiographical narratives. Narratives, as already discussed, (1) involve the articulation of implicit orientations and the patterns of import associated with them, (2) thereby also evaluate and re-evaluate these (in particular in light of the coherence and integration of whole persons), (3) make explicit gaps in perspectives, and (4) can bridge gaps in external and internal perspectives by means of free indirect style, which makes them the artefacts best suited for the re-establishment of lost coherence and unity in self-experience. This understanding of narrativity, moreover, does not encompass the so-called ethical Narrativity thesis (Strawson 2004), according to which narratives are the only means to well-being and flourishing. Rather, they are, here, considered as a suitable and useful tool for the restoration of lost implicit continuity in the cases that warrant such. This does not imply that in the absence of loss of continuity or its devastating effects (e.g. distress, suffering, emotional discomfort, etc.), one should resort to narratives in order to lead a good life and achieve well-being. Let me first examine some views on the narrative nature of the self* and the person and later on elaborate in detail on the role of narratives in restoring the sense of coherent and unified experience of oneself as a person.

In developing his account of the narrative sense of self, Goldie (2012; 2012a) adopts Schechtman's distinction between person- and self-narratives, according to which a person narrative requires one to "recognize oneself as continuing, see past actions and experiences as having implications for one's current rights and responsibilities, and recognize a future that will be impacted by the past and present" (Schechtman 2007, as in Goldie 2012a, 1066). According to Schechtman, a self-narrative additionally requires that one is able to identify with or have empathic access to one's past or future selves through narrative (Goldie 2012a, 1066). Schechtman's narrative self-constitution view, moreover, conceives of the self as

stable, with traits, "which define the person in her stability through change" (Schechtman 2005 as in Goldie 2012a, 1066), whereby these traits include character traits and all kinds of psychological dispositions, evaluative dispositions, sentiments, and personality traits (Goldie 2012a, 1066). Thus, what is in the core of the coherence and continuity of persons over time is a narrative self, which itself is characterized by particular defining traits that do not undergo radical change and secure the experience of continuity and coherence of the person over time. This appears to be the narrative understanding of the self* that Strawson (2004) opposes so radically. The self* here is that which takes care of the continuity, survival, and coherence of the person, in particular in view of it being constituted by narratives. According to Schechtman (as in Goldie 2012a), moreover, we identify with our past by means of empathic access that is based on the stability of defining traits. And for empathic access, it is required that one recalls episodes from one's past "from the inside, with a suitable richness of phenomenology" (Goldie 2012a, 1067) and that one sympathizes with the states that are recalled in this way (Goldie 2012a, 1067). And the stable self or the stability of its defining traits is what ensures this empathic access or identification with the past. Here, Goldie disagrees with Schechtman and proposes that the narrative sense of self does requires neither empathic access nor a stable self. Rather, what is needed is "the self of personal identity, the self to which we refer when using the word 'I' in autobiographical person narratives" (Goldie 2012a, 1068). And, as I proposed above, this view is compatible with Strawson's (1999; 2004) arguments for the episodic nature of self*-experience, which is implicitly coherent and unified within the context of one's self-experience as a person[35]. Thus, it might be suggested that when referring to the narrative self or the narrative sense of self, in order to capture this subtle yet significant difference, me might refer to the narrative person as the unified and coherent integration of multiple selves*. But whenever it breaks down, narratives, especially in terms of their perspectival nature can be used to restore the lost integration.

Thus, we can conceive of the narrator, of the person[36] engaged in thinking through the narrative of their life or particular episodes of their life, as someone attempting to achieve

[35] Here, the question arises as to how our implicit sense of self*-integration, unification, and coherence within the framework of self-experience as a person arises and what it amounts to. Finding oneself in the world as a distinct *embodied* and *acting* entity in the world can be established by means of our essentially embodied nature. Thus, although we might experience ourselves as distinct mental presences, or selves* (in particular when engaged in self-reflection, for instance), these selves* are unified in a single embodied entity, which is actively engaged in the world. While it can be argued that we can experience ourselves as persons only in terms of a narrative, I propose that prior to that and central to the integration and unification of self*-experience is the embodied nature of human beings that establishes a background sense of existing in the world as a single entity, which acts, experiences, perceives, etc. at different time points.

[36] It is important to explicitly draw attention to a possible distinction between (a) experiencing oneself as a person or (b) being a person and experiencing oneself as a person who thinks through or creates an explicit narrative of one's life or episodes from one's life. As pointed out, although we are habitually aware of ourselves as persons, it is not necessary that we are habitually aware of ourselves as narrating persons. Only in cases in

the integration of the present self*, multiple past selves*, and possible future selves* by means of evaluation and emotional responses, that is, by taking stock and emotionally responding to how she* experienced certain events or might experience such in the future without obliterating or invalidating the experiences of the respective selves*. And this is what narrative perspectives can achieve. This view, moreover, shifts the focus of the discussions of the narrative aspects of the self and personal identity from questions of survival to such about integration and opens up additional space for questions regarding the role of embodiment and enaction in self-experience and personal identity. In the sub-section to follow, I will attempt to demonstrate how the loss of implicit self*-integration of the experience of oneself as a coherent and unified person can be mended with the help of narratives.

3.3. Narrative Perspectives and Self*-reintegration in Depression

We can gain insight into how narratives can achieve the re-integration of self*-experience by first examining their perspectival nature in particular, in view of how it makes the engagement (e.g. emotional and evaluative) with instances of radically different ways of existence and experience. To do this, I find Goldie's (2011; 2012, Chapter 3) view of grief as a narrative process especially illustrative. I am also going to propose that depression, similarly to grief, can be conceived as a process, which is best understood and explained in narratives.

Grief, according to Goldie (2011; 2012, Chapter 3), is a process encompassing various components and instances and stretching over time. Upon experiencing a significant loss, the one who is grieving relates to her past in a special way, namely by realizing that things cannot ever be the same as they used to be, that something significant, which colours the main aspects of one's existence has been irrevocably lost. Grief, thus, involves a particular way of thinking about the past and the future, which is characterized by a radical difference in external and internal perspective that can be best understood and explained by a narrative (Goldie 2012, 56).

Grief can recur with different variations during the course of one's life (Goldie 2012, 62). It is characterized by a particular pattern, which involves "[...] characteristic thoughts, judgments, feelings, memories, imaginings, actions, expressive actions, habitual actions, and much else besides, unfolding over time, but none of which is essential at any particular time.

which the implicit continuity of our self*-experience within the framework of experiencing ourselves as persons is shattered and this is experienced as painful and distressing and we engage in narratively thinking through or creating an explicit narrative that can restore the lost sense of coherence, unification, and integration, we become narrators. Otherwise, we can experience ourselves as persons capable of narrating.

It involves emotional dispositions as well as particular experiences, and there will be characteristic interactions between these" (Goldie 2012, 62). Grieving, moreover, is a structurally heterogeneous process consisting of different parts or stages that do not continue throughout the process. Similarly to other processes, grief can also be interrupted by various events. If, for instance, the grieving person is rendered unconscious, her grief will be interrupted and then resume after she regains consciousness (Goldie 2012, 63). Grief, moreover, is not a transient or short-lived emotional episode but rather is sustained over longer periods of time. Focusing only events that cause grief and understanding it as a state rather than a process fail to capture and explain how it is sustained for long periods after learning about the loss (Goldie 2012, 63).

When grieving, we often look back to past episodes from the perspective of irrevocable loss that colors our memories of episodes with the one we have lost. In remembering past episodes with her, there is a triple ironic gap – we now know that this person is irrevocably lost, we in addition also affectively respond to the remembered episodes in a different way in view of the loss, and we also evaluate these in a different manner. Narratives of grief, respectively present us with the external perspective of the grieving narrator and her internal perspective at the time when the remembered events happened. And these are integrated in a meaningful and coherent whole in the narrative of grieving by means of free indirect style or its psychological correlate as suggested by Goldie (2011; 2012).

Depression, similarly to grief, can be understood as a process. It is commonly recurrent and depressive episodes resurface multiple times during one's life. Although mainly depressive episodes are characterized by changes in affective experience, thinking, and behaviour, being afflicted with the illness itself introduces for many a radically different perspective that colours how they remember the past and think about the future. Like grief, it also is characterized by a pattern of changes across multiple aspects of human functioning and existence such as affective experiences, cognitive style, thoughts, bodily feelings, actions, etc. These phenomena can appear in various combinations, so that depression is also manifested differently both across episodes and even within a single episode. If, for instance, the feelings of dread and anxiety are accompanied by experiences of social alienation, the general experiential profile can be characterized by experiences of social hostility and threat. In contrast, the same person might also experience instances of diminished ability and in this case feel anxious with respect to the performance of particular tasks that require these.

Depression can also be interrupted and then resume or recur again. As the result of successful treatment, one might experience recoveries and absence of depressive episodes,

which though in many cases can recur. Moreover, even during a depressive episode some might experience a temporary alleviation resulting from the deployment of coping strategies.

Depression, or its experience in particular, can be sustained by various factors such as psychological vulnerability, economical and social hardship, etc. Moreover, as I am going to argue later in this work (Section 5.1 and 5.2 of this chapter), some aspects of the experiential profile of depressive experience can be particularly pronounced and sustained by the individual interpretation of underlying causal and triggering factors and socially shared cultural conceptions of the illness that one encounters. For instance, for some individuals the experience of anxiety and looming threat can be more strongly pronounced and perpetuated during depressive episodes in line with their understanding of the illness as resulting from abuse they were subjected to. In such cases, these particular manifestations of depression or components of the heterogeneous experiential profile of the disorder can be sustained over longer times by inhabiting a more demanding and hostile environment. Depression also colours how we remember the past and envision the future. First-person testimonies describing the experience of depression during depressive episodes, for instance, refer to feeling disconnected from one's past. To many, the non-depressive periods appear as if from another world, like they did not happen to them but to someone else. The radical changes in evaluative and emotional import, in such cases, present the remembered enjoyment and pleasure of time spent with family and friends as ridiculous, enviable, etc. or the concern with benign everyday problems as exaggerated, overrated, and pointless. Moreover, probably most poignantly in cases of recurring and officially diagnosed chronic depression, the realization that the 'careless' times of not being plagued by depression themselves are compounded by grief over the loss of a former non-depressive way of being. In these cases, in addition, one might often experience fear and uncertainty in particular with respect to the recurrence or constant ominous presence of the illness. Specifically regarding the prognosis of recovery from depressive episodes one also evaluates and affectively responds to the times to come as holding no promise of alleviation or improvement of the current predicament of suffering.

Depression, as I am going to show in the chapters to follow involves a radical change in the existential background (Ratcliffe 2005, 2008, 2015) that constitute a different way of being, of finding oneself in the world that encompasses also a markedly altered pattern of emotional and evaluative import. The discrepancies in emotional import between depressive and non-depressive episodes, which can be associated with disturbances of self*-integration, (1) call for or prompt explication for their successful integration into a meaningful and coherent whole and (2) can be understood and explained in a narratives as they can breach

the gap between perspective with the help of free indirect speech (Goldie (2012, 70-72) argues for the essential role of narrative perspectives in dealing with traumatic experience in general).

Narratives, as suggested by Goldie (2011; 2012) have explanatory, revelatory, and expressive powers and can thereby explain and understand grief. Depression, as discussed above, can be understood as a process similarly to grief and most importantly involves a radical shift in patterns of evaluative and emotional import that can be integrated in the process of narrating or narratively thinking through the story of one's depression or life. This might be even more so the case during times of recovery, when the alleviation from suffering makes it possible to focus, remember, evaluate and generally attempt to understand the experience one was subjected to. Then, in the process of remembering depressive episodes, one can resort to the use of free indirect style or its psychological variant as suggested by Goldie (2011; 2012) and by articulating, refining, and evaluating and affectively responding to what one went through during depressive episodes achieve unity, coherence, and meaningfulness of one's experience as an integrated and coherent person.

During depressive episodes, the experience of others, oneself, and the world changes radically (see Jacobs et al. 2014 for a detailed discussion of the changes in the experience during depressive episodes as described in first-person accounts). And for many of those suffering with the condition, this is accompanied by feelings of painful loss of integration and coherence. What used to move one, to bring one pleasure and comfort earlier has become a burdensome chore or appears oppressive and threatening. One's former hopeful orientation towards the times to come is replaced by dread, anxiety, and worry. Friends and family suddenly seem critical, hostile, and judgmental, as if they come from another world, and one is filled with guilt, shame, and disgust, ruminates on past episodes and engages in self-denigration. And facing this radical change, one might often ask oneself "Who have I become?", "Why have I been replaced by this self that fails to continues my former life?", etc. Thus, one here appears to oneself as a distinct mental presence, which though is not related to or integrated in an encompassing experience of oneself as a unified and coherent person. What used to be at the core of leading the life of the particular person one is was disrupted by a self*, a mental presence, which is not coherent and cannot be meaningfully integrated in the trajectory of one's life and self-experience. What might be an additional factor here, moreover, is the absence of agentive engagement, for instance reflection, which underlies the changes in import that are part of the existential background. In such cases, the present self*, thus, is not the result of one's resolve towards personal transformation, for instance, so that it is not embedded and integrated in any way in one's personal unity and

coherence. One has been, so to say, passively exposed to a radical change that one fails to comprehend and find meaning to. One way to do this, though, is by thinking through it in narrative terms or constructing a publicly related narrative about one's depression. Thereby, from an external perspective, one evaluates and interprets the internal perspective of the depressive self*, which then having been taken stock of can become part of the unified and coherent self-experience of the person narrating about her illness.

Narratives, especially explicit and publicly related ones have been deployed in various therapeutic approaches such as psychoanalysis, narrative therapy, etc. (Rita Charon (2006), for instance, advocates strongly for the use of narratives across different therapeutic contexts). In particular in view of the considerations discussed above, in cases of depression they can be understood as having a two-fold purpose: on the one hand, they capture and organize the radical change in experience, thought, and action that are characteristic of depression into a meaningful and coherent structure and integrate these in the disrupted continuity of one's life, and on the other help to overcome the trauma inflicted by the illness on one. As I am going to reveal in the chapters to follow, those who have suffered and are suffering from the illness find themselves in the world in a radically different manner, which alters markedly the patterns of emotional and evaluative significance or import. Similarly to grief, depression infuses all aspects of existence, turns the mundane into threatening, bleak, and oppressive, the pleasurable into a burdensome chore, etc. and thereby constitutes a radically different perspective in the sense of a different manner of evaluating and affectively responding to the world. It could be argued that all instances of radical change like, for instance, in social environment or developmental or life stages (e.g. puberty, adolescence, maturation, etc.), are associated with transformations of patterns of evaluative and emotional import that are best explained and understood with narratives. While this is undoubtedly the case, mental illnesses and traumatic experiences can be said to involve a disruption and disturbance of the coherence and continuity of self-experience and life as I am going to propose in the next section.

4. First-person Narratives of Illness

Memoirs of mental illness in general[37] and depression in particular[38] have recently largely increased in number and accordingly attracted growing attention from both the general public and the research community across different disciplines who deploy them as primary sources for studying the experience of mental illness, its impact on those suffering from them, the social, cultural, and political context surrounding psychiatric disorders (e.g. Adame and Hornstein 2006; Hornstein 2009; Hyden 1997; Jacobs et al. 2014; Kangas 2001; Mollow 2006; Radden 2008, 2009; Stone 2004; Woods 2011; Young 2009). Although they might have only recently gained popularity among the research community, the so-called memoirs of madness are not a recent invention. To the genre of autopathography (Hunsaker Hawkins 1999; 1999a) belong not only current and modern accounts of clinical depression among others, but also as such of melancholia that can be traced back to the Middle Ages (Radden 2009). Autopathographies are commonly book-length stories of living with a long-term or chronic condition, which place the patient at the centre and portray the course of her illness, the larger social, political, cultural, and historical framework of being afflicted with the particular condition (Hawkins 1999, 127). These narratives of illness also emphasize different aspects of being ill – treatment, course and progression of the disease, personal coping strategies and the like and are motivated by various aims such as communicating one's struggles and experiences stigmatization of various illnesses, the often long and frustrating search for a successful treatment and learning to live with what is often a life-long and disabling medical condition. Telling stories about one's illness is "informed by a sense of responsibility to the common-sense world" (Frank 1995, 17) and pathographies are also created for others to bear witness to how one restored and re-established meaning, order, and coherence in one's life. They might provide guidelines, instances, and orientation in the unfamiliar territory of illness, which one suddenly inhabits. Although stories of illness are not recipes for successful coping, treatment, or living with a medical condition at face value, they can offer significant support in understanding one's experience of and with a particular illness.

[37] For instance such as the autoniograhical accounts produced by Beers (1981), Bell (2007), Sèchehaye (1951), Frame (1961), Jamison (1995), Millett (1990), Kaysen (1993), Saks (2007), Vega (2007) that focus on various aspects of experiencing and living with different psychopathological conditions like schizophrenia, obsessive-compulsive disorder, bipolar disorder, etc. (for a comprehensive list of published first-person accounts of mental illness see Hornstein 2011).

[38] The large number of depression memoirs published in the last 50 years include among others those that I focus on here (e.g. Brampton 2008; Crafton 2009; Danquah 1998; Hatfield 2008; Lewis 2002; Plath 1963; Smith 1999; Solomon 2001; Thompson 1995; Styron 1990; Wurtzel 1994).

Pathographies present us with a picture of illness as experienced and lived with in the context of the individual patient's life (Hawkins 1999, 128). Stories of illness are produced in response to the "[…] absence of order and coherence", "[…] the drastic interruption of a life of meaning and purpose by an illness that often seems arbitrary, cruel, and senseless; and by treatment procedures that often can appear as likewise arbitrary, cruel, and senseless – especially to the person undergoing them" (Hawkins 1999a, 3). Their main task is, thus, to re-establish the lost order and coherence, to re-discover or create meaning that has been lost (Hawkins 1999a; Frank 1995[39]). In a detailed examination of pathographical writings, Anne Hunsaker Hawkins (1999a) focuses on the examination of how the authors deal with their illness, in particular "the myths, attitudes, and beliefs of our culture that a sick person uses to come to terms with illness" (Hawkins 1999a, 4). These, I am going to argue later, are not conventions of the genre of pathography in particular, but rather constantly impact and shape the experience of (mental) illness. Moreover, pathographies are also motivated by the need to re-claim the patient's voice in medicine, which was silenced by the focus on disease based on the biomedical model. Under the influence of the biomedical model, the subject of a case report shifts from the individual afflicted with it to the specific biomedical condition expressed in dysfunctions, signs, and symptoms. Pathography reclaims the voice of the patient so as to "[…] assert the phenomenological, the subjective, and the experiential side of illness" (Hawkins 199a, 12) and also both express and shape how medical experts, those afflicted with the illness, and the general public understand illness (experience).

In addition to their role in re-establishing a sense of coherence, meaning, and purpose in particular with respect to self-experience, pathographical accounts are produced with different intents regarding their audience. Hawkins (1999a, 3-11) distinguishes among three major groups with respect to this. In the first group can be found accounts motivated by "didactic or altruistic principles" (Hawkins 1999a, 4), i.e. with the purpose of helping others that blend a personal account with practical information[40]. The group of angry pathographies, in contrast, demonstrates an increasing discontent with traditional medicine and declining trust in it "by the expression of anger at callous or needlessly depersonalizing

[39] Arthur Frank (1995, 53-54) points also to a further motivation to tell the story of one's illness, namely to communicate to concerned loved ones, family members, friends, colleagues, medical practitioners, etc. the progress of one's illness and how the ill person feels. This prompts the production and communication of illness stories sometimes without the patient's willingness to do so: "Stories of the illness have to be told to medical workers, health bureaucrats, employers and work associates, family and friends. Whether ill people want to tell stories or not, illness calls for stories". Thereby, stories of illness are not only the published accounts of the experience and life with illness but all narratives that are created to make sense and communicate the various aspects of being ill.

[40] Andrew Solomon's (2001) "The Noonday Demon: An Atlas of Depression" can be grouped here as it includes detailed discussions of treatments, the aetiology of depression, suggestions for alternative treatments, etc. that exceed the account of his own experience with the illness.

medical treatment" (Hawkins 199a, 5). These pathographies, Hawkins (1999a, 8) considers rather uncharacteristic of the genre and the majority of illness accounts, accordingly, include also praise of the medical system[41]. The third group of pathographical works also originate from dissatisfaction with the way medicine is practiced but focus on finding alternative treatments (Hawkins 1999a, 9).

Narrating about one's illness experience and its impact on the trajectory of one's life, moreover, as argued in the previous chapter, can aid the restoration of self*-integration and coherence. Illness can have varying impacts on the one's self-experience and self-understanding and Arthur Frank (1995) proposes to distinguish between three types of narratives of illness with respect to this – the restitution, the chaos, and the quest narrative. Restitution narratives are the ones that are most frequently told, mainly by those who have been recently ill and rarely by those who suffer from a chronic condition (Frank 1995, 77). As their name suggests, their plot revolves around the desire and expectation of the restitution of health and the return to everyday life. In contrast, chaos narratives lack order – the events are narrated as they are experienced and lack (causal) order (Frank 1995, 97). They are, strictly speaking, not stories that can be told but rather lived as to tell a prototypical story one need some reflective distance and establish a sequence of events (Frank 1995, 98). The last type of narratives, quest narratives, "[…] accept illness and seek to *use* it" (Frank 1995, 115; emphasis in the original). The illness is something the ill person learns from and describes in her own voice in the story. And indeed, the majority of published stories of illness are quest stories (Frank 1995, 115) that focus on one's journey[42] through illness to finding the purpose of suffering[43].

Quest stories can further be differentiated into three main groups – memoirs[44], manifestos, and automythology (Frank 1995, 119-126). In memoirs, the illness story is combined with the story of other events in the author's life. For instance, in first-person accounts of depression, the authors frequently narrate not only the story of their illness but also recollect experiences and events from their early childhood in particular, which might be related to the onset or development of the disorder. The chronological order of memoirs

[41] Kate Millet's (1990) account of bipolar disorder, "The Loony-bin Trip", can be placed in this group.
[42] Some depression memoirs in particular explicitly refer to the illness as a journey and adopt this in their titles as for instance Tracy Thompson (1995) in her account "The Beast: A Journey through Depression" and Meri Nana-Ama Danquah (1998) in "Willow Weep for me: A Black Woman's Journey through Depression".
[43] For instance, Gwyneth Lewis (2002) interprets her depression as a call for authenticity, truth, and creativity and Sally Brampton (2008) acknowledges that depression taught her to be more appreciative of and engaged in life
[44] Frank (1995) uses the term 'memoir' here in the narrow specific sense introduced above. Throughout this work I adopt the term 'memoir' in a broader sense, which refers to published (semi-)autobiographical accounts of illness. Although, most of the published first-person accounts of depression I have considered here exhibit the structure of memoirs as defined by Frank (1995), I do not wish to claim that all of them do so.

is interrupted as the illness interrupts the story of the past or the story of the illness is interrupted by the recollection of relevant events in the past (Frank 1995, 120). In manifestos, "[…] the truth that has been learned is prophetic, often carrying demands for social action" (Frank 1995, 120-121). The author does not desire a return to health but wants to expose the social suppression of suffering. Illness, for them, is social issue and not simply a personal affliction, which is communicated in the story. Automythology, in contrast, emphasizes personal change rather than social reformation. The author is re-born and re-invents herself in the process of being ill (Frank 1995, 122).

Published accounts of mental illness in addition to varying in intent (Hawkins 1999; 1999a) and in the impact of the illness on the self (Frank 1995), focus on the emotional distress that is both the result of living with a mental illness and an essential aspect of its symptoms (in particular in affective disorders such as major depression, bipolar depression, anxiety disorders, etc.). Accordingly, they have frequently been deployed for the study of emotional distress in particular. In line with Hawkins (1999) and Frank (1995), Alexandra Adame and Gail Hornstein propose that the medical conceptions of mental illness might aid neither patient nor medical professionals as "[t]he present-day medical discourse of medical imbalances and faulty neurotransmitters fails to capture the complexities of many people's subjective experience of distress and coping" (Adame and Hornstein 2006, 137). Moreover, in mental illness, unlike physical illness, "medical discourse has the power to dictate a person's identity" (Adame and Hornstein 2006, 137) – being diagnosed with depression, one is transformed to a depressive and being diagnosed with schizophrenia, one becomes a schizophrenic as opposed to having cancer, HIV, or another somatic disease. First-person accounts of mental illness, thus, also serve the task of negotiating the influence of medical discourse on one's identity, which can be itself experienced as traumatic and disturbing.

Focusing on the authors' subjective experience of distress, Adame and Hornstein (2006) identify three types of subjective experiences of emotional distress – "traumatic interruption", "revelation/purposeful suffering", and "continuity" (Adame and Hornstein 2006, 143). In the "traumatic interruption"-cluster, the author's life is disrupted and "thrown into a state of chaos" (Adame and Hornstein 2006, 143) by the sudden onset of an emotional crisis. After the emotional crisis passes, though, the author's life and self are not significantly changed. William Styron (1990), for instance, describes his experience with depression in a similar way. In "revelation/purposeful suffering" experiences, the emotional crisis that interrupts the author's life "becomes a catalyst for a personal revelation or breakthrough" (Adame and Hornstein 2006, 144). Unlike cases of "traumatic interruption", here the insights gained from and during the emotional crisis lead to a reconstruction of the own self and may

transform one's life narrative. Gwyneth Lewis' (2002) and Meri Nana-Ama Danquah's (1998) memoirs possess these characteristics. In "continuity-"experiences of emotional distress, the emotional crisis does not lead to an interruption of the author's life narrative and there is no distinction between the self before and after the episode(s) of distress. For these reasons, some might not even consider the emotions distress as a sign of mental illness but rather a personality trait, for instance. Here, it could be suggested that the majority of those who have suffered from a mental illness from an early age are more likely to experience emotional distress as continuous such as for instance in cases of early-onset depression as described by Elizabeth Wurtzel (1994) and Jeffrey Smith (1999).

With respect to their purpose and meaning, narratives of emotional distress can be classified in three general types – "psychiatric oppression", "psychiatric empowerment", and "healing" (Adame and Hornstein 2006, 146). In the first type, one feels oppressed, abused, etc. by the medical system in general. By creating a narrative, the authors aim at regaining their voice that was taken away by psychiatry (Adame and Hornstein 2006, 146-148). Narratives of "psychiatric empowerment", in contrast, usually advocate for certain treatments that were effective and exhibit a positive attitude towards the medical establishment (Adame and Hornstein 2006, 148-149). In "healing narratives", "writing is itself therapeutic, as part of the individual's healing process" (Adame and Hornstein 2006, 149).

Memoirs of mental illness, it can be concluded, have multifaceted purposes and functions. On the one hand, in narrating about experiencing and living with mental illness, their authors focus first and foremost on describing and making sense of profound emotional suffering not merely for themselves but also for others who are afflicted with mental maladies. Moreover, thereby they restore the lost meaning, coherence, and purpose of their existence that can be brought about the devastating and disabling effects of the illness and by its disturbance of one's sense of implicit self-integration. In addition to this, memoirs of mental illness also portray the larger social, cultural, political, and institutional settings in which mental illness is embedded and illustrate their impacts on both experiencing and living with it. But their reliability as sources for the study of the subjective experience of depression in particular has not remained uncontested. In what follows, I am going to present a recently advanced criticism, which challenges their epistemological status in particular in view of genre-specific requirements, which transform them into descriptions of socially and culturally shared conceptions of illness, symptoms, identity, and the relationship between the two. I am then going to demonstrate that social and cultural beliefs and assumptions about

mental illness, depression, etc. operate at the level of illness-experience rather than merely at the level of its description[45].

5. Limitations of the Study of Memoirs of Illness

Jennifer Radden and Somogy Varga (2014, 100) argue for the indeterminate epistemological status of depression memoirs as they view the descriptions of inner states in them as representative of the "discourse on depression within the medium of literature" and not of the "concrete and "raw" experience of depression itself". Depression, I am going to suggest, is associated with rather complex heterogeneous experience that is not characterized by a specific "depression quale" or "raw" experience. Although the experience one is subjected during a depressive episode is radically different from non-pathological or not altered (affective) experience, numerous patient reports, testimonies, and first-personal reports describe it as comprising various different phenomena (sometimes even differing among depressive episodes experienced by the same individual), which are embedded in complex social and cultural context. Being depressed is finding oneself in the world in a markedly different way, which encompasses diverse symptomatic experiences, their immediate interpretations and meaning, and the impact of these on experience itself.

Radden and Varga (2104) argue (1) that memoirs reveal how experiences are made sense of, how they are organized and narrated in order to achieve a coherent self-representation based on the requirements of the autobiographical genre for coherence and closure. As with all works of literature, in memoirs there is also intervention of editorial work, adherence to stylistic requirements for expressions such as elaborate and complex metaphors, and the use of specific literary and linguistic devices for achieving more dramatic effect, which culminate in descriptions of experience that are stylistically inflated and, in many cases, not unambiguously portraying the actual experience of depression. Moreover, the laws and requirements for the description of experience in works of autopathography are (2) "pervasively influenced, and constrained, by the social or cultural meanings characterizing illnesses and disabilities" (Radden and Varga 2014, 104) and by conceptions of self and identity. Thereby, Radden and Varga claim, what is being described is not the immediate experience associated with depression, but rather the dominant conceptions and ideas about depression and how it is related to the own self and identity. These can also impact the identification with illness and symptoms at the level of reflection and recollection, as the

[45] The discussion of the epistemological value of memoirs of depression in the section to follow was presented at the Second Annual Conference of the European Philosophical Society for the Study of Emotions in June 2015 in Edinburgh and in the form of a poster at the Ninth Conference of the Society for Analytic Philosophy (GAP 9) in September 2015 in Osnabrück.

dominant cultural and social conceptions of identity and depression portray the condition and its symptoms as closely related and even constitutive of identity. Subsequently, symptoms might be described as constitutive of one's identity even if they have not been experienced in this manner. The stigmatization of depression also additionally influences the genre-specific requirements regarding which experiences can be included in an account of this type. Thus, memoirs in particular might not include descriptions of socially disvalued or inacceptable experiences in cases in which these are nonetheless described, though, one might tend to do this in a rather alienating manner in contrast to a general identification with illness symptoms.

Memoirs (3) are compiled and finished after recovery, not during a depressive phase which means that what is being narrated is recalled from autobiographical memory. This is considered problematic due to the co-constructive processes that operate in autobiographical recollection and involve „the co-construction of what is recalled, establishing a link of the present self of the author with a set of past experiences, but in a loop-like, dynamic way [...]" (Radden and Varga 2014,103). Moreover, the changes in moods that constitute depression are incomprehensible and might elude description, which in the case of their recollection might even more readily prompt the active co-construction. Thus, Radden and Varga (2014, 100) claim that the epistemological value of depression memoirs in particular is indeterminate as the descriptions of inner states they provide are representative of the "discourse on depression within the medium of literature" and not of the "concrete and "raw" experience of depression itself"

5.1. Influences on the Descriptions of the Experience of Depression in Memoirs

To illustrate the influences on descriptions of depressive experience in memoirs, here, we can consider several passages from William Styron's (1990) "Darkness Visible". This account is characterized by a focus on descriptions of changes in affective experience, thinking, and action rather than on creating a life-story, which includes recollections and interpretations of possible causal and triggering factors. Respectively, in it, Styron provides us with numerous detailed descriptions of what it feels like to be depressed and what meaning and significance the illness has for him. For instance, he understands depression in the following manner:

> […] never let it be doubted that depression, in its extreme form, is madness. The madness results from an aberrant biochemical process. […] such madness is chemically induced amid the neurotransmitters of the brain, probably as the result of systemic stress […]. With all this upheaval in the brain tissues, it is no wonder that the mind begins to feel aggravated, stricken, and the muddied thought processes register the distress of an organ in convulsion. […] (Styron 1990, 46)

Depression, according to him and in line with widely spread current conceptions, is the result of a chemical imbalance, which is caused by psychological stress. The afflictions in the form of symptoms are experienced as signs of a diseased organ, the brain. The source of the suffering is the brain with its disordered chemistry and this is experienced as beyond one's control – one is left at the mercy of the disease. Similarly, various experiential phenomena are described as beyond one's control and resulting from a chemical or hormonal imbalance as in this passage:

> I had now reached that phase of the disorder where all sense of hope had vanished, along with the idea of a futurity; my brain, in thrall to its outlaw hormones, had become less and organ of thought than an instrument registering, minute by minute, varying degrees of its own suffering. (Styron 1990, 58)

Styron identifies depression primarily with the distortion of rational thought by calling it a madness – the ultimate capacity of the mind or brain, to be rational is compromised and one is left at the mercy of hormonal and neurotransmitter-induced changes in mood. The conception of depression as an affliction of the brain that results in distortions of mental functions is also reflected in the mechanistic view of worsening symptoms beyond one's control:

> […] as the disorder gradually took full possession of my system, I began to conceive that my mind itself was like one of those outmoded small-town telephone exchanges, being gradually inundated by floodwaters: one by one, the normal circuits began to drown, causing some of the functions of the body and nearly all of those of instinct and intellect to slowly disconnect. (Styron 1990, 47)

These meanings of depression and its symptoms are coherently and consistently reflected in the emphases throughout the memoir that depression is a storm that cannot be controlled and this triggers a further lack of hope and prospects for change:

> Told that someone's mood disorder has evolved into a storm – a veritable howling tempest in the brain, which is indeed what a clinical depression resembles like nothing else [...] (Styron 1990, 37)

In line with the metaphor comparing depression to a storm, the thoughts of suicide are described as fleeting images carried by icy winds:

> […] thoughts of death had long been common during my siege, blowing through my mind like icy gusts of wind, they were the formless shapes of doom that I suppose are dreamed of by people in the grip of any severe affliction. (Styron 1990, 26-27)

Based on the considerations raised by Radden and Varga (2014), thus, this description of suicidal ideation as coming in the form of fleeting images beyond one's control might not adequately capture its "raw" form during the depressive episode prior to recollection and narration. Rather, it can be said to result from the general beliefs and assumptions about

depression as a disorder of the brain that incapacitates one, inflicts immense suffering and is beyond one's control and the stylistic requirements peculiar to the genre of pathography, which demand coherence and consistency of description. Indeed, memoirs offer detailed explication of the social and cultural significance of symptoms and illness as the literary requirements they are subjected to necessitate the detailed and elaborate descriptions of shared cultural and social contextualization of depression. In order to achieve autobiographical coherence and integrate the general contextualization of the illness, their authors describe the various endeavours of understanding what depression is, the sources deployed for this, the social, cultural and institutional conventions. Thereby, memoirs are suitable for capturing the various sources of meaning of illness and symptoms that deserve to be studied in their own right. But the requirements for coherence and consistency are only partly imposed by genre-specific literary conventions. Anonymous reports of experience, similarly, aim at establishing a consistent and coherent narrative, which encompasses not only individual symptoms or experiences but rather also how these impact the patient's life and her self-experience and -understanding. In the next sub-section, I am going to present an examination of several testimonies produced in response to the DDQ UK specifically in view of the influences of requirements for consistency and coherence and the influence of social, cultural, and personal meanings and conceptualizations of depression on both descriptions of experience and the experience of illness in general.

5.2. Influences on Anonymous Testimonies of Depression

Chronic or recurring illness disrupts the order and coherence of the patient's life and "[…] becomes embodied in a particular life trajectory, environed in a concrete life world" (Kleinman 1988, 31) and is imbued with particular meaning and significance. For instance, the individual suffering from depression does not merely experience more sadness, more hopelessness and despair, more guilt and shame, but finds herself in a world, in which these experiences also immediately carry specific significance or meaning – she should not be sad or hopeless as she has a family, a job, she should not be embarrassed or ashamed of her achievements as she has accomplished so much, she should enjoy her life, perform her everyday activities, be a caring and loving mother, a successful professional and the like. Consequently, the sadness, hopelessness, and grief become also inappropriate, unjustified, signs of self-indulgence, weakness, and lack of appreciation. Moreover, they are also undesired, painful, intolerable, devastating and disabling and make it impossible to enjoy life and function normally. The individual experiences associated with depression thereby carry particular meanings even prior to reflecting on them specifically for the purpose of writing

an autopathographical account. In his comprehensive and insightful research of the experience of illness, Arthur Kleinman (1998, 3-31) argues that illness experience is imbued with three main types of meaning that shape and colour it – cultural, social, and personal. Social and cultural meanings are determined by the knowledge about illness, symptoms, disability, etc. shared by particular social and cultural groups. Personal meaning is the individual significance that is attached to the symptoms of illness – as precluding one from actively participating in social interactions, as disabling and making successful performance in everyday life impossible, for instance. These are, according to him, an integral part of the experience of illness and its symptoms and not interpretations or evaluations triggered upon recollection and during the process of creating a narrative as Radden and Varga (2014) seem to suggest.

In order to investigate if the cultural, social, and personal meanings of illness and symptoms are indeed peculiar only to descriptions in memoirs, I am going to examine several anonymous testimonies of the experience of depression, which do not belong to this genre and are thus not subjected to requirements for coherence, for the description of dominant conceptions of depression, identity, and the relationship between the two. Respectively, if these influences operate only in genre-specific works, the coherence and consistence of description observed in the examples from Styron's memoir would not be detectable here. In choosing the sample of testimonies to be studied, I focus on responses to the DDQ UK whose authors identified as depressed at the time of participating in the survey. Thereby, they are less likely to engage in the co-constructive processes involved in recollection. I focus on examining their responses to two questions, Q1B and Q11B[46] that inquire about affective experience in particular and one's understanding of depression. Based on the responses to Q1B, I identified the three most commonly described phenomena (feelings of diminished self-worth, suicidal thoughts and feelings and feelings of hopelessness) and analysed these with respect to the conceptions of depression reported in the answers to Q11B.

Consider, for instance, how this respondent understands and conceives of depression:

> I know depression is an illness but at the same time I feel like I caused it. The doctor explained that it could be because of genetic reasons […]. Also my psychologist believes that because I feel like I am to blame for the violence caused by my biological towards me and my mum, which started when she was pregnant with me so I have always felt to blame because of that. (R16UK, Q11B)

[46] Q11B: *What do you think depression is and what, in your view, caused your depression?*

When describing the changes in her moods and emotions, she writes:

> Some days I don't want to get up because I fear that I will do everything wrong and I don't want to let people down. I hate everything about myself and wish I could change but I know that I never would be able to. It is as if I am being suffocated and I feel trapped with no escape apart from death but I don't actually want to die but at times it feels like the only option I can choose. (R16UK, Q1B)

The respondent identifies depression aminly with feelings of guilt and shame and low self-esteem. The understanding of depression as being causally related to oneself is echoed in the characteristic states of guilt, self-blame, and diminished self-worth that are described in the second passage. These experiences of guilt, self-blame, and low self-esteem are charged with personal meaning (Kleinman 1988) that is not generated at the level of the deliberate and complex reflection in the process of writing an autobiography but are already present in such brief anonymous first-person narratives. The meanings of depression and its symptoms are communicated and made sense of in the form of an implicit or explicit narrative and this narrative shapes the experience itself, not merely its description (Kleinman 1988). Combined with the socially shared conception of depression as an illness based on a genetic predisposition, the experiences of hopelessness and lack of prospects and probably the inability to intervene and change the course of the illness culminate in a sense of being unable to alter one's unbearable predicament, which accentuates the anticipation of death as the only possibly relief from one's current suffering.

These processes can be observed in further anonymous descriptions of depressive experience as well, which are characterized by varying conceptions of depression and respectively most prominent experiential phenomena:

> I think depression is when the chemicals in your brain just can't handle the things that make you unhappy and eventually give up. An unhappy isolated childhood, bullying and sexual abuse caused my depression. (R24UK, Q11B)

> I feel isolated, suicidal, worthless, paranoid ... I have been depressed for such a long time I don't really remember what it feels like not to be. (R24UK, Q1B)

The first passage refers to the culturally and socially shared conception of depression as an illness resulting from a chemical imbalance itself caused by psychological trauma. This implies a two-fold continuity of identification – the respondent identifies with the illness at a bodily level (a chemical imbalance) and at a psychological level (the same person who underwent bullying and abuse earlier). Moreover, in the response to Q1B, the respondent experiences the symptoms as an integral part of oneself as they seem to have been present for a substantial period. The conception of depression as a chemical imbalance attributes the source of the symptoms to the own diseased brain, which cannot handle the negative experiences. This medical understanding of depression is reflected in the way dominant

experiences are presented – an uncompleted list of symptoms, similar to the format of diagnostic manuals patients are usually familiar with.

For still others, depression is more similar to a personality or character trait that has always been present to at least some extent and is commonly triggered by adverse life events:

> I think, with me, it has been ever present but it never came to the surface as I was able to deal with it better before or there weren't events […] that have brought all my depression to the surface all at once. I always had elements of paranoia and depression but thought everyone had times/issues that I was experiencing. (R60UK, Q11B)

> […] the non-depressed periods creep up on you and before you know it you are questioning why you feel 'ok'. But generally when you are not depressed you don't foresee a bleak future and there is a sense of mental clarity and that things can be achieved […]. When I am depressed it builds and builds from a low moment that triggers something that then accelerates through a thinking process that is eternally negative that links one bad thought/experience to the next until you try and shake yourself out of it. This is essentially a dark time of hopelessness and fears for the future. (R60UK, Q1B)

In the first passage, the respondent appears to identify with those feelings even in non-depressed periods and they are considered constitutive of one's identity. The understanding of depression as constitutive of the own identity is reflected in the description of the almost not noticeable onset of a depressive episode that seems to be an uncontrollable accumulation of negative affect resembling a downward spiral one fails to escape from just like the circumstances that were mentioned as triggers.

Some attribute very specific personal meaning to depression as for instance described in this passage:

> depression maybe comes when your creativity is stifled and you can't express yourself so what's the point I have always had periods of mild depression but when I split with my boyfriend 4 years ago it got far worse, more intense and frequent (R65UK, Q11B)

> I feel: black empty dark hopeless worthless unimportant I think about dying troubled traumatised like a shroud of darkness has descended on me (R65UK, Q1B)

Depression is, here, identified with a lack of creativity that influences the description of phenomena – a chaotic list of different states. Analogously, the inability, which is emphasized in the first passage is mirrored in the metaphor of the shroud that descends upon one and thereby restricts possible actions. The actual experience seems to be of inability, an inability to control and regulate the affective states one is subjected to and is not merely induced by the conception of depression as lack of creativity.

The understanding of depression as a chemical imbalance, which changes how one finds oneself in the world can for some be associated with the alienation of symptoms and of the disorder from oneself as well:

> A chemical imbalance that makes the world seem different and affects how I deal with and view my life and the world I was put on an anti-depressant to control my headaches and this along with a few traumatic events contributed to this (R147UK, Q11B)
>
> Much more extreme – I'm either happy or really down […] The overwhelming feeling is just hopelessness and this drags everything else down – any happy thought will disappear into the black hole really quickly The analogy I'd use is when I'm depressed my emotions/moods are like a fierce storm out at sea whereas when I'm not the sea is calm with small waves and ripples (R147UK, Q1B)

Depression is clearly a chemical imbalance and the origin of symptoms and the symptoms themselves are not considered part of one's identity. The dominant experience of hopelessness is analogously experienced as beyond control, a storm assailing one similarly to falling victim to aberrant biochemical processes.

The cultural, social, and personal meaning of symptoms and depression (Kleinman 1988) in general are to be observed in both instances of reports of experience. The excerpts from memoirs as much as the descriptions provided by currently depressed individuals in responses to the DDQ UK both exhibit similar patterns in which the experience of depression and particular phenomena that constitute it are closely related. The experience of depression and (chronic) illness in general cannot be understood as a specific quale, or "raw experience". The *reflective experiential phenomena* described in first-person reports in both published autobiographical accounts of illness and anonymous testimonies are always embedded in a complex context of various patterns of meaning. The changes in background structures or background orientations, which underlie these alterations in reflective phenomena are not the direct subject such influences, though. Thus, by identifying and studying changes in these structures, we can also better understand what heterogeneous reflective manifestations described in first-person accounts have in common. This also makes it possible to establish cross-cultural aspects and influences on experience and common underlying structural changes in the experiential background that might be manifested in different reflective experiences described in first-person reports. To identify such influences, published accounts offer a very rich source – they provide us with a detailed and comprehensive narrative that covers social, cultural, institutional, and personal aspects of living with depression.

5.3. Narrativity and Anonymous Testimonies of Depression

Being testimonies of experience *produced in response to a survey*, it might be argued that the responses to the DDQ are not narratives in the sense of (life) stories characterized by a beginning, middle, and an end and a narrator's and character's perspective, which establish a

sense of self-integration and coherence over time. While not all answers submitted to the DDQ UK and DDQ BG present us with canonical life-stories, I do believe that they are also narrative testimonies, which can provide us with insights into the experience of depression. Consider, for instance the following testimonies provided by two of the respondents to the DDQ UK:

> [My emotions and moods are] Negative. Self hate. Angry. (R8UK, Q1B)
>
> The world is against me and is very frightening. (R8UK, Q2B)
>
> No-one cares. They [other people including friends and family] are all selfish and don't understand. (R8UK, Q3B)
>
> [My body feels] Very tired and uncomfortable. (R8UK, Q4B)
>
> It's hard to do anything because nothing seems to matter and it's very hard to concentrate on anything. (R8UK, Q5B)
>
> It [time] goes slower, it drags. Occasionally I just loose chunks of time. (R8UK, Q6B)
>
> It[depression] makes it very hard to think or concentrate. Rational thought is almost impossible, (R8UK, Q7B)
>
> There's very little good about my life when I'm depressed. (R8UK, Q8B)
>
> Yes. What it is I'm depressed about. I find it difficult to understand my own feelings/thoughts and consequently it is very difficult to explain or describe them. (R8UK, Q10B[47])
>
> A malfunction of the brain made worse by actual circumstances. (R8UK, Q11B)

> Either feeling totally numb and experiencing a total 'nothingness' or feeling absolutely devastated when there was nothing to explain it at all. I would be in tears for hours and have no idea why. I didn't want to do anything. Everything I ever used to be interested in just stopped, such as cooking or swimming. I didn't want to see anyone, I just wanted to stay in bed all day. First thing in the morning I would wake up and burst into tears and feel like getting out of bed was the hardest thing ever. I used to not be able to sleep at night because I was so sad.
>
> I remember thinking all the time that it was as if a weight had dropped in the pit of my stomach, the sort of feeling you get when something really bad has happened, like someone has died, but nothing had happened. I couldn't explain it at all.
>
> It was different from not being depressed because I would feel sad for such a long time. I would go days, weeks and months feeling sad, or there would be more days of feeling like that then there were where I felt happy. On days where I felt numb I remember wanting to just feel something. But then the days where I felt something, I felt like it was the worst feeling in the world and I would have never wished it upon anyone.

[47] Q10B: *Are there aspects of depression that you find particularly difficult to convey to others? If so, could you try as best you can to indicate what they are and why they are so hard to express.*

I'm a very sociable person – I love people and I love doing things like cooking, especially cooking for other people, so when I don't want to do those things for a very long time I tend to know that there's something wrong. (R22UK, Q1B; emphasis added)

Everything seems grey. It's like there's no colour to anything. Everything you do seems the same day in and day out. *I didn't realise it at the time but I would take things totally out of perspective, there was no ability to rationalise.* If I passed someone I knew on the street and they didn't say hello to me I would beat myself up saying that everyone hated me. It didn't matter how many times the people around me said they loved me, I just wouldn't believe them.

Everything seems 10 times harder. I had to do everything in such tiny steps. Just the simple task of getting out of bed or leaving a building would be a huge deal. I would have to tell myself "first get into a sitting position. Then we'll worry about the rest of it afterwards."

I would see everything as such an ordeal, all these little things bundled into one huge thing. I just felt like there was this massive problem and I had no idea what to do about it.

I could be surrounded by friends, which I was in reality, but still feel ridiculously lonely and like no one cared about me at all. (R22UK, Q2B; emphasis added)

It seems like everyone is having an amazing time and you're the one missing out. It's so easy to beat yourself up and think there's something wrong with you. It feels like no one else has ever experienced anything like this before, like you're all on your own.

Also, I used to think that family and friends didn't care, that if they went to bed at night instead of staying up and checking I was OK or worrying about me then that meant that they didn't care at all. It felt like everyone was lying to me, like they were just telling me they loved me and cared to make me feel better. I felt like a huge burden on everyone. (R22UK, Q3B)

Lethargic, like it's [the own body] full of lead. My legs felt heavy all the time and I felt ridiculously tired. It was a horrible cycle – the more I felt tired, the more I stayed in bed, so that when I did get up I'd feel even more lethargic. Sometimes I would feel so numb I felt like I couldn't eat anything, or I'd feel "too sad" to eat.

I think a lot of people have this impression that depression is a purely mental illness, and I can't explain it but it totally affects you physically as well and your body just goes into meltdown mode. (R22UK, Q4B)

Things seem almost impossible. Just getting out of bed is difficult. I used to eat a lot of ready meals or things that wouldn't take long to prepare, or I'd just snack, because cooking just felt too difficult.

It was an effort to do things like have a shower and get dressed. Everything was so difficult. It would take a lot of encouragement for me to begin to do anything. (R22UK, Q5B)

I can't really remember but I think time used to go a lot more slowly. I would also forget a lot that had happened – things I'd done, things I was supposed to be doing/saying. I would start sentences and forget what I was saying. (R22UK, Q6B)

> It makes it quite difficult. It's a lot harder to take stuff in because you feel like you're not really there. I was at university for some of the time I was depressed and I really struggled to concentrate. I also seemed to forget a lot of information or what I had been saying. (R22UK, Q7B)
>
> Life seems completely pointless when depressed. Depression is the worst feeling in the world and when you're absorbed in its depths you just don't even want to be there, anything to stop the numbness and pain. You can't see far into the future so you can't see aspirations or dreams. Everything I ever wanted to do with my life before seemed impossible now. I also would think that I would never get out, that I'd be depressed forever. It brings quite irrational thinking because it's not a rational illness. It makes you think all sorts of things about life and yourself that aren't true. I thought I'd never escape from the depths of depression and never achieve anything with my life. (R22UK, Q8B)
>
> It's really difficult to just "cheer up" or be happy. People seem to get a bit irritated that you can't just feel better when you want to. I think people feel you're exaggerating it but if it is exaggerated then it's because it feels exaggerated to you and there feels like nothing you can do about it. Others may see the depression as something you can change but it is your reality, it totally consumes you. It's quite difficult to explain the physical symptoms that come with it and that something which seems a normal task to someone else seems like the biggest hurdle to you. (R22UK, Q10B)
>
> To me depression is a mental illness, and can be due to chemical imbalances in the brain. It can affect anyone and is the mental equivalent of having a physical illness like chickenpox. It just takes a lot longer to recover from. It's very ongoing.
>
> I think a large number of factors contributed to my depression. I really struggled growing up with identifying with those around me such as peers and family. I felt completely different to everyone else so I had quite a low self image from a young age. I felt frustrated that I couldn't communicate my feelings very well so I got angry a lot of the time. I grew up with a brother and sister who were naturally very smart and I felt like the complete opposite. They seemed to do well at school quite easily whereas I really struggled even though I tried hard. I felt like an outsider, I felt stupid, I felt ugly, and I didn't want to be the person I was.
>
> It gradually started going downhill. I had to go through a lot of changes and I didn't cope well with change. I got really fed up and low and couldn't see a way out of the situations that I came across. My life just seemed completely pointless to me. (R22UK, Q11B)

While both respondents focus on describing the emotional torment they undergo during depressive episodes, the first testimony lacks an external narrator perspective and is restricted to a minimally narrative report of experience. Rather than relating to the experiences and events described here and integrating these in a framework of external meaningfulness and coherence, this respondent remains confined to the internal perspective of an episodic, depressive self that might even not be experienced as integrated in one's self-experience as a person. In contrast, the author of the second testimony engages in an explicit evaluation of the depressive predicament described from an internal perspective in particular by means of

a comparison of the episodic, depressive self* (Strawson 1999; 2004) and the person narrating about this episode of her life. But this contrast does not necessarily imply that the testimonies like the first one are not in any way narratives, which reliably express and organize the experience of depression. While they might be lower in narrativity, they still present us essentially with narrative testimonies solely from an internal perspective. And indeed, as mentioned earlier in this chapter, according to Frank (1995, 98), narratives of mental illness are often chaos narratives of this sort. Thereby, we can gain insight into the immediate, present, or episodic experience of depression that has not been re-integrated into a coherent and meaningful self-narrative of the person narrator. Here, the episodic depressive self* dominates coherent and integrated self-experience and indeed, at least some of the respondents to the DDQ UK who indicated being depressed when completing the questionnaire like the author of the first testimony fail to adopt an external narrator perspective. To them, the current experience of depression is all-encompassing and overwhelming and makes adopting a perspective different than the present impossible. Nevertheless, these testimonies lower in narrativity present us with acts of interpretation and articulation (Taylor 1985) of particularly distressing experience and moreover illustrate the devastating effects of depression on one's sense of meaning, purpose, and coherence. Thus, although the anonymous testimonies provided in response to the DDQ UK have a lower degree of narrativity, they are nonetheless both an appropriate medium for explaining and understanding depression and for studying its experience.

6. Descriptions of Experience in Memoirs and Anonymous Testimonies of Depression: Language and Metaphors

The responses to the DDQ UK and the studied memoirs[48] describe the experience of the illness as one of profound disconnectedness and alienation. Although these different formats of testimonies go along with specific characteristics, limitations, and requirements, the various phenomena described in them converge consistently. Published accounts tend to less frequently include descriptions of socially undesirable or inappropriate affective experiences, behaviours, and thoughts such as anger, hostility, and (intense) irritability, and the like (with the exception of the following passages from Brampton 2008, 83; Crafton 2009, 6; Danquah 1998, 40, 186; Smith 1999, 57, 178; Solomon 2001, 47; Thompson 1995, 37, 45; 56). Memoirs also utilize a wide range of linguistic devices when describing the experience of depression

[48] The memoirs of depression I examined for developing this dissertation include only a fraction of the large number of published autobiographical accounts of depression and are Brampton 2008; Cawthrone Crafton 2009; Danquah 1998; Hatfield 2008; Lewis 2002; Plath 1963; Smith 1999; Solomon 2001; Thompson 1995; Styron 1990; Wurtzel 1994.

such as complex and stylistically elaborate metaphors. For instance, the sense of disconnectedness from the world and others is often described as if one is observing the world through a glass wall, viewing it from a great distance, or being prevent to engage with it by an (invisible) obstacle or barrier as eloquently described by Elizabeth Wurtzel (Wurtzel 1996, 101) in this passage (see also Plath 1963, 196; Wurtzel 1996, 101, 218 for similar metaphorical descriptions):

> *Instead I walked away from Ruby lost in vertigo. The Yard seemed like a phantom. I moved through it in the plastic bubble that separated my fogworld from everything around me.*

The anguish and terror of depressive episodes is often metaphorically compared to impenetrable darkness enveloping and engulfing one in a state of permanent and inescapable suffering:

> Because with every day that goes by, I feel myself becoming more and more invisible, getting covered over more thickly with darkness, coats and coats of darkness that are going to suffocate me in the sweltering heat of the summer sun that I can't even see anymore, even though I can feel it burn. (Wurtzel 1996, 54)

Indeed, the metaphoric association of depression with darkness and blackness is probably one of the most common figures across different cultures and social groups and has a long tradition starting from Hippocrates who considered depression as an excess of black bile and moving to Medieval conceptions of the black night of the soul. It has been suggested that it captures "[…] not only the sense of darkness – induced fear, gloom, or dejection experienced by sufferers of melancholia, but also the clouding of thought, consciousness, and judgment […]" (McMullen and Conway 2002, 168). The world of depression is one of impenetrable and suffocating darkness – there are no prospects for change, no one to turn to, and one feels and believes that this horror will never end (e.g. Malai Ali 2007, 17; Wurtzel 1995, 61, 108-109, 156).

The world in depression can also appear grey, dull, and colourless to some (e.g. Crafton 2009, 31; Solomon 2001, 17, 49). Having lost the ability to experience pleasure or any positive affective responses, the joys of the world are gone and it is coloured in a uniform dull greyness, which fails to move or touch one in any way:

> Depression starts out insipid, fogs the days into a dull colour (Solomon 2001, 17)

The eventual loss of all affective experience, not only of positively valenced affective responses, is sometimes described as feelings of profound numbness, inner emptiness, soullessness, or even not feeling alive anymore as one's affective anchoring in the world has been lost (see also Hatfield 2008, 244; Plath 1963, 2-3):

> I guess I should have been excited the way most of the other girls were, but I couldn't get myself to react. I felt very still and very empty, the way the eye of

> a tornado must feel, moving dully along in the middle of the surrounding hullabaloo. (Plath 1963, 2-3)

The dissolution of one's relation to the world and the loss of hold is often likened to an incontrollable fall and loss of a firm foothold (e.g. Brampton 2008, 42; Solomon 2001, 17, 27) as in one of the most distinctive passages from Andrew Solomon's memoirs

> In the first place, it's [the abyss] dark. You are falling away from the sunlight towards a place where the shadows are black. Inside it, you cannot see, and the dangers are everywhere (it's neither soft-bottomed nor soft-sided, the abyss). While you are falling, you don't know how deep you can go, or whether you can in any way stop yourself. You hit invisible things over and over again until you are shredded, and yet your environment is too unstable to catch onto anything. (Solomon 2001, 27)

It has indeed been suggested (McMullen and Conway 2002) that describing depression as a descent is the central and most commonly encountered metaphors in descriptions of the experience of the illness. The notion of a descent captures not only the experiences of being controlled by the illness, but also the general change in moods in depression, which is felt in feelings of being altogether low, down, flat, depressed, etc. (McMulen and Conway 2002, 171-173).

The loss of agency underlying some aspects of the experience of disconnectedness slows down one's pace and the world and others are described by some as moving at a higher speed that one fails to catch up with:

> My world is filled with underwater voices, people, lists of things to do. They gurgle and dart in and out of my vision and reach. But they are so fast and slippery that I can never keep up. (Manning 1995, 99)

These common metaphoric descriptions frequently exhibit remarkable linguistic and stylistic complexity. Elaborate and captivating descriptions of depression as "[…] a storm – a veritable howling tempest in the brain" (Styron 1989, 37) or a vine twisted around a tree so that

> its leaves seemed from a distance to be the leaves of the tree; only up close you could see how few living oak branches were left, and how a few desperate little budding sticks of oak stuck like a row of thumbs up the massive trunk, their leaves continuing to photosynthesize in the ignorant way of mechanical biology. […]
>
> My depression had grown on me as that vine had conquered the oak; it had been a sucking thing that had wrapped itself around me, ugly and more alive than I. (Solomon 2001, 18)

are the product of careful professional choice of words, their arrangement in stylistic figures that attempt to convey the intensity and anguish of the experience of depression. Indeed, many of the authors of published accounts of depression are experts in creative writing (e.g. William Styron, Elizabeth Wurtzel), journalism (e.g. Andrew Solomon, Sally Brampton),

poetry (e.g. Sylvia Plath, Gwyneth Lewis), etc. Thus, it might be claimed that their descriptions of experience are stylistically inflated, linguistically elaborate depictions of various phenomena that might easily be misinterpreted. While it is indeed the case that descriptions of experience of this complexity, elaboration, and style are more commonly found in published accounts by professional writers, these share central metaphors with anonymous, mainly non-professional, testimonies such as those in the DDQ and address by large the same phenomena. Like the authors of published first-person accounts, the respondents to the DDQ resort to colour-metaphors in their testimonies. For instance, 25 (20.49%) of the respondents to the DDQ UK likened depression to darkness or blackness. The loss of hope, for example, transforms the world into one of impenetrable darkness:[49]

> All I can see/feel is pain and darkness and cannot foresee anything else in the future (R192UK, Q1B)
>
> Everything's black and hopeless, there's no end to the misery and everything will go wrong. (R110UK, Q8B)

For some, a black blanket, curtain, or cloud has descended and trapped them in a world devoid of hope, pleasure, and meaning that they cannot escape from:

> It is though a black blanket smothers me and takes away all pleasure, interest, or enthusiasm for anything. (R282UK, Q1B)
>
> For me depression is not a black dog as I love dogs and have one myself. For me depression is like a big black blanket. This blanket engulfs me and I spend so much time thrashing about trying to find my way out. I liken it to cartoons of my childhood in which the character is suddenly engulfed in black by the illustrator and tries to push the curtain up to reveal the previous background scenery. The other way I can describe it is like being trapped in a stage curtain. Ironic as I love acting. (R228UK, Q1B)

Like the authors of published memoirs, 23 (18.85%) of the respondents to the DDQ UK, describe the world as devoid of colour, grey, dull, and unattractive. For some, this is akin to an actual change in perceptual quality of what is experienced. It feels as if colours have actually changed and there is "greyness or a shadow on the edge of the vision" (R313UK, Q2B)[50].

[49] The four responses to follow were administered the code *Darkness, blackness*. Passages utilizing metaphors of darkness and blackness are: R14UK, Q1B; R21UK, Q8B; R23UK, Q1B; R54UK, Q2B; R65UK, Q1B; R97UK, Q1B; R110UK, Q8B; R117UK, Q1B, Q2B; R118UK, Q1B; R147UK, Q1B; R153UK, Q2B; R162UK, Q3B; R180UK, Q8B; R186UK, Q1B; R192UK, Q3B; R228UK, Q1B; R239UK, Q2B; R282UK, Q1B; R253UK, Q1B; R291UK, Q1B; R292UK, Q7B; R307UK, Q4B; R325UK, Q2B; R366UK, Q1B; R371UK, Q2B.

[50] This excerpt was administered the code *Grey, bleak, colourless*. Responses describing the world as lacking in color and dull are: R16UK, Q8B; R22UK, Q2B; R23UK, Q2B; R47UK, Q2B; R51UK, Q2B; R53UK, Q2B; R80UK, Q2B; R105UK, Q2B; R117UK, Q2B, Q7B, Q8B; R150UK, Q1B; R153UK, Q2B; R154UK, Q1B; R186UK, Q2B; R190UK, Q2B; R192UK, Q2B; R224UK, Q2B; R282UK, Q2B; R285UK, Q8B; R313UK, Q2B; R334UK, Q2B; R347UK, Q1B, Q2B; R370UK, Q2B; R371UK, Q2B.

Feeling removed from the world is also described metaphorical terms like a perceptible barrier and discrepancy or detunement from the overall pace of life in 4 (3.28%) of the anonymous testimonies in response to the DDQ UK:

> I felt slightly pulled back from reality, as though there was cotton wool between my brain and my senses. (R17UK, Q2B)[51]
>
> Yes it does, seems like I'm slow motion and the world is going too fast for me to keep up. (R200UK, Q2B)[52]

Often, the authors of published first-person accounts (Crafton 2009, 83; Lewis 2002, xviii; Malai Ali 2007, 4; Solomon 2001, 16; Thompson 1995, 13; Styron 1989, 5) and 19 (15.57%) of the respondents to the DDQ UK refer to the experience of depression as beyond description. The radical changes in how they find themselves in the world resist being put into the words even by highly experienced experts and professionals as William Styron points out:

> Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self – to the mediating intellect – as to verge close to being beyond description. (Styron 1989, 5)

It is hard to put to words not only the elusive changes in moods and the unbearable suffering but also the various alterations in how one acts and responds to the world, feels related to others, and thinks. The participants in the survey, similarly, frequently explicitly refer to this difficulty to find the appropriate words to express what they are experiencing during depressive episodes[53]:

> At its most basic the black dog scenario describes it well and this is difficult to convey although the books have helped. A permanent hangover to try and illustrate the sense of everything closing in and the feeling of hopelessness. (R60UK, Q10B)

Some attribute this difficulty to describe the experience of depression or individual aspects of it in particular to the lack of a proper linguistic apparatus or vocabulary. It is indeed the case that we more often than not do not have words capturing the visceral feeling of desperation and hopelessness, the sense of disconnectedness, etc. as we rarely if ever reflect on their 'positive' counterparts – feeling hopeful, feeling connected to the world that are the background of our experience, thought, and behaviour most of the time. Thus, what is

[51] This excerpt was administered the code *Precluding contact with the world*. Responses describing the experience of disconnectedness in this way are: R17UK, Q2B; R118UK, Q2B; R129UK, Q2B.

[52] This excerpt was administered the code *The world is moving too fast*. Responses describing the experience of disconnectedness from the world in terms of slowing down are: R118UK, Q1B, Q2B; R169UK, Q1B; R200UK, Q2B; R331UK, Q6B.

[53] The five excerpts to follow were administered the code *Difficulty putting experience to words*. Responses referring to the failure to describe the experience of depression are: R16UK, Q10B; R24UK, Q10B; R53UK, Q1B; R60UK, Q10B; R110UK, Q10B; R115UK, Q10B; R117UK, Q1B, Q10B; R118UK, Q1B, Q7B; R137UK, Q1B; R190UK, Q2B; R239UK, Q10B; R240UK, Q10B; R253UK, Q1B; R259UK, Q10B; R288UK, Q10B; R307UK, Q1B, Q10B; R334UK, Q10B; R341UK, Q1B; R347UK, Q10B.

frequently beyond description are these commonly taken for granted background orientations that, accordingly, are also not represented in language as observed also by some of the respondents to the DDQ UK:

> The physicality of emotion, how emotions translate into my corporeal being, is exceedingly difficult to describe in any meaningful way. Earlier I described it as being like a black hole in my abdomen, and that is as genuinely close to a description I can provide. I think this is difficult to communicate simply because there aren't words for it. There's no word that succinctly and accurately describes the physical sensation.
>
> The other thing I really struggle to communicate is how my emotive and rational thoughts interact with one another. I can rationally think "I shouldn't feel like I am worthless" and still have an emotive thought "I am worthless." Describing how those two things co-habit in the mind is deeply difficult, and I have no real words to describe how those things relate to one another.
>
> There is not a simple causal relationship between one emotion and one thought, the relationships are far, far more complicated than that, but I struggle to define clearly HOW those emotive/rational interactions go on. (R307UK, Q10B)
>
> Words cannot convey the anguish of depression. (R137UK, Q1B)

Although some of experiential phenomena associated with depression might bear some superficial resemblance to non-pathological (negative) instances, they are markedly qualitatively different and often this radical discrepancy is not reflected in language as observed by this respondent to the DDQ UK:

> I've always said that, despite the fact that I've suffered from depression for more than half my life now, it's very very hard to put into words how exactly it feels as I was trying to explain it to my husband a few years ago. It's hard to get across just how being 'depressed' differs from being just 'fed up'. I said it was like the difference between having a cold and having 'flu; if you have' flu you don't have to ask if you have it, you just know as it's so debilitating. (R334UK, Q10B)

In 17 (13.93%) of the testimonies, the experience of suicidal ideation in particular is identified as beyond description or not being explainable or communicable to others. This might be specifically due to the fact that death by suicide is socially undesirable and unacceptable as defined by long-standing religious and cultural beliefs[54]:

> I think for me the hardest part of depression to communicate is the hopelessness and the disconnected – and of course the point at which suicide becomes a viable option. […]
>
> As for suicide... I have lost friends to suicide and I completely understand how painful that is – for me I also understand what it's like to be in that place and

[54] The two excerpts to follow were administered the code *I cannot explain suicidal ideation.* Responses describing immense difficulty in describing the experience of being suicidal are: R16UK, Q10B; R23UK, Q10B; R28UK, Q10B; R53UK, Q10B; R124UK, Q10B; R128UK, Q10B; R133UK, Q10B; R143UK, Q10B; R218UK, Q10B; R231UK, Q10B; R253UK, Q10B; R269UK, Q10B; R271UK, Q10B; R291UK, Q10B; R341UK, Q10B; R370UK, Q10B; R371UK, Q10B.

> to try to die because it can't be any worse than life. I attempted suicide three times, two of which were almost 'successful' for want of a better word. People are so upset and disappointment – and I do understand that – but what most people cannot understand is that place where there is nothing to be done except to exit life. (R271UK, Q10B)
>
> I don't tend to tell people about suicidal thoughts as I do feel I should embrace life rather that taking the coward's way out. And others DO see it as that! (R269UK, Q10B)

In line with the general indescribability of the experience of depression, the answers provided in response to the questions in Section B of the DDQ are of varying length. Most problematic appears to be the description of changes in affective experience, in particular how one's emotions and moods change during depressive episodes and frequently those who report of having difficulty putting to words the changes in experience when depressed provide shorter answers in response to Q1B in particular. Many of them merely list the different emotions and moods, thoughts and behaviours they are most commonly subjected to during depressive episodes and some also explicitly refer to the indescribability of depressive experience as for instance in these passages:

> I feel isolated, suicidal, worthless, paranoid...
>
> I have been depressed for such a long time I don't really remember what it feels like not to be. (R24UK, Q1B)
>
> sad all the time
>
> unable to socialise
>
> not able to answer the phone
>
> only meet people out of my house so that i am in control
>
> tearful
>
> unable to eat or sleep
>
> had to take time from work
>
> feel not in control of emotions feel that i watch the world go on by me and i am not a part of it
>
> feel that no one understands
>
> normally a confident sociable person taken me really by surprise and feel a lack of control over my own life (R115UK, Q1B)

The lack of appropriate linguistic means for describing the experience of depression, thus, can be one of the reasons for brief, list-like testimonies of depressive experience in addition to the failure to adopt an external narrator perspective.

The responses provided to the DDQ BG were also of varying length. As only 15 respondents took part in the survey, their answer did not describe all changes in experience reported in the British version. In spite of this, the testimonies covered all three main themes whereby the respondents described the experience as one of loss of connected from a shared

world in terms of the loss of possibility, agency, and intersubjectivity. The descriptions, though, almost never deploy the use of the metaphors discussed earlier. Only two respondents refer to changes in the world and the general lack of prospects in terms of darkness and blackness. This might be due to the fact that communicating the experience of depression is commonly associated with strong social stigmatization, so that there might be no particular linguistic figures and specific expressions that are commonly deployed for its communication. One further participant consistently identified the experience of depression with being in hell[55]. Her immense suffering during depressive episodes was not associated with a prospect for alleviation and thus similarly to hell, she was destined to eternal damnation, to a never-ending endurance of relentless pain and torment, which equals a punishment. Interestingly, the same respondent also compared depressive episodes and depression to nightmares, which she at first could not wake up from but later successfully battled and was able to recover. Like nightmares, depression (especially upon recovery) seems like one's worst nightmare – a torment that might appear arbitrary and meaningless but is after all temporary and transient.

7. Conclusion

Among the abundance of narrative theories of the self, which have not remained uncontested, I hope to have demonstrated above, that we can focus on their role in self-experience in particular in terms of aiding the sense of personal coherence and unification. Thereby, most importantly for the aims of the present work, we can understand narrative accounts as both means towards personal self-integration in the face of loss of coherence and unity and as the allowing an insight into the processes of changes in experience, thinking, and behaviour that are characteristic of mental illnesses. Narrative perspectives, in particular, as suggested by Goldie (2011; 2012) are instrumental in both achieving coherence and unification and understanding and explaining radical shifts of evaluative and emotional import, which can be associated with loss of experienced personal coherence and unity.

Testimonies of illness experience, or pathographies, as I reviewed in this chapter are motivated by various aims – to communicate what is feels like to experience and live with a serious, often disabling, condition, to offer others guidance in the unfamiliar territory of illness, to re-establish the continuity and coherence lost to illness, and to reclaim the voice

[55] Only two of the respondents to the DDQ UK compared the experience of depression to hell. Both of them emphasise the encompassing changes and emotional torment that characterise depressive episodes by comparing the world to a "hell where everything has gone wrong or is broken" (R350UK, Q2B), which is beyond description of comprehension by those who have not been afflicted with the condition: "It's hard to convey how much of a living hell it is living like that and how hard every day can be, and how you are trapped inside your own head, not that you just spend a long time thinking about yourself" (R17UK, Q10B).

of the patient. First-person accounts of illness in general and depression in particular can be produced in various formats that utilize different styles, belong to different genres, and have varying degree of narrativity. As I hope to have demonstrated, though, they are, in spite of the certain limitations and problems associated with their study, an invaluable source for understanding what it feels like to be depressed.

3. Loss of Possibility

The experience of depression comprises a vast realm of changes, which exceed the alterations in affective experience such as disproportionate or inappropriate feelings of sadness, guilt, etc., the general motor retardation or acceleration, and the negatively charged beliefs specified by the DSM IV. What individuals suffering from depression describe is a different way of finding themselves in the world characterized by disengaged observation of life and a failure to engage and interact with the world. To them, the world and their lives seem empty, meaningless, and pointless. Both published memoirs and anonymous testimonies of depression describe a way of being in the world, which is characterized by its failure to offer, entice, or in any way move one into pursuing any projects that might have made up one's life. This is in stark contrast with how we commonly encounter the world. It is generally disclosed first and foremost in terms of the possible ways it can be engaged with, so that our existence is experienced a continued meaningful project. We rarely if ever experience it as detached observers but have a pre-reflective sense of how it can be engaged with. In psychopathology in general and depression in particular, the space of possibilities that the world offers changes radically (van den Berg 1972/2013; Ratcliffe 2015, 33-74). This radical change comes in the form of a shift or ultimate eradication of the experienced possibilities that is in stark contrast to periods prior to the illness and goes along with a host of more or less specific background orientations or existential feelings (Ratcliffe 2005; 2008; 2015) manifested in reflectively experienced affective states, thought, and behaviour. In this chapter, I am going to engage in the examination of the experienced loss of possibilities described in first-person testimonies of depression. In doing so, I am first going to elaborate on the pre-reflective sense of possibility, which is one of the background structures of experience. Then, I am going to proceed to proposing how the disturbance of the experience of possibility disturbs the background of meaningful engagement with the world. In doing this, I am also going to develop a framework of alterations in the existential background that we normally take for granted but are radically altered in depression such as aspects of bodily and temporal experience, a prospective orientation towards a significant future, and the experience of suicidality.

1. The Experience of Possibility

This experience of the possibilities for active engagement offered by the world, it has been argued, is pre-reflective and pre-intentional (see Ratcliffe 2008, 2015 for a detailed discussion of the pre-reflective and pre-intentional nature of the existential background) and is an

essential aspect of the background of all affective experience, thought, and behaviour. Commonly, we encounter the entities in the world as embedded in a meaningful context, which varies among different subjects so that one and the same entity presents itself in markedly different ways to different subjects. Consider the following example introduced by Jan Hendrik van den Berg:

> To the hunter, the oak tree is a shelter for birds and an opportunity to find cover for himself. To the timber dealer, the oak tree is an object that can be measured, counted and sold. To the young, romantic girl, it is part of her love-landscape. […]
>
> Never do we see objects without anything else. […] We see things within their context and in connection with ourselves: a unity which can be broken only to the detriment of the parts. A significant unity. We might say we see the significance things have for us. If we don't see the significance, we don't see anything at all" (van den Berg 1972/2013, 37-38).

The entities we encounter in the world are essentially characterized by how we relate to them and commonly are both meaningfully embedded in the world and establish the fundamental sense of how they can be interacted with. The synthesis of these two aspects culminates in the experience of what is possible for one and might be commonly termed as individual or personal perspective that is characterized by varying patterns of possibilities among subjects as suggested by van den Berg (1972/2013, 46-47):

> The woman, the man, the child, the adolescent and the aged person […] observe different streets. They see their age, their background, their upbringing, their sex, their occupation and their intelligence; they see all their own qualities and characteristics in the street around them. The subject qualities are the aspects of a world, physiognomies of the objects of everyday existence.

Thus, although they might be encountering one and the same street, it discloses different patterns of possibilities for each of them, which are shaped based on their individual histories. What is common, though, to all of them, is that the street can be practically engaged with in a general manner in the sense that it *affords* carrying out a variety of practical projects or activities. But the specific *individual possibilities* for active engagement can differ greatly: To the toddler, it is a vast unexplored realm of fascinating objects, to the inexperienced driver, it is a challenge to navigate through on the basis of traffic regulations, etc. Thereby, the common everyday encounter of a street is imbued with a sense of what is possible for each and every individual subject by integrating a sense of what the street affords and in terms of one's personal history, abilities, and practical projects.[56] The former aspect amounts to a

[56] In experience, we rarely if ever distinguish between the two aspects of the sense of possibility. Whenever we encounter an entity in the world, we first experience it in terms of its individual significance in the particular situation, which is based on the general or common affordances as well (e.g. when carrying a heavy bag, a chair

rather general sense of what an entity encountered in the world can afford for particular groups such as species that share basic constitution (Gibson 1979; Merleau-Ponty 1945/2002) and thus commonly encompasses an intersubjective perspective as well. The latter aspect is a sense of the individual significance of the entities in the world that can even vary greatly for one and the same subject based on her current strivings and practical endeavours.[57]

But when walking out of our doorstep on our way to work, we rarely if ever experience either one of these aspects. Rather, we simply set on our way to work, down the street, which is at this moment essentially encountered as offering us the possibility to get to work rather than being walkable and practically significant in view of our endeavour to get to work on time. Thus, in our everyday experience, the sense of the general affordances offered by the world and of their individual significance for us is seamlessly integrated in the experience of the *individualized possibilities* these offer.

In general, when we experience various entities in the world they are encountered as generally intersubjectively present. But the particular possibilities these offer might differ radically among subjects as observed above and as pointed out by Matthew Ratclife:

> The cup […] is experienced as potentially accessible to others as well. I may also recognize that my own possibilities for perceptual access differ from someone else's. […] For example, something might appear 'also available to other observers in this way', 'currently available to her or them but not to me or us', or 'currently available to me or us but not to them' (Ratcliffe 2015, 43).

The individual significance, which frames the variations in the experience of individual possibility, can vary across people as a result of different factors. What might be of practical utility to me and not to you can be due to the particular practical projects we are pursuing (Ratcliffe 2015, Chapter 6). Subsequently, a particular entity might appear desirable and necessary for me and useless for you[58]. Moreover, I might not possess the same bodily

might have the significance of something to relieve our weight, which would be based on what it commonly affords for others as well).

[57] In addition to the experience of individual significance, which is part of the sense of possibility, our experiential background encompasses also a sense of how we are *able* to engage with the world. While the sense of possibility is associated with what the world offer, the sense of ability establishes the background of how the individual agent can engage with it and is thereby an aspect of how we experience ourselves as agents that can potentially engage with the world. The disturbances of the experience of agency in depression are going to be the subject of the next chapter.

[58] For the purposes of this chapter, I am not going to elaborate on the experience of intersubjectivity, i.e. how we encounter, perceive, experience, and engage with other people that is the subject of Chapter 5 "Loss of Intersubjectivity and Social Isolation: Loneliness, Shame, and Guilt". The intersubjective aspect of the experience of possibility here refers to the shared or common nature of general affordances and individual significance and not to specific patterns or modes of intersubjective communication and relation. The experience of general affordances and individual significance is intersubjectively shaped as these are commonly experienced as shared with others in the sense stipulated above. The experience of individual significance is as well interpersonally shaped in this sense as it is on the one hand shaped by individual factors but experienced as potentially shared or different from that experienced by others.

characteristics and skills necessary for the utilization and manipulation of a particular object that someone else might have despite its relevance for the practical projects we both currently have. In this case, one and the same entity can appear as desirable but unattainable or even threatening to me and as desirable and handy to someone else. The experience of personal significance, thus, is also closely associated with one's particular and very individualized bodily constitution and ability. The experience of possibility from such a highly individualized but yet interpersonally oriented perspective gives one the fundamental sense of co-inhabiting a world, which generally offers possibilities to others that though might differ from those offered to one. This establishes one aspect of sharing a common reality of practical engagement with others – regardless of the differences in individual significance, we encounter the world and entities in it as potentially to be engaged with or deployed in some way by others as well. Thus, even when experiencing individualized possibilities, we have a background sense of individualized engagement in shared reality. Respectively, we can experience some possibilities as present for others only, while this might not be the case for us. Thereby, it is important to note here, they do not cease being possibilities per se, rather they are not possibilities for one resulting from a radical loss of personal significance. And, indeed, this is what many of the individuals afflicted with depression report of: while there are many avenues for engagements with the world, these are present or accessible for others only as their individual significance for one has disappeared. Thus, one can still encounter possibilities per se that are intersubjectively shared in general but the individual significance these have for different subjects differs radically.

The synthesis of the pre-reflective sense of general affordances and individual significance in the experience of possibility enables our active engagement with the world by establishing what might be called a passive component of being actively embedded in a world (in the next chapter, I am going to discuss a further aspect of being engaged with the world, which is closely related to the experience of ability). Moreover, by experiencing what is possible for us and others, we can also adopt an anticipatory stance with respect to future engagements with the world. For instance, by experiencing the street in front of our home as offering me the possibility to get on my way to work, I pre-reflectively anticipate that once I embark upon this project, I will encounter particular further engagements or interactions that are possible when walking down the street such as crossing it, waiting at the traffic lights, bypassing other pedestrians, etc. Thereby, the sense of possibility comes along with an anticipatory structure with respect to the pattern of further engagements with the world and the course and fulfilment of our current practical projects.

At least some of our engagements with the world, it can be suggested, have a habitual character. If we go back to the example of walking down the street to get to work in the morning, we can see that we are automatically drawn into the individual actions, which it comprises. We do not experience the street in a detached manner and only after deliberation realize that it is walkable and that it will be the shortest route to get to the office. Rather, we immediately experience it as the way to be walked to work. Thus, we can say that are actively engaged in the world and feel embedded in it, at least to some respect, by means of the possibilities for habitual engagement it offers.[59]

A habitual engagement can be characterized as a set of patterned interactions, which are on the one hand based on the affordances the world offers and on the other on the individual significance these have for one. It "[…] presupposes a form of "understanding" that the body has of the world in which it carries out its operations" (Moya 2014). Thereby, our engagements with the world develop against the backdrop of implicit or pre-reflective sense of both being engaged in a particular interaction at the moment and an anticipation of the further patterns of interaction to come. And thereby, we also pre-reflectively anticipate the possibilities to be offered by the world.

So, an experienced loss of possibilities will subsequently also affect our orientations towards the future. Encountering the world as failing to offer certain possibilities for engagement at the present moment inevitably affects also what we pre-reflectively anticipate with respect to our possible future engagements with it. Consider, for instance a case in which one's habitual interactions with the world are rendered impossible as the world fails to offer certain possibilities anymore because a particular practice has been abandoned or obliterated. We can, here, then imagine someone who, for example, used to practice a certain profession, let's say a teacher. This person, then, is with respect to his meaningful existence in present-day society and professional life, embedded in the world and actively engaged with it at least to some respect in terms of specific projects or endeavours within the domain of having this occupation. Being a teacher goes along with a certain set of possible engagements, which also encompass an anticipation of other future engagements coherent with these. These can be to pursue a specific career path in certain educational institutions, to acquire additional qualifications, which will enable transitions to other types of educational institutions, and the like. But if the practice of teaching as we know it today were to be suddenly abolished due to certain reasons (e.g. technological advances, which render human

[59] It is important to note here again that this is only one aspect of our experience of being embedded in and actively engaged with the world. Habitual engagements, in addition to a pre-reflective sense of possibility include the experience of the own abilities, in particular of the skills that we utilize when carrying out routine activities, which as I am going to discuss in detail in the next chapter.

instructors obsolete in the classroom), the general framework of interacting with the world as a teacher in not viable anymore. In this case, the teacher in our example will not merely lose her job but rather the possibility to be engaged with the world in the particular set of ways she used to be. Moreover, she would also lose the specific prospective or anticipatory orientation that went along with the possibilities she encountered previously. Thereby, at least some aspects of her active and meaningful embeddedness in the world will be radically disturbed. In depression, something of this sort seems to happen, but at a radically different scale. Those afflicted with the illness often report of experiencing the world as a closed off realm devoid of any possibilities for engagement – in a stark contrast to what it used to offer prior to the onset of the illness, now it is empty, meaningless, and pointless. Accordingly, the anticipatory structure that goes along with the experience of possibilities is also radically disturbed for them. The future does not appear as full of prospects for further engagements but is framed in anxious anticipation of a continuation of the present existence. In what follows, I am going to suggest that we can understand some of the phenomena reported by individuals suffering from depression, such as feelings of disconnectedness, of despair, hopelessness, and sadness, as instances of reflective manifestations of altered background orientations, which themselves are occasioned by an experienced loss of possibility.

In sum, it can be said that the experience of possibility, which figures as a major structure of experience is the result of the integration of the experience of what is potentially possible and the experience of individual significance. The former aspect is of rather abstract and general nature and is closely associated with the entity being experienced, it is a basic sense of what kind of interactions it potentially affords – a cup, for instance, can afford holding it in one's hand, feeling its surface, filling it with liquid, etc. The second aspect is rather individualized and dependent on one's particular current practical projects and abilities – the very same cup can be desirable if one is thirsty and it is filled with water, or can be filled with water, but be a mere obstacle if one is hungry and wants to reach the meal positioned behind it. These two aspects are in a constant intimate interplay as what an object affords determines its basic relevance and grounds one's practical projects while the individual significance of an entity is constituted by how one is (to be) interacting with it. Their integration in experience commonly provides us with a unified experience of embeddedness and meaningfulness, of being engaged with the world and participating in life as we rarely perceive either basic affordances or individual significance in isolation from each other in everyday situations of practical engagement. In this sense, we experience ourselves as essentially related to the world, on the one hand by means of what it potentially affords, and on the other in terms of what particular significance these affordances have for us. We

rarely, if ever, experience an entity without this kind of context that comes with it and only upon detached deliberation interact with it. The fundamental experience of possibility, thereby, establishes a sense of how we find ourselves in the world and constitutes various background orientations that we, in the absence of radical alterations, rarely if ever reflect on.

2. Loss of Possibility and Disconnectedness

Commonly, we are rarely if ever reflectively aware of the possibilities the world offers as we feel embedded in it in terms of the practical endeavours we are engaged in. We do not reflectively experience the world as endowed with specific patterns of possibilities, but rather simply act on these. But, as already mentioned in the previous section, this can also radically change. Here, I am going to suggest that some of the phenomena described by individuals suffering with depression, in particular feelings of being disconnected from the world or merely passively observing it are manifestations of a background orientation of loss of embeddedness or relatedness to the world that itself is established by an experienced loss of possibilities. The background orientation of disembeddedness, I am going to suggest, can be understood as based on the loss of two types of individual significance – (action) enticement and affective significance. The experienced loss of possibility in depression, though, is related to further changes in the experiential background as well, such as bodily and temporal experience, and background orientations of loss of hope and suicidality, which are going to be the subjects of the remaining sections of this chapter.

Some of the most widely-popularized descriptions of depression to be found in published accounts describe the condition as characterized by an acute sense of disconnectedness and disengagement from the world. Rather than being actively immersed in various projects, individuals suffering from depression often report of having become mere observers of life and the world. A background orientation of disconnectedness in several variants is described by 52 (42.62%)[60] of the examined responses to the DDQ UK. To 30 (24.59%) of the respondents to the DDQ UK the experienced loss of possibilities is manifested most poignantly in the form of a disengagement from active interactions with

[60] As previously mentioned, when discussing the various experiences that were reported in the testimonies, I am also going to indicate the number of respondents to the DDQ UK who described these. When doing this, I am also going to refer to the total number of respondents who described the respective background orientation the particular reflective experiential phenomena are manifestations of. As in many cases the respondents describe more than one of its manifestations, this number corresponds to the sum of respondents who report at least one of its manifestations. For these reasons, the sum of the numbers of responses describing individual manifestations is not identical (and exceeds) the number of responses describing the background orientation.

the world. Instead of being immersed in the pace of life, they feel as passive and disengaged observers of the active engagements of others as for instance described by this respondent to the DDQ UK (see also Brampton 2008, 66, 171; Danquah 1998, 44; Lewis 2002, 225; Plath 1963, 17, 169-170; Smith 1999, 4; Solomon 2001, 17, 18, 50, 88; Thompson 1995, 45, 89; Wurtzel 1995, 54, 101, 208 for descriptions of experiences of disconnectedness and disengagement):[61]

> […] the world seems to be happening around you. It is all busy and hectic around you. It's like on TV when the main character stands still and they fast-forward the street scene of people milling around them […] (R112UK, Q2B)

Their mode of existence, of finding themselves in the world has changed radically and is now characterised, among other things, by the passivity of detached observation of others' active engagements with the world. The lack of possibility here can be understood as involving primarily loss of individual significance. Only one's individualized possibilities for active engagement have gone missing, while the world still offers such for others. Not being engaged with the world, then, turns one into a passive contemplator of others' practical endeavours.

But an experienced disengagement from the world also comes along with a sense of alienation from other subjects as well at the fundamental level of sharing individual significance. To the depressive, others then are encountered first and foremost as active participators in life especially in contrast to the own failure of engagement. The world is not essentially shared with them, as it now offers them a wide range of possibilities while these have been extinguished for one. And this particular experience of disconnectedness from others as well, primarily in terms of the radical discrepancy in the realm of possibility available to them and to oneself, is very poignantly captured in metaphorical descriptions, which liken it to a deceleration or even a complete stagnation that can be found in the responses to the DDQ UK as in this passage:

> The world appears to move faster, as if you are moving slowly and they are moving more quickly. It is difficult to keep up with it. […] (R118UK, Q2B)

The reflective feelings of disconnectedness are also often described and experienced in terms of a preclusion of active engagement. While possibilities for engagement might be still

[61] The four excerpts to follow were administered the code *Disconnectedness and disengagement*. Responses describing the experience of disconnectedness and disengagement form the world are: R16UK, Q7B; R17UK, Q1B, Q2B; R20UK, Q1B; R21UK, Q2B; R22UK, Q7B; R41UK, Q2B; R80UK, Q7B; R84UK, Q1B, Q2B; R112UK, Q1B, Q2B; R115UK, Q1B; R117UK, Q1B, Q5B, Q6B; R118UK, Q1B, Q2B; R124UK, Q3B; R128UK, Q1B, Q2B; R129UK, Q2B; R143UK, Q2B; R154UK, Q1B; R157UK, Q2B; R162UK, Q7B; R169UK, Q2B; R192UK, Q1B; R228UK, Q1B, Q2B; R231UK, Q2B; R246UK, Q2B; R271UK, Q2B; R282UK, Q2B; R285UK, Q2B; R308UK, Q2B, Q6B; R350UK, Q2B; R371UK, Q1B, Q3B.

perceived if feels as if something is standing between these and the individual suffering from depression and thereby keeping them outside of her reach as reported in this passage:

> Everything around me seems to carry on with routines and time scheduled activities, it feels like I'm watching it all happen but am not part of it: as though I'm inside a bubble. […] (R117UK, Q6B)

Here, the possibilities grounding various routine activities are kept at distance from the individual suffering from depression. While they might still to some respect appear significant in the context of everyday life, they are merely not within reach, closed off for her. And all she can do is merely contemplate how life revolves around her. This culminates in a profound isolation from a still meaningful world.

The loss of individual significance can for some be most poignantly felt in terms of the absence of enticement or appeal to engage with the world in a particular way. While the experience of affordances as significant is synthesized in the pre-reflective sense of possibility, not all of these directly entice us into acting on them. They can be significant in terms of their practical utility, for instance. But the orientation of disconnectedness and disengagement described by individuals suffering from depression comes for some in terms of the loss of enticement, which makes certain affordance not appear enticingly significant anymore. Consider, for instance, how this respondent to the DDQ UK describes the experience of disconnectedness and disengagement:

> I stop doing things. Nothing seems attractive. I feel disconnected from the rest of the world, like a spectator. (R84UK, Q1B)

The disturbance of active engagement for her comes in the form of lack of appeal of any activity. While these might still be encountered as possible per se, most probably for others, they are not significant for one as they fail to in any way mover her to action. This, subsequently, results in the abandonment of practical projects that parallels the experience of oneself as a passive observer of the world.

The loss of individual significance, especially its enticing aspects, makes the world appear monotonous, grey, bleak, and bland. Respectively, 10 respondents to the DDQ UK (8.2%) describe their experience of disconnectedness and disengagement in terms of the numbing or blunting of how they perceive the world in the different modalities (see also Brampton 2008, 29):[62]

> Everything seems grey. It's like there's no colour to anything. Everything you do seems the same day in and day out. (R22UK, Q2B)

[62] The excerpt to follow was administered the code *Numbing of the senses*. Responses describing the experience of the world as bland or grey are: R17UK, Q2B; R22UK, Q2B; R51UK, Q2B; R110UK, Q2B; R124UK, Q2B; R192UK, Q1B, Q2B; R228UK, Q1B; R237UK, Q2B; R270UK, Q2B; R307UK, Q2B; R343UK, Q2B.

A world, which fails to offer enticement also fails to affectively move one. And indeed, one primary mode of our active engagements with the world is by means of affectively responding to it, being affectively touched and moved by it. Commonly, we not only undergo various reflective and intentional emotional episodes but also find ourselves in different moods that provide the background of affective experience by disposing us to reflectively respond in particular ways. For instance, when in an irritable mood, one is more likely to respond with feelings of irritation, frustrations, anger, etc. to an otherwise neutral event. Moods, in this sense, not only possess a particular phenomenology of their own, but also provide one with particular affective tendencies or dispositions that shape how we affectively respond (Stephan 2016). Unlike existential feelings, moods are always reflectively experienced, i.e. we are aware of feeling a particular way – of feeling sad, down, low, elated, euphoric, etc. with respect to nothing in particular while also responding in the respective ways to (almost) everything around us that is relevant. Moods themselves do no establish individual patterns of significance, rather they are the fundamental manifestation of what patterns of (affective) significance we are responsive to, so that finding oneself in a world that is characterized by threat and insecurity, one frequently experiences episodes of free-floating anxiety and is more likely to respond with feelings of fear and anxiety to various states of affairs and events in the world. The patterns of individual significance constitute thereby our affective relatedness to the world. When pre-reflectively experiencing oneself as embedded and immersed in the world, one does this also in terms of how one is affected by it, how one is moved, enticed, repulsed, or threatened by the various entities, events, etc. that make up the world. In depression, this affective relatedness changes radically. Frequently, individuals suffering from the disorder describe a failure to affectively respond to the world, certain flatness or numbness of affect that is both terrifying and painful. And 29 (23.77%) of the respondents to the DDQ UK refer to a flattening or loss of affective experience (see also Lewis 2002, 1; Plath 1963, 2-3, 196; Solomon 2001, 45, 46; Thompson 1995, 73, 112; Wurtzel 1995, 22):[63]

> Emotionally it felt like a great insurmountable nothingness. I didn't feel sad, angry, or any other emotion. […] I felt an uncomfortable nothingness (R350UK, Q1B)

[63] The three excerpts to follow were administered the code *Emotional numbness*. Responses describing the loss of affective experience are: R16UK, Q1B; R17UK, Q1B; R21UK, Q1B; R22UK, Q1B; R23UK, Q7B; R28UK, Q1B; R37UK, Q1B; R49UK, Q1B; R53UK, Q2B; R54UK, Q2B; R61UK, Q1B; R80UK, Q1B; R89UK, Q1B; R112UK, Q1B; R118UK, Q5B; R124UK, Q1B, Q2B; R133UK, Q1B; R137UK, Q1B; R150UK, Q1B; R157UK, Q8B; R189UK, Q7B; R218UK, Q1B; R224UK, Q1B; R253UK, Q1B; R270UK, Q1B; R291UK, Q8B; R350UK, Q1B; R352UK, Q1B; R367UK, Q1B.

The painfully experienced absence of affective relatedness is paralleled by a failure of being moved by the world to act. Similarly to the failure to experience any emotion, activities present themselves as insignificant, so that one might only by sheer force of everyday routine or social norms. Thereby, the passivity of emotional disconnectedness is accompanied by one of lost enticement towards action, so that one's life has been reduced to a sheer forceful existence powered only by, for instance, social structure as one of the respondents to the DDQ UK recollects here:

> Sometimes the depression manifests itself as a numbness where I just force myself to go through life, doing what people expect me to do, trying not to think about how I want it all to end. (R240UK, Q1B)

In instances of emotional numbness, what is lost is the essence of what made one act and engage with the world, of existence that is experienced as meaningful and active. The void left by the absence of significance is itself painfully experienced and might for some individuals suffering from depression be the most troubling symptom. Unlike the experience of absence in perceptual domains, the felt loss here is not experienced in terms of the loss of a particular object of experience (this of course does not imply that we can and do have meta-experience, e.g. emotional responses, in particular with respect to our affective experience; see Jaeger and Bartsch 2006). It is not the case that when experiencing loss of affect, one becomes suddenly aware of the absence of something that was the object of a particular experience as for instance in visual experiences of absence when we become aware that the chair in the corner of the room is not there anymore. In cases of affective numbness, what has been lost is not the object of a meta-experience that had our affective experience as an object for we are aware of our affective experience in this way only in rare cases. Commonly, we are immersed in our affective experience and action: when we experience fear, we are immersed in the fearfulness of the situation rather than being aware of being afraid in terms of recognising the situation as fearful and only subsequently experiencing fear. What seems to be lost in depression is this first-hand unmediated immersion is affective experience. Thereby, not only a range of positive affective feelings and emotions, that present things as pleasant and enjoyable, are absent What seems to be lost is not merely a range of positive affective significance, which, for example, but one's fundamental disposition to respond to affective significance at all. And this crystalizes to the foreground of experience in the form of unsettling, distressing, or even unbearable feelings of emptiness, deadness, soullessness, of loss of something essential to human nature, which transforms life into an unbearable existence described in this passage:

> The worst part is the feeling of numbness, where the thought of going on just seems unbearable. (R49UK, Q1B)

In the absence of pathology, the world is commonly experienced as a realm of possibilities, which ground our situatedness and embeddeness in it. We rarely encounter the world in a detached manner, rather when experiencing ourselves in the world, this experience comes first and foremost in terms of how we are embedded in it – how we can and do interact with the world. Pre-reflectively, we are aware of what it offers and how what it offers is significant to us. This sense of fundamental possibility is the result of the synthesis of two aspects of experience – the perception what (practical) engagements the world affords and what the individual significance of these is with respect to already established practical projects, goals, etc. The experience of fundamental possibility and the actual practical engagements with the world are constantly intertwined in a dynamic interplay – what the world affords constitutes what practical projects can be engaged with and pursued and once engaged in particular practical projects, what the world offers is imbued with individual significance, which determines whether and how the various affordances are felt, i.e. what is felt as enticing, worth pursuing, threatening, etc. But as evidenced by first-person testimonies of individuals suffering from depression, this can radically change so that one becomes and feels like a detached observer of the world and life. As discussed above a background orientation of detachment can be established by the loss of individual significance and is manifested in several foregrounded or reflective phenomena. The loss of individual significance itself can also come in different variations – to some what is lost is the enticing aspect the possibilities offered by the world while to others their affective significance is missing. The former culminates in passivity, experiences of disengagement and passive contemplation of life and the latter is manifested in the painful absence of affective experience. In both, though, the world appears distant, irrelevant, removed, and not significant. Instead of being immersed in its pace, one merely observes it.

3. Loss of Possibility and Bodily Experience

The testimonies of individuals afflicted with depression are also replete with descriptions of altered bodily experience of various sorts[64] ranging from diffuse feelings of bodily constriction, through sensations of overwhelming bodily heaviness, to specific somatic complaints similar to those associated with the flu (Ratcliffe, Broome, Smith, and Bowden 2013). Here, I am going to propose that some of these are manifestations of the experienced

[64] Cross-cultural studies of psychopathology also indicate that in some cultures depression might be experienced and encountered by health professionals primarily as a bodily illness, which is characterized along with more specific somatic complaints (such as particular pains and physical symptoms such as dizziness, elevated heart rate, etc.) by changes in diffuse bodily sensations (Kleinman 2004).

loss of possibilities, which disturbs our bodily immersion in active engagements with the world established by the so-called 'lived-body'.

Commonly, we are rarely reflectively aware of our body. Rather, it is present to us in experience in a so-called 'as-'mode[65] that establishes both its transparency and sets it as a boundary between subject and world (Fuchs 2005). It is, in this sense a so-called 'lived body' (Leib), which occupies the background of experience and makes it possible for us to experience and engage with the world. Thereby, we experience the world through our bodies, but also the state of our bodies shapes how we experience the world. So that, for instance, "[a] world that fails to entice, to draw one in, corresponds to a sluggish body, one that is not primed for action. A heavy, aching body is a world full of difficulties, where tasks appear daunting, insurmountable" (Ratcliffe 2015, 86). Thus, a change in the world, in particular in the enticing aspects of possibilities will also be manifested at the level of bodily experience. More specifically, these changes will be manifested in the loss of bodily transparency, which in turn places the own body to the foreground of experience so that it now becomes the object of experience and action rather than its background, a so-called 'living body' (Körper) (see Fuchs 2005 and Fuchs and Schlimme 2009 for a detailed discussion of the transformation of the lived body into a living body in psychopathology). Here, I am going to engage in an examination of the background orientation of altered bodily experience, which is described by 26 (21.31%) of the respondents to the DDQ UK.

Among the descriptions of changes in bodily experience in testimonies of depression, some refer in particular to sensations of bodily oppression (e.g. Hatfield 2008, 243, 245-246; Smith 1999, 5; Solomon 2001, 16, 18; Wurtzel 1995, 107). Instead of being experienced through its transparency in being enticed or moved to action by the world, the own body becomes the object of experience in terms of the impact the world exerts on it. More specifically, instead of being moved to engage with the world, one is burdened and oppressed by its demands. The world, from an inviting and enticing realm of possible engagements, becomes as described by six (4.92%) of the respondents to the DDQ UK "[…] a weight on my shoulders" (R14UK, Q1B)[66]. Thereby, the lived body loses its common transparency and moves closer to the foreground of experience in feelings of oppression and restriction. It is important to note that thereby it is still to some respect the medium for experiencing the

[65] In our common interactions with the world, the body remains concealed and is experienced in the entities we encounter. The transparency of the lived body can be subjected to a range of changes in the absence of pathology as well, for instance during the acquisition of new patterns of movements or actions. By acquiring and mastering these, it recedes to the background of experience and is transparent in the performance of habitual actions and routine movements (Fuchs 2005).

[66] The two excerpts to follow were administered the code *Being weighted down*. Responses describing feeling physically burdened by the world are: R14UK, Q1B; R66UK, Q4B; R85UK, Q4B; R118UK, Q1B; R166UK, Q4B; R271UK, Q2B.

world as suggested by the aforementioned passage from the DDQ UK. This can be considered an initial stage of its transition to a living body (Körper), or corporealzation (Fuchs 2005, 99-100), in which it is available in experience only and exclusively as the object of such.[67]

The accumulation of sensations of oppression and being weighted down can culminate in feelings of physical resistance, whereby one feels as if "[…] physically pushing against the world to move […]" (R166UK, Q4B). The loss of enticement presents the world as actively resisting engagement, so that ultimately practical endeavours and actions appear difficult not because one lacks the necessary abilities for them, but because they fail to occasion bodily potentiation, which has to be now achieved by the subject herself.

This general absence of fundamental bodily affectability or excitability is also mirrored in the significant decrease of basic appetite behaviour. The burdened, weighted down body is experienced as numb and hollow and may in some cases even fail to be experience basic (biological) strivings and urges as for instance pointed out by this respondent:[68]

Sometimes I felt so numb I felt like I couldn't eat (R22UK, Q4B).

Changes in appetite, both in the form of its significant diminishment or increase, were reported by 21 (17.21%) of the respondents to the DDQ UK. The aforementioned loss of appetite can be contrasted by tendencies towards binge-eating or over-eating, which can function as an attempt to re-establish the lost bodily affectability by means of ingesting food or as ways to comfort oneself: "I eat more than normal and tend to hit the carbs and alcohol more. (R237UK, Q4B)", "I overeat to comfort myself." (R171UK, Q4B). The loss of appetite and the tendencies towards over eating or an increased hunger drive can also alternate: "Very hungry or no appetite at all." (R186UK, Q4B). In some cases, the changes in appetite can be also the result of general feelings of being unwell or sickness or side effects

[67] This is only one of the instances of altered bodily experience in depression, which are manifestations of the transformation of the lived body into a living body. Here, similarly to the changes in embeddeness discussed in the previous section, the changes in bodily experience are related to changes in the world. Other bodily phenomena described in testimonies of depression, though also related to a corporealization of the lived body, are associated with agent-related disturbances of embodiment such as alterations in the condition, abilities, etc. of the own body, which transform how the world is disclosed to one (see Chapter 4 "Loss of Ability and Agency"). Thus, bodily sensations of being oppressed, overwhelmed or restricted present us with only one of the aspects of essential role of the body in our embeddedness and active engagement with the world.

[68] The five excerpts to follow were administered the code *Changes in appetite*. Responses reporting of changes in appetitive behaviour are: R22UK, Q4B; R24UK, Q4B; R28UK, Q5B; R38UK, Q4B; R40UK, Q4B; R105UK, Q1B; R115UK, Q1B; R143UK, Q1B; R150UK, Q5B; R157UK, Q1B; R161UK, Q1B; R166UK, Q4B; R171UK, Q4B; R186UK, Q4B; R190UK, Q1B; R218UK, Q5B; R237UK, Q4B; R269UK, Q1B; R270UK, Q4B; R323UK, Q1B; R341UK, Q1B. Memoirs also include descriptions of changes in appetitive behaviour (e.g. Danquah 1998, 68), albeit more rarely than anonymous accounts.

of particular medication. Nevertheless, they show a general association with experiences of bodily numbness that are manifestations of the experienced loss of enticement in particular.

In sum, it can be, thus, claimed that at least some of the alterations in bodily experience described by individuals suffering from depression are manifestations of the experienced lack of possibilities. The loss of enticing significance, which discloses the world as a bland and monotonous realm, which fails to move one into practical engagement disturbs the transparency of the lived body. In a failure to be enticed by the world, the own body moves closer to the foreground of experience and is now present in the subject's awareness in sensations of overwhelming oppression and resistance. Rather than failing to engage with the world as the result of depletion of bodily resources and resisting the enticements of the world, the lived body here is transformed into an object of experience by a world, which fails to offer it enticement or potentiation.

4. Loss of Possibilities and Temporal Experience

Changes in the experience of time have been observed in different psychopathological conditions and have received substantial attention in particular in studies in phenomenology and phenomenological psychopathology (cf. Strauss 1947; van den Berg 1972/2013; Fuchs 2001, 2005, 2010; Ratcliffe 2012a). In phenomenology, traditionally, temporal experience is considered one of the fundamental aspects of experience and self-consciousness and is a central aspect of the development of higher-order experiences and conceptualizations of the self. In both published accounts of depressive experience and the responses to the DDQ UK individuals frequently describe feelings of the general deceleration of temporal flow. Time, in general, feels as if going "really, really, really slowly" (R97UK, Q6B), it "seems to drag on. (R93UK, Q6B)" so that the "[d]ay seems longer" (R80UK, Q6B) and it "feels like life is never ending and far too long." (R239UK, Q6B). This experience might appear as incomprehensible and resisting detailed description as it is in a stark contrast to our common orientation characterized by immersion in meaningful activity, in which time is lived rather than reflectively experienced. The general deceleration of temporal flow can often be described rather briefly and vaguely. To some, time simply "seems to drag" (R128UK, Q6B), or to go "[s]lower" (R37UK, Q6B). In addition, one can also feel as if running out of time, as if life (or a major portion of it) has already passed and one does not have that much time left, etc. (Ratcliffe 2012a). Some of these instances of changes in temporal experience, namely certain forms of the experienced deceleration of temporal flow and a sense of the imminence of the present, I am going to argue, are manifestations of the experienced loss of possibilities,

while others can be better understood as expressions of alterations in further structures of experience such as, for instance, agency.

It has been suggested that we generally experience the flow of time in an implicit, pre-reflective manner, for instance when immersed in meaningful interactions with the world. Implicit time or lived time is "the movement of life itself […] inherent in [one's] bodily commitment in the respective situation, with its valences and tasks" (Fuchs 2010a, 3) in which past, present, and future are synthesized in the pre-reflective experience of time passing. According to Fuchs (2010a), implicit temporality requires two main conditions: the synthesis of inner time consciousness and the basic affective-conative momentum. Adopting a Husserlian framework, he argues that the synthesis of inner time consciousness is the result of the integration of the "indeterminate anticipation of what is to come" (Fuchs 2010a, 3) or protention, the momentary impression of experience at the current moment or presentation, and the retention of what has just been experienced. The basic affective-conative momentum provides one with the origin of drives, urges, strivings, goal-directedness and basic self-affection.

Explicit or experienced time, in contrast, is the separation of the no longer, now, and yet to come. The interruption of lived time makes its passage apparent and disintegrates the synthesis of past, present, and future. Experienced time is produced mainly by a "rift in being" (Fuchs 2010a, 5), that interrupts the immersion in meaningful interaction and creates a gap between past, present, and future. The past is disconnected from the present and turns into a "remembered past". One becomes aware of the passage of time as it separates us from what it held and is now lost in the present. Similarly, there is a rift between the present and the future that offers the satisfaction of present desires and urges. This creates "a general appetitive tension" (Fuchs 2010a, 5) and the future is experienced as a period of 'not yet'. Sudden shifts between implicit and explicit time can be common in particular situations in everyday life in which our immersion in meaningful activity is disturbed by a sudden shock such as in moments of surprise, disappointment, etc. when we suddenly become aware of the segmentation of past, present, and future and reflectively experience the passage of time. In depression, explicit time dominates over implicit time and one becomes aware of the present moment in terms of how it differs from the past and the future. The now of current existence becomes dominant by obliterating the past and failing to transition to a (different) future.

The experienced loss of possibility impacts both conditions for implicit time and its explication is manifested in feelings (1) of time slowing down or dragging, (2) of the permanence of the present (moment) and the inability to imagine a (different) future, and (3)

of the longing for temporary alleviation that might occur in particular situations or periods of the day. These different variants of changes in temporal experience constituted by the experienced loss of possibilities were reported by 56 (45.9%) of the respondents to the DDQ UK and authors of memoirs and each of them will be addressed in detail in what follows.

The breakdown of prospective orientation grounded in the disclosure of a world that fails to entice one into active engagement disturbs the retention-presentation-protention synthesis by disrupting processes of protention. The absence of enticement culminating in a sense of not being moved to engage with the world fails to provide one with the anticipation of a different future. Consequently, one becomes painfully aware of the present specifically in virtue of its failure to transition to a future moment experienced most frequently in terms of a deceleration of temporal flow (1) described by 27 (22.13%) of the respondents to the DDQ UK (see also Solomon 2001, 49, 53-54 for further descriptions of this instance of deceleration of temporal flow):[69]

> […] I lie awake and the time creep along making the day seem endless. Every time I look at the clock it appears that the hands are moving slower and slower. (R154UK, Q6B)

The disturbance of the protention of the present also make it impossible to contemplate any future activities as one feels confined to the present moment (2), which dominates experience as for instance described by 14 (11.48%) of the respondents to the DDQ UK (see also Solomon 2001, 55):[70]

> I live minute to minute and can't plan ahead at all. (R160UK, Q6B)
>
> When I am depressed I can't focus on anything in the future and I try not to make plans. (R20UK, Q8B)

The loss of possibility can in some cases completely block processes of protention, so that one is subjected to continuous presentation that makes the present appear ever-lasting and dominating over both the past and the future. In such cases, one might even be unable to imagine a future or recall a past that significantly differs from the present. The imminence of the present moment dominates and extinguishes the possibility of projecting into another time, so that on the one hand a viable anymore and on the other one feels dissociated from

[69] The excerpt to follow was administered the code *Time drags*. Responses, which describe experiencing time in a decelerated pace are: R8UK, Q6B; R14UK, Q6B; R20UK, Q6B; R22UK, Q6B; R30UK, Q6B; R37UK, Q6B; R53UK, Q6B; R65UK, Q6B; R89UK, Q6B; R93UK, Q6B; R97UK, Q6B; R128UK, Q6B; R129UK, Q6B; R134UK, Q6B; R137UK, Q6B; R147UK, Q6B; R153UK, Q6B; R154UK, Q6B; R224UK, Q6B; R269UK, Q6B; R285UK, Q6B; R292UK, Q6B; R325UK, Q6B; R341UK, Q6B; R343UK, Q6B; R347UK, Q6B; R361UK, Q6B.

[70] The three excerpts to follow were administered the code *Stuck to the present*. Further responses describing the experience of the failure of protention in terms of being confined to the present moment are: R17UK, Q8B; R20UK, Q8B; R61UK, Q6B; R124UK, Q8B; R150UK, Q7B; R160UK, Q6B; R166UK, Q8B; R231UK, Q6B; R239UK, Q6B; R270UK, Q6B; R285UK, Q1B; R307UK, Q6B; R367UK, Q6B; R370UK, Q6B.

the past that seems to not have a relation to one's present as reported by this respondent to the DDQ UK:

> The future us too much to think about – going to the toilet is as far as I go! The past feels like someone else's life, and I don't know who I am because I'm so different from that person. (R124UK, Q8B)

The dominance and permanence of the present also affect how the passage of time till rare moments of alleviation from the overwhelming pain and suffering of depression appear stretched out in time. Some individuals suffering from depression report of sleep or the security and calm atmosphere if their own homes alleviating, at least partly, their distress. These become the only desired moments yet to come that though are separated from the present by an un bridgeable rift resulting from the disturbed synthesis of protention and retention. Accordingly, one becomes acutely aware of the passage of time specifically in view of the anticipation of the fulfilment of present desires for relief and alleviation from the suffering and pain as reported by 22 (18.03%) of the responses to the DDQ UK[71] (see also Hatfield 2008, 244; Solomon 2001, 49, 53-54 who describe similar experiences):

> Each day feels so long not 24 hours but a 100 hours, I can't wait to go to bed and sleep but it seems to take so long to get to bed time (R225UK, Q6B)

The experienced lack of possibility in depression disturbs the passive synthesis of the retention-presentation-protention structure that grounds the experience of implicit time. Thereby, lived time is extinguished by experienced time and one becomes painfully aware of the gap between past, present, and future. The current moment becomes dominant and appears everlasting as one might fail to experience any possibilities or prospects for a change in the future. Locked in the present, one becomes painfully aware of the passage of time, which is otherwise merely lived rather than explicitly experienced.

5. Loss of Hope

One of the most frequently reported experiences in both memoirs and anonymous reports of depressed individuals is that of having lost hope. The overwhelming feelings of hopelessness or on some cognitivist conceptions the adoption of hopeful attitudes and their central role in depression have been widely recognized in research and considered among the central phenomena characterizing the condition (e.g. Karp 1996; Beck, Weissman, Lester,

[71] The excerpt to follow was administered the code *Waiting for alleviation*. Passages, which describe experiencing a deceleration of temporal flow in particular with respect to the anticipation of a particular event, time of date, etc. are: R16UK, Q6B; R17UK, Q6B; R21UK, Q6B; R24UK, Q6B; R41UK, Q1B; R49UK, Q6B; R80UK, Q6B; R84UK, Q6B; R110UK, Q6B; R115UK, Q6B; R124UK, Q6B; R130UK, Q6B; R137UK, Q6B; R143UK, Q6B; R145UK, Q5B, Q6B; R169UK, Q6B; R180UK, Q6B; R225UK, Q6B; R240UK, Q6B; R253UK, Q6B; R291UK, Q6B; R371UK, Q6B.

and Trexler 1974). It has recently been argued that the experiences of hopelessness reported by individuals suffering from depression are not limited to the loss of a wide number of hopes or all intentional hopes, but rather that what is lost is the possibility for hope in general (Ratcliffe 2015, Chapter 4). This kind of general and fundamental hope, so-called 'existential hope', Ratcliffe (2015) argues, provides us with the basis for contemplating future prospects and possibilities. In what follows, I am going to introduce Ratcliffe's concept of existential hope and what the experience of having lost it amounts to. Then, I am going to propose that what is lost is the affective disposition to hope, which presents the present predicament (one of suffering and emotional torment in depression) as permanent and everlasting as it fails to offer any prospects for a change (for the better). The impossibility of a significantly different future, in turn, makes hoping for anything and everything impossible and is manifested in reflective experiences of despair, hopelessness, sadness, pointlessness of existence and particular cognitive tendencies towards negative evaluation.

5.1. Existential Hope

In depression, descriptions of experiences of having lost hope, according to Ratcliffe (2015, Chapter 4), refer not only to instances of ceasing to hope for a particular positive outcome or change, but also to the impossibility of entertaining a hopeful attitude towards any state of affairs. What individuals suffering from depression experience is losing this more fundamental sense of hope that constitutes a particular background orientation, that of hopes being possible. This kind of existential hope is "[…] a phenomenological backdrop against which states of the kind 'I hope that *p*' are possible" (Ratcliffe 2015, 103). Existential hope conceived in this manner, thus, is a fundamental orientation that is presupposed for hoping for anything in particular. Commonly, most of the time we find ourselves in an orientation of existential hope and have a fundamental sense that things can have a positive outcome so that even when our particular hopes are disappointed or lost, we can still entertain the possibility of a hopeful future in general. Existential hope, moreover, provides all our projects, endeavours, and actions with their particular significance – only in terms of a possible (positive) outcome what we do has a particular meaning and is worth doing[72]. Existential hope, according to Ratcliffe (2015), is not the mere disposition to experience hope or adopt hopeful attitudes, but rather possesses a distinct phenomenology of its own.

[72] Experiences akin to the loss of existential hope are not peculiar only to depression. There are many situations in everyday life when we might feel uprooted, dispirited, despaired, and without a purpose. For instance, in cases of grief, the loss of a beloved partner can be associated with a collapse of so-called systems of meaning (Ratcliffe 2015). Particular major social, cultural, and political changes can also be associated with similar experiences (see Ratcliffe's (2015, Chapter 4) discussion of Lear's concept of radical hope).

It is not merely a fundamental sense that there is a future but that the future offers *significant possibilities*, which makes it possible to hope for anything in particular. Thereby, existential hope discloses the world as a space of significant possibilities in a pre-reflective manner and impacts all experience, thought, and action. Upon losing existential hope, one finds oneself in a world, in which the future fails to offer any significant possibilities that can be actualized as there are no prospects towards a change for the better. This fundamental background renders all hopes impossible, extinguishes the capacity to have any kind of specific or general hopes and the loss of the "possibility of adopting an attitude of the kind 'I hope that *p*' [is] experienced *as* a loss" (Ratcliffe 2015, 103; emphasis in the original). Conceiving of existential hope in this way, Ratcliffe (2015) explicitly argues that it is not an affective disposition or a capacity. What is lost in depression is the experience of a particular space of possibilities, significant possibilities for things to change for the better. While I agree with Ratcliffe (2015) that existential hope is a background orientation that undergoes radical changes in depression, I am going to propose that what is at the core of experiences of hopelessness is rather the disturbance of the *affective disposition of hoping*, which is a manifestation of an experienced loss of possibilities that itself is based on the lack of individual significance discussed in the previous sections. Conceiving of hope as a fundamental affective disposition that provides us with a sense of a significant future, I am going to argue, captures the fundamental character of the loss of existential hope in depression and the central role of the experienced loss of fundamental possibilities.

5.2. Hope as an Affective Disposition

The dispositional nature of hope, on my proposal, can be best understood by examining the nature of habitual engagements with the world from the standpoint of phenomenology. Habitual engagements, in my view, establish a specific anticipatory structure, which is essential to understanding the disposition to be hopeful. Central to this understanding of hope as an affective disposition is the prospective structure, which is necessary for anticipating a significant or better future. I am going to propose that the loss of individual significance, which presents the world as devoid of individual possibilities, radically disturbs one's habitual engagements with the world. This disturbance, most importantly, goes along with the breakdown of the anticipation of a significant future or such that offers prospects for change. Subsequently, one also fails to hope for anything and finds oneself in a background orientation that has a distinct phenomenology. I understand habitual engagements as (sets of) patterned interactions with the world such as concrete instances of occupations, lifestyles, etc. that can encompass more or less specific activities. Crucial to

understanding their role in the anticipation of a significant or different future is, according to me, their role in structuring how we engage with the present and the future, which provides us with an anticipation of familiarity, coherence, and consistency. Moreover, like any severe chronic recurrent condition, depression has a disruptive effect on the trajectory of one's life, which also markedly disturbs one's habitual engagements understood in this way. Thus, depression in particular has a double impact on habitual engagements – on the one hand, the changes in the experience of individual possibility disturbs one's habitual engagements, and on the other, these might be rendered impossible by its devastating effects qua being a severe long-term, chronic or recurrent condition.

Here, we can refer to Merleau-Ponty's (1945/2002) conception of habit to illustrate this particular role habitual engagements play in how the anticipation of a significant or better future and the experience of the present. According to him, a habit can be understood as

> […] that strange and marvelous bodily power of creating and repeating certain experiential forms that is always at work at the very foundation of our experience and that establishes us in a "world" in the first place. Habit is our body's power of carving its own paths through the sensuous multiplicity of being, so that we are not directly assailed by the radical novelty of each passing moment but instead able to rely upon structures of repetition that hold onto the past and recreate it for us, and in so doing, create a stable situation in which we can function (Talero 2006, 195).

Habit, thereby, provides us not merely with a set of patterned motor abilities, which we deploy automatically at individual moments, but rather establishes an integration of past, present, and possible future interactions. Being habitually engaged with the world, we do not only have at our disposal sets of interactions that transform the present into a structured, action-prompting reality, but also envisage what is to come in terms of how it integrates with these interactional patterns. The future, thus, is anticipated as a *coherent continuation* of the present engagement in a pre-reflective manner. Habits are not merely (bodily) abilities that we exercise, they are also ways of experiencing the world as a particular interactional space. Conceiving of habits this way, they incorporate embodied abilities, which have been developed and automatized in response to what the world offers (what the world affords and how what it affords is significant for our practical projects). These are pre-reflective dispositions that among other things orient the subject towards what is to come and place her in a world of current and future individual significance. Pre-reflectively anticipating what is to come within a habitual engagement, the future comes towards one in terms of prospects for interaction and possible outcomes, of satisfaction of strivings and achievements of currently pursued goals. And this anticipation of a significant future is also what is at stake in existential hope.

When hoping, we are essentially entertaining not only an explicit reflective attitude, which presents particular future outcomes as likely, but rather we are anticipating a particular type of future, one which is consistent with our current engagements in terms of their continuation or successful fulfilment. When habitual engagements break down, for instance because the world fails to offer possibilities for them or fails to entice one into such, it also stops making sense, it is a realm devoid of significance with which one cannot engage. The abilities and dispositions one possesses and has relied on so far are of no use anymore as they are not called for by the current situation. This disruption simultaneously changes how the future is experienced, the subject cannot anymore anticipate it as one in which she will be embedded and engaged along the familiar patterns of habitual engagement, she is not able anymore to envision a way of dealing with whatever is to come as it is not continuous with what the past presented her with.

When hoping, we are not knowledgeable about the future but have a general orientation, which includes an anticipation of positive outcome. In that way, hope is a general background disposition to be oriented towards the future in a particular manner, namely as imbued with significant possibilities coherent and continuous with our current practical engagements. Our habitual engagements and the prospects they establish provide us with pre-reflective anticipation of the course of what is beyond our control and pose a structure of possible interactions and engagements that gives us prospects with respect to what we can expect. When habitual interactions break down, everything not only loses its significance as the goal cannot be attained, but the fundamental structure of (hopeful) anticipation is also obliterated. Then, we are faced either with uncertainty with respect to what is to come or with the certainty that the current state of failed (habitual) engagement will last. In the former case, our general hopeful orientation towards the future can be replaced by one of anxiety and fearful anticipation of negative events, threats, failure, doom, etc. In the latter case, hopelessness and despair, especially with respect to the permanence of the current condition (commonly one that is of rather unpleasant and painful nature) settle upon one. The future in such cases, is envisioned not as providing one with prospects for habitual engagements and thus satisfaction of current strivings and urges, but rather as an extension and continuation of the present that is itself characterized solely by suffering, and pain in the case of depression.

Existential hope on this reading can be understood as a fundamental orientation towards the future in terms of the possibilities for continuation and fulfilment of present endeavours of for a change for the better it holds. Having a hopeful orientation towards the future is made possible by, first, being able to anticipate a future, which, second, is such that

it can potentially differ from the present (for the better) or is coherent and continuous with it. In what follows, I am going to suggest that in depression the affective disposition to hope is extinguished as one (1) cannot anticipate a future different from the present and (2) cannot anticipate a coherence and continuation of present engagements in the future. This disrupts our common background orientation of existential hope and establishes background orientations of hopelessness and despair, loss of meaning and purpose, and insecurity and threat. This breakdown is, moreover, also associated with specific changes in cognitive style.

5.3. Inhabiting a Hopeless Orientation: What it is Like to be Unable to Hope

To hope, on this reading, is to be disposed to anticipate the future as offering possibilities consistent and coherent with current engagements and prospects for a change for the better. This projection establishes a background orientation of (present) meaningfulness as current engagements are not experienced as pointless and futile and one can pre-reflectively anticipate a significant future (particularly in the cases when current engagements might not be successful). For this to happen, though, we need to experience the world as offering a space of significant possibilities, which enable habitual engagement. In the framework of habitual engagements, we are oriented towards the future in terms of the prospects it offers, which are based on how we currently interact with the world. In depression, the current situation is characterized by loss of possibilities that can disturb one's projection into a (meaningful or better) future. Finding oneself in a world, which has changed radically, one's habitual engagements are rendered impossible. Most importantly, this goes along with a breakdown of our taken for granted hopeful anticipatory structure, which envisions the present as offering prospects for further meaningful engagement and potential change. When unable to hope, the future, thus is disclosed as devoid of such prospects so that it is now anticipated only in terms of the continuation of the present predicament of suffering and its lack of meaning specifically with respect to the practical endeavours of the present.

I suggest that we can understand the experiences of anxiety and threat, hopeless, despair, and meaninglessness described in first-person testimonies as indicative of this breakdown of the disposition to hope. In what follows, I am going to engage in a detailed examination of the various phenomena reported by individuals suffering from depression, which are indicative of a failure to hope for a better or a significant future.

5.3.1.Lack of Security

The breakdown of (habitual) engagements, as introduced above, goes along with a failure of our common anticipation of the future as offering prospects for engagement consistent and coherent with current ones, which discloses it as somewhat familiar to one. Although we are commonly not knowledgeable about what the future will bring, we have a background sense of familiarity associated with it especially in the absence of radical changes in how we are engaged with the world. For instance, everyday life is also replete with minor disturbances of this anticipation of a familiar future such as those that one might be subjected to right before embarking on a new career path. In such cases, one abandons for many different reasons a specific instance of engagement with the world (undoubtedly one that is very clearly circumscribed and localized such as a profession rather than a way of being), which has had a habitual character. This engagement, though, presented the future as comprising specific possibilities that were then consistent with how one was engaged. Despite of not knowing with any certainty whether these would actually obtain in the future, one nonetheless could anticipate a certain trajectory of the developments of one's life that were coherent and consistent with its present stage. But upon abandoning one's current occupation, for example, because one has been fired, this trajectory had been disrupted – one cannot anticipate a promotion, one cannot anticipate a pay check, etc. This might in some cases frame the anticipation of the future in unfamiliarity. Commonly, though, in non-pathological cases that do not involve major and radical shifts in the possibilities offered by the world, we can still anticipate at least some level of familiarity with respect to the future even in cases when one is not certain exactly what possibilities it can offer. In such cases, we are more likely to be subjected only to unfamiliarity and uncertainty regarding specific future engagement or the possibilities for such. One then might anxiously anticipate the unfamiliarity of the future with regard to specific developments while others that have not changed will be anticipated in an atmosphere of familiarity. In the case of losing one's job or opting for a new career path, one would experience specific intentional fears and insecurities with respect to career development or financial security.

In depression, in contrast, the breakdown of habitual engagements is more encompassing and pervasive – as the world fails to offer significant or enticing possibilities for engagement in general, there are also no prospects for any future ones that seem even slightly familiar. This breakdown establishes a background of insecurity described in its various manifestations by 65 (53.28%) of the respondents to the DDQ UK mainly in terms of anxious anticipation of an unfamiliar and uncertain future. This background of unfamiliarity envelops all possible future developments and subsequently subjects one to a

general fearful apprehension or free-floating anxiety rather than specific episodes or feelings of fear directed at particular future events or states of affairs as for example described by 28 respondents (22.95%) to the DDQ UK and exemplified by this passage (Danquah 1998, 38-39; Hatfield 2008, 234, 244; Malai Ali 2007, ix, xi, 3-4, 8, 15, 17, 22; Smith 1999, 198; Solomon 2001, 28-29, 49, 50, 51; Styron 1989, 9, 45, 58; Thompson 1995, 35, 42, 47; Wurtzel 1995, 235 also describe experiences of anxious anticipation of the future):[73]

> I am paranoid and pessimistic, convinced something bad will happen to me or others (R85, Q2B)

The anticipation of a threatening and insecure future also shapes how the present is experienced. Being itself characterised by the breakdown of active engagements, the present is, like the future, an unfamiliar realm, which is emphasized even more by a prospective orientation of anxious anticipation. Thus, against this background of unfamiliarity, envisioning a future of threat colours the experiences of everyday life in the present, in which occurrences and events seem indicative of the doom that is anticipated in the future and respectively one feels afraid of the world and others in general as described by 47 (38.52%) of the respondents to the DDQ UK and in the following passages (see also Danquah 1998, 185-186; Solomon 2001, 28-29; Styron 1989, 44-45 for descriptions of the world and others as threatening):[74]

> I remember a specific time that would be best to describe how- when I was feeling at my worst- the world appeared to me. I was walking through a hallway at my high school, and around twenty people walked towards me, at once I felt panic, as though they were closing in on me and I had shrunk to half my size, and even that they would severely hurt me if they came too close. Even someone knocking on my room door at home could cause severe anxiety that I was going to get hurt. (R331UK, Q2B)

The experiences of the world and others as essentially hostile, threatening, and insecure can for some be directly related to tendencies towards isolation and withdrawal that might

[73] The excerpt to follow was administered the code S*ense of impending doom*. Responses describing experiences of anxiety or fearful anticipation of the future are: R17UK, Q4B; R21UK, Q1B; R41UK, Q1B; R53UK, Q1B; R85UK, Q1B, Q2B; R97UK, Q1B; R118UK, Q1B; R129UK, Q7B; R137UK, Q6B; R150UK, Q1B; R157UK, Q1B; R160UK, Q1B, Q2B; R161UK, Q1B; R186UK, Q1B; R200UK, Q1B; R212UK, Q1B, Q7B; R228, Q7B; R231UK, Q4B; R246UK, Q1B; R253UK, Q2B; R303UK, Q1B; R312UK, Q1B, Q2B, Q8B; R316UK, Q2B; R325UK, Q7B; R334UK, Q8B; R343UK, Q1B, Q7B; R367UK, Q1B.

[74] The excerpt to follow was administered the code *Hostile world*. Responses describing experiences of anxiety in particular with respect to the outside world are: R8UK, Q2B; R14UK, Q2B; R21UK, Q7B; R24UK, Q1B, Q2B; R37UK, Q1B; R54UK, Q2B; R60UK, Q2B; R61UK, Q2B; R66UK, Q2B; R80UK, Q8B; R85UK, Q1B, Q5B, Q8B; R89UK, Q2B; R93UK, Q2B; R105UK, Q2B; R110UK, Q2B; R115UK, Q2B, Q7B; R117, Q3B; R129UK, Q3B; R130UK, Q3B; R134UK, Q3B; R137UK, Q1B, Q2B, Q5B; R150UK, Q7B; R155UK, Q2B; R168UK, Q2B; R180UK, Q8B; R218UK, Q2B; R231UK, Q5B; R237UK, Q8B; R240UK, Q2B; R253UK, Q1B; R269UK, Q5B; R270UK, Q2B; R271UK, Q5B; R282UK, Q2B; R288UK, Q2B, Q3B; R292UK, Q2B; R303UK, Q2B; R307UK, Q7B; R312UK, Q5B; R325UK, Q2B; R331UK, Q2B; R334UK, Q1B, Q2B, Q7B; R347UK, Q2B; R352UK, Q2B; R355UK, Q2B; R366UK, Q2B; R367UK, Q8B.

culminate in the complete abandonment of social activities and interactions reported by 5 (4.1%) of the respondents to the DDQ UK:[75]

> feeling that everyone hates me and is laughing at me because I have let everyone down. […] Withdrawing - most of the time I am reclusive but the worse my depression gets the more terrified I am of having to deal with people or things such as bills or other everyday situations. (R357UK, Q1B)

The disturbance of habitual engagements in these cases places one in a background orientation of insecurity and threat, which are manifested in various experiences like the ones discussed above. These instances of anxiety are in many cases also accompanied by experiences of hopelessness, despair, and meaninglessness. The latter ones, while distinct in quality from the feelings of anxiety and threat are also established by the disturbance of the anticipation of a future characterized by prospects for engagements consistent and coherent and the present and a change for the better.

5.3.2. Hopelessness and Despair

The loss of the affective disposition to hope makes the present predicament most pronounced in terms of the lack of prospects for a better future for a change or the better. By failing to anticipate as significant future, the state of present suffering and emotional pain appears permanent and ever-lasting. This background orientation of hopelessness was reorted by 46 (37.7%) of the respondents to the DDQ UK.

The loss of enticement transforms one's life into a passive existence, which does not offer any prospects for change as the future stretches before one as merely a continuation of the disengagement, passivity, and pain of the present. This loss of prospects for a significant future is for the majority of individuals suffering from depression most apparent in terms of the lack of prospects for alleviation of current suffering and emotional torment. Failing to anticipate a better future here in particular shapes how the present episodes of emotional distress and overwhelming pain are felt – these now appear permanent, never ending, and ever-lasting as described by 15 (12.3%) respondents to the DDQ UK (see also Crafton 2009, 3; Danquah 1998, 57; Hatfield 2008, 244; Malai Ali 2007, 22; Smith 1999, 21; Solomon 2001, 16; Wurtzel 1995, 21-22, 110-111, 191, 234-235):[76]

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[75] The excerpt to follow was administered the code *Withdrawing from an insecure world*. Responses, which describe avoiding social encounters and interactions and isolation specifically in view of the threat posed by the world and others are: R115UK, Q7B; R259UK, Q1B; R292UK, Q2B; R347UK, Q5B; R357UK, Q1B.

[76] The three excerpts to follow were administered the code *Suffering will last forever*. Responses, which received this code are: R8UK, Q8B; R22UK, Q8B; R51UK, Q8B; R75UK, Q8B; R110UK, Q8B; R113UK, Q8B; R137UK, Q8B; R169UK, Q8B; R186UK, Q1B; R189UK, Q7B; R192UK, Q1B; R231UK, Q1B; R240UK, Q6B; R323UK, Q8B; R347UK, Q1B

> Life will never end, or change. Everything is negative. I lose my imagination, in particular, being able to imagine any different state other than depression. Life is a chore. (R169UK, Q8B)

Life becomes a plight that not only has to be endured but does not offer any prospect for change, what is to come is just more of the present suffering and pain. Here, some could object that this is not an expression of a change in the experiential background but the result of the recurrence of depressive episodes or the chronic and often life-long nature of the condition. While depression is in most of the cases recurrent and for many a life-long presence, this cannot account for the encompassing and overwhelming lack of prospects, though. Many individuals suffering with depression have developed successful coping strategies that to some extent alleviate its devastating effects so that. Thus, if the sense of lack of prospects for a better future were merely the result of its recurrent or chronic nature, only some specific hopes would be obliterated during depressive episodes, for instance regarding those about the course and duration of the episode as this respondent to the DDQ UK suggests:

> All I can see/feel is pain and darkness and I cannot foresee anything else in the future. I think 'here we go again', I know the next weeks will be terrible and I don't want to go through it again. (R192UK, Q1B)

But many other consistently report that particularly in cases of recurrences of depressive episodes and although they know that these end at some point, their current predicament of suffering is experienced as permanent as everlasting, so that for them ultimately "[it] is impossible to feel that things will ever be different (even though I know I have been depressed before and come out of it) (R189UK, Q7B).

Anticipating the future as failing to offer any prospects for further (habitual) engagements also makes it impossible for one to even attempt to imagine, envision, or plan any meaningful activities that might restore an active engagement. Consequently, any explicit plans or life-projects are rendered impossible, so that the trajectory of one's life is disrupted and one feels confined to being depressed forever as for instance explicitly pointed out by 32 (26.23%) respondents to the DDQ UK (see also Crafton 2009, 1; Hatfield 2008, 244; Lewis 2002, 31; Smith 1999, 7; Solomon 2001, 67; Styron 1989, 2, 16, and Wurtzel 1995, 220, 268, 289 for further descriptions of the experience of a lack of significant future):[77]

[77] The two excerpts to follow were administered the code *Lack of a significant future*. Responses describing the experience of the current predicament as permanent and ever-lasting in terms of the lack of propsects for a change for the better are: R16UK, Q8B; R17UK, Q8B; R20UK, Q8B; R22UK, Q8B; R28UK, Q2B; R37UK, Q1B; R41UK, Q8B; R60UK, Q1B; R61UK, Q8B; R65UK, Q1B; R105UK, Q7B; R115UK, Q2B, Q8B; R130UK, Q8B; R160UK, Q8B; R166UK, Q8B; R168UK, Q8B; R180UK, Q8B; R192UK, Q1B; R218UK, Q8B; R239UK, Q1B; R271UK, Q8B; R285UK, Q1B; R288UK, Q2B, Q8B; R307UK, Q1B, Q2B; R323UK, Q1B; R343UK, Q8B; R347UK, Q8B; R349UK, Q8B; R350UK, Q2B; R355UK, Q8B; R357UK, Q2B; R370UK, Q1B.

> You can't see far into the future so you can't see aspirations or dreams. Everything I ever wanted to do with my life before seemed impossible now. I also would think that I would never get out, that I'd be depressed forever. (R22UK, Q8B)

Commonly, we are able to anticipate the future as offering prospects for potential change only if it differs significantly from the present. In depression, in contrast, one is not able to anticipate a future in this sense, i.e. in the sense of being characterised by significance as it is anticipated only as a continuation of the oppressive and tormenting present, which encloses and entraps the subject. And even if one were to somehow still attempt to engage with the world and thereby bring about a pattern of engagement that structures the anticipation of a meaningful future, a hopeful orientation would still not be possible and the world would still remain depleted of significance as illustrated in the following passage:

> I remember a time when I was very young – 6 or less years old. The world seemed so large and full of possibilities. It seemed brighter and prettier. Now I feel that the world is small. That I could go anywhere and do anything and nothing for me would change. (R130UK, Q8B)

Despite being able to imagine or contemplate a change that can bring along different patterns of significance or enticement, this still would not make a difference. One's predicament would remain the same, a predicament devoid of significance, enticement, and most importantly a significant or better and meaningful future. This alludes not so much to a failure or ineffectiveness of the own attempts at changing the current predicament, but rather to their general futility: even if something was amenable to change, the change would not have any impact on the individual. She is trapped in the present situation specifically in terms of the impossibility of change (for the better). Thereby the lack of prospects for change is attributed to the world, which cannot offer any possibilities for a better future, even in cases, in which one can still contemplate a possible intervention to induce such.[78]

In line with this, only a small number of the respondents to the DDQ UK, 4 (3.28%), associated the experienced lack of prospects for a better future with their inability to change their current predicament. One of them described this especially poignantly in the following manner:[79]

> I felt trapped, like nothing I did could make things better. (R21UK, Q8B)

[78] In her semi-autobiographical account of depression, Sylvia Plath (1963, 196) includes a similar description of the loss of hope and prospects for change. Feeling trapped under a bell jar, she also is able to contemplate an intervention that could otherwise change her current predicament, which though still seems futile.

[79] This passage was administered the code *Inability to induce change*. Responses describing the experience of a lack fo significant future related to one's personal failure or inability to induce change are: R16UK, Q1B; R21UK, Q8B; R171UK, Q1B, Q7B; R246UK, Q8B.

In these cases, the experiences of hopelessness can be explicitly related to (an alleged) failure to (successfully) change one's predicament that results from some more or less specific inabilities, shortcoming, or flaws possessed by the individual.

5.3.3.Loss of Point and Purpose

Being essentially a pre-reflective anticipation of the future, the disposition to hope also has an impact on how the present, in particular in view of its meaningfulness, is experienced. Not being able to anticipate a future characterized by change and significance, the present also appears as devoid of purpose. Our experience of how we find ourselves in the world in the present and interact with it (especially the significance of individual practical projects we are engaged in) is framed by its purposiveness and value with respect to the outcomes of our practical projects. For instance, we are more likely to engage with practical projects that have a clear purpose and have impact on one. On the contrary, we are commonly dishearted and unmotivated if we are to be engaged in projects, which either are aimed at an unspecific outcome or have no impact whatsoever. Thus, lacking prospects with respect to the future, one might find oneself inhabiting a background orientation of loss of point and purpose that shapes how one experiences existence, specific projects and endeavours, and makes certain negatively valenced affective responses more likely. This general background is the most commonly described orientation constituted by the lack of possibilities in depression as 93 (76.23%) of the respondents to the DDQ UK reported experiencing at least one of its manifestations that I am going to address here.

Individuals suffering from depression frequently describe in both memoirs (Hatfield 2008, 247; Plath 1963, 135; Wurtzel 1995, 12, 48, 292) and anonymous testimonies experiencing various activities as pointless or without any purpose and sgnificance, as for instance 18 (14.75%) of the respondents to the DDQ UK do. To them, many of our mundane activities are encountrered as lacking any meaning, significance, and practical purpose like in this passage:[80]

> Things either appear to be useless or too effortful to make myself do it. I stop caring about cleaning – my usual obsessive cleanliness gnaws on me, but I can't justify doing a task I have to repeat. (R124UK, Q5B)

[80] The excerpt to follow was administered the code *Activities are pointless*. Responses describing various active engagements with the world as pointless, meaningless, or useless against the background of a loss of an anticipation of a significant or different future are: R8UK, Q5B; R24UK, Q5B; R28UK, Q1B; R30UK, Q5B; R38UK, Q1B; R60UK, Q5B; R85UK, Q5B; R115UK, Q5B; R124UK, Q5B; R134UK, Q8B; R147UK, Q2B; R154UK, Q5B; R169UK, Q5B; R186UK, Q1B; R225UK, Q5B; R228UK, Q5B, Q8B; R253UK, Q8B; R291UK, Q1B.

As described in this passage, at least some activities lose their point and purpose. Cleaning one's home now appears utterly pointless, especially given that it will have to be done again in the future. Although this particular activity has been performed multiple times in spite of the need to be repeated later, what seems to have changed now is that the prospect of having to repeat it itself is devoid of significance. And this is obviously not a newly found realization. The lack of future prospects deprives the activity that will anyway have to be repeated of any meaning or purpose it used to have. One is suddenly struck by the realization that these mundane tasks make no difference as there are no prospects for a general meaningful engagement in the future as well.

When prospects for change have disappeared, not only individual projects or activities are experienced as having lost their meaning, but leading a life in general can also seem to lack any point and purpose. Here, it is not only the case that one fails to anticipate any alleviation or relief from the present suffering but also that existence in general seems to lack any deep meaning – there is no point and purpose in bothering to get through life as nothing is going to change anyway for one as described by some of the authors of memoirs of depression (e.g. Crafton 2009, 13-14; Danquah 1998, 44; Plath 1963, 135; Solomon 2001, 15) and 41 of the respondents to the DDQ UK (33.61%):[81]

> It makes me doubt whether life is worth it. Everything seems pointless, it seems like there is no hope left. When I'm not depressed I have ambitions, but when I am it feels like there's no point in trying because I'll just fail anyway. (R292UK, Q8B)[82]

The lack of a hopeful attitude and the subsequent experiences of lack of purpose and meaning of life in general can for some come in the form of a revelation that is not available to others. Moreover, it can be most poignant with respect to the stark contrast to non-depressed people who, according to some, have a delusional or deceptive appreciation of life as meaningful and essentially having a purpose as some of the respondents to the DDQ UK explicitly point out:

> There's no point, it [life]'s a ridiculous sham and anyone truly OK with experiencing life must be insane or brainwashed. (R224UK, Q8B)

[81] The two excerpts to follow were administered the code *Life is pointless*. Responses describing experiencing life as lacking meaning, point, or purpose are: R17UK, Q8B; R22UK, Q8B; R24UK, Q8B; R28UK, Q2B; R38UK, Q8B; R53UK, Q8B; R65UK, Q8B; R75UK, Q8B; R85UK, Q1B; R113UK, Q8B; R129UK, Q8B; R130UK, Q8B; R137UK, Q8B; R150UK, Q2B; R153UK, Q8B; R154UK, Q2B; R155UK, Q8B; R157UK, Q8B; R160UK, Q2B; R161UK, Q6B; R166UK, Q8B; R186UK, Q1B; R189UK, Q8B; R192UK, Q8B; R200UK, Q8B; R224UK, Q2B, Q8B; R225UK, Q2B; R231UK, Q8B; R269UK, Q2B; R291UK, Q8B; R292UK, Q8B; R303UK, Q1B; R307UK, Q8B; R323UK, Q1B; R334UK, Q2B; R347UK, Q8B; R352UK, Q8B; R357UK, Q8B; R361UK, Q8B; R367UK, Q8B; R370UK, Q8B.

[82] In the section to follow, I am going to discuss in detail suicidal ideation and feelings of being suicidal as these exceed instances of loss of hope.

The background orientations of lack of point and purpose can also come to foreground of experience in the form the form of the low mood characteristic of depression. The sense of hopelessness and of meaninglessness of existence settle in an oppressive mood reported by 26 (21.31%) respondents to the DDQ UK, which colours one's perception of everything and makes the world appear dull, bland, flat, unenjoyeable:[83]

> When I'm not depressed, I appreciate my surroundings, things like nice weather, but when I'm depressed, it doesn't make a difference. It might as well be always grey and raining – it wouldn't make me more or less miserable. (R53UK, Q2B)

Moods, here can be understood as diffuse affective states that lack a particular intentional object but colour or shape how we affectively respond to the states of affairs and events in the world (Stephan 2016).

In the low mood of depression in particular crystalize several aspects of the background orientations of hopelessness and loss of point and purpose, so that also various situations, events, and states of affairs now occasion predominantly if not exclusively negative emotional responses (Stephan 2016). Consequently, 14 (11.48%) of the responses to the DDQ UK include descriptions of being more emotionally liable and being more frequently subjected to negative emotions in response to various things (e.g. Danquah 1998, 149; Lewis 2002, 162; Thompson 1995, 46; Wurtzel 1995, 283):[84]

> I find my temper is easily frayed. Whilst not teary a lot of the time I become frightened that once I start crying I may be unable to stop. I feel I have no reason to be upset and cannot think of why I am upset but I just am. (R162UK, Q1B)

Being subjected to low mood, one is also more prone to outbursts of negative emotional responses like sadness that can either be directed at particular events or states of affairs or seem to be unsolicited or triggered by anything in particular as reported by 19 (15.57%) respondents to the DDQ UK (see also Danquah 1998, 76; Hatfield 2008, 233 for descriptions of feelings of sadness):[85]

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[83] The passage to follow was administered the code *Low mood*. Responses describing the experience of low mood are: R8UK, Q1B; R20UK, Q1B; R41UK, Q1B; R47UK, Q1B; R49UK, Q1B; R60UK, Q1B; R85UK, Q1B; R93UK, Q7B; R105UK, Q1B; R107UK, Q7B; R130UK, Q1B, Q2B; R133UK, Q1B; R137UK, Q1B; R145UK, Q1B, Q8B; R153UK, Q1B, Q2B; R154UK, Q1B; R166UK, Q1B, Q4B; R169UK, Q8B; R192UK, Q8B; R231UK, Q1B; R259UK, Q1B; R312UK, Q1B; R325UK, Q1B; R343UK, Q1B; R347UK, Q2B; R370UK, Q2B.

[84] The excerpt to follow was administered the code *Emotional instability*. Responses describing a general tendency towards negative emotional responses are: R40UK, Q4B; R60UK, Q2B; R115UK, Q1B; R147UK, Q1B; R150UK, Q1B; R162UK, Q1B; R166UK, Q1B; R168UK, Q1B; R239UK, Q1B; R269UK, Q1B; R334UK, Q1B; R357UK, Q1B; R366UK, Q1B, R371UK, Q2B.

[85] The excerpt to follow was administered the code *Sadness*. Responses describing feelings of sadness are: R17UK, Q1B; R20UK, Q1B; R21UK, Q1B; R22UK, Q1B; R23UK, Q1B; R80UK, Q2B; R115UK, Q1B; R117UK, Q1B, Q2B, Q4B; R130UK, Q1B; R162UK, Q1B; R166UK, Q1B; R200UK, Q1B; R212UK, Q1B; R218UK, Q1B; R231UK, Q1B; R307UK, Q1B; R313UK, Q1B; R331UK, Q1B; R371UK, Q1B.

> Depression is an overwhelming sadness that feels like grief. It also feels completely out of control – I just have to wait for it to pass. I liken it to a wound that has to be left to bleed.
>
> When I'm not depressed I can be objective.
>
> When I'm depressed I can only feel the sadness. (R313UK, Q1B)

Accordingly, as many as 34 (27.87%) of the respondents to the DDQ UK and authors of memoirs (e.g. Brampton 2008, 58, 90; Hatfield 2008, 245; Lewis 2002, xi; Smith 1999, 57; Thompson 1995, 62, 118; Wurtzel 1995, 188, 189, 214, 215, 276) also report of crying outbursts that can be understood as an automatic bodily reaction produced in response to the overwhelming grief over the loss of a meaningful and significantly different future:[86]

> I would cry most days without any apparent reason. (R53UK, Q1B)

The general background of loss of hope (for a significant or better future) and a sense of hopelessness of life in general transform even formerly enjoyable and pleasurable activities into burdensome and demanding. This might be especially the case for occupations that lack an essential practical utility in everyday life and were formerly pursued mainly in view of their enjoyable nature such as hobbies, recreational activities, etc. Indeed the lack of pleasure experienced by individuals suffering from depression is one of the most common symptoms of the illness and is included in its diagnostic criteria and accordingly is consistently described by the authors of memoirs (e.g. Brampton 2008, 51, 244; Danquah 1998, 32; Lewis 2002, xi, 3; Malai Ali 2007, 25; Plath 1963, 105-106; Smith 1999, 3-4, 5, 18; Solomon 2001, 19; Styron 1989, 14) and 32 (26.23%) of the respondents to the DDQ UK, as for instance in this passage:[87]

> I find no joy in activities that would normally please me.
>
> I see no point in these activities (R186UK, Q1B)

The loss of existential hope in depression places one in a predicament characterized by the lack of prospects (for significant change) that obliterates all sense of hope, pleasure, and even meaning and purposefulness of one's life in general and individual practical projects in

[86] The excerpt to follow was administered the code *Crying*. Responses describing Further passages crying outbursts that might be uncontrollable and not occasioned by anything in particular are: R20UK, Q1B; R22UK, Q1B; R40UK, Q4B; R53UK, Q1B; R66UK, Q1B; R80UK, Q1B; R93UK, Q1B; R105UK, Q1B; R110UK, Q5B; R112UK, Q1B; R115UK, Q1B; R117UK, Q1B, Q3B; R118UK, Q1B; R130UK, Q1B; R162UK, Q1B; R166UK, Q1B; R168UK, Q1B, Q5B; R192UK, Q1B; R200UK, Q1B; R212UK, Q1B; R218UK Q1B; R228UK, Q1B; R231UK, Q1B; R237UK, Q1B; R261UK, Q1B; R325UK, Q1B; R334UK, Q1B; R341UK, Q1B, Q7B; R343UK, Q1B; R357UK, Q1B; R361UK, Q1B; R366UK, Q1B; R367UK, Q1B; R371UK, Q1B.

[87] The excerpt to follow was administered the code *Lack of pleasure*. Further passages, which describe experiences of lack of pleasure and received this code are: R16UK, Q5B; R20UK, Q1B, Q2B; R22UK, Q1B; R23UK, Q2B; R37UK, Q1B; R107UK, Q7B; R115UK, Q8B; R117UK, Q1B, Q8B; R128UK, Q1B; R137UK, Q5B; R150UK, Q1B, Q8B; R157UK, Q1B; R166UK, Q1B, Q2B, Q8B; R169UK, Q8B; R186UK, Q1B, Q2B; R212UK, Q2B; R228UK, Q5B, Q8B; R240UK, Q2B; R253UK, Q1B; R259UK, Q2B; R269UK, Q1B; R270UK, Q1B; R282UK, Q1B, Q2B; R285UK, Q8B; R291UK, Q8B; R307UK, Q2B, Q8B; R331UK, Q1B; R334UK, Q1B; R341UK, Q1B; R355UK, Q8B; R366UK, Q5B, Q8B; R370UK, Q2B.

particular. The experienced loss of fundamental possibilities disrupts habitual engagement, which presents the future as an extension of the present state of suffering. Being unable to anticipate a significant future, the oppressive character of the present becomes more pronounced. The failure of prospective projection cancels one's disposition to anticipate any positive outcomes, thus to hope for a change for the better. Subsequently, all aspects of one's experience and thought are subjected to the impact of the loss of hope – one's mood respectively drops to a low level, which colours how one affectively responds, acts, and thinks. Moreover, the failure to hope for a change or anticipate a significant future is manifested in changes in how one thinks about the present, the future, and one's life in general. Frequently, individuals suffering from depression report of radical changes in their style of thinking[88], which commonly revolve around the loss of prospects. In the section to follow, I am going to examine these in detail and propose that they, similarly to the affective experiences reviewed above are expressive of the loss of existential hope.

5.3.4.Cognitive Manifestations of the Loss of Hope

The changes in cognitive processing or thinking associated with depression have traditionally been in the focus of research and occupy a central role in the development and experience of the condition according to some theories and therapeutic approaches. Classical cognitive theories of depression argue that the illness is caused by aberrant cognitive processing, which originates from the activation of negatively charged beliefs about oneself, the world, and one's future, the so-called cognitive triad (Beck 1979, Chapter 5; Beck and Alford 2009, Chapter 12). Unlike cognitive models of depression (e.g. Beck 1979), I am going to focus on the particular style of cognitive processing in depression rather than the content of so-called 'dysfunctional schemata or beliefs', which according to some, are central to the experience of depression (see Beck 1979; Beck and Alford 2009). Unlike in cognitive models of depression, the characteristic changes in question are not the cause of depressive experience. Moreover, the negatively charged cognitive states and processes frequently described in reports of depressive experience are also not (deliberate) rationalizations that arise from or are caused by alterations in (reflective) experience. In depression, the disturbance of anticipating a significant future disposes one to contemplation of the permanent nature of one's current state and a tendency towards focusing on the negative characteristics of each and every situation, a kind of downward spiral that one can break only with great difficulty.

[88] See Ratcliffe 2015 (71-74) for a detailed discussion of the relationship between existential feelings and cognitive styles.

It is important to note here, that this is not a cognitive bias that results from a set of dysfunctional beliefs with a particular content. Rather, such cognitive styles are processes that are grounded in the general way one finds oneself in the world and can have different contents depending on the particular predicament one finds oneself in and further specific situational and personal factors. By focusing on changes in cognitive processing instead of on changes in specific content, we can identify structural changes in the underlying fundamental experience. Examining the overall tendencies to engage in negative evaluations regardless of their objects, thereby, allows us to conceive of various changes as rooted in the loss of possibilities in general and the disturbance of an anticipation of a significant or a positive future in particular.

The domination and permanence of the current state of loss of prospects and hope makes all negative aspects of one's current situation capture one's attention as they are not only what characterizes the present state but also indications of what is to come. Accordingly, 27 (22.13%) of the respondents to the DDQ UK and authors of memoirs (Malai Ali 2007, 3; Solomon 2001, 55; Thompson 1995, 88-89) describe engaging in 'irrational' thinking and negative evaluations, which are subsequently during non-depressive episodes recognized as faulty or inappropriate as for instance described in this passage:[89]

> […] I don't want to think, because my thinking is […] negative. My ability to think logically or realistically or from an outside perspective is challenged because everything is jaded. (R124UK, Q7B)

Being subjected to such cognitive processes, one feels as if trapped in a spiral that accumulates all negatively charged aspects around one. Even merely witnessing reports of the evils in the world can trigger a contemplation of the hopelessness and lack of prospects the whole world is facing as described by 25 (20.49%) of the responses to the DDQ UK and some of the authors of memoirs (Danquah 1998, 149; Smith 1999, 57; Wurtzel 1995, 115, 239, 240):[90]

> Every television programme, conversations with a friend or the most simplest sights send me into a downwards spiral of thoughts about all the negative aspects of the world (R367UK, Q2B).

[89] The excerpt to follow was administered the code *Irrationality*. Responses, which also describe instances of engaging in irrational thinking are: R8UK, Q7B; R22UK, Q8B; R41UK, Q8B; R93UK, Q7B; R124UK, Q7B; R137UK, Q7B; R150UK, Q7B; R160UK, Q2B; R161UK, Q7B; R169UK, Q7B; R190UK, Q1B; R192UK, Q7B; R237UK, Q7B; R239UK, Q2B; R259UK, Q7B; R291UK, Q7B; R292UK, Q7B; R311UK, Q7B; R312UK, Q7B; R334UK, Q1B, Q7B; R343UK, Q7B; R347UK, Q7B; R352UK, Q7B; R355UK, Q1B; R357UK, Q7B; R352UK, Q5B; R366UK, Q7B.

[90] The four excerpts to follow were administered the code *Downward spiral*. Responses, which describe circular patterns of negative thoughts are: R14UK, Q7B; R28UK, Q7B; R30UK, Q7B; R37UK, Q7B; R41UK, Q7B; R54UK, Q7B; R60UK, Q1B, Q7B, Q8B; R80UK, Q1B; R117UK, Q8B; R129UK, Q7B; R134UK, Q7B; R150UK, Q1B, Q8B; R169UK, Q7B; R192UK, Q7B; R199UK, Q5B; R224UK, Q7B; R225UK, Q7B; R231UK, Q2B; R253UK, Q7B; R291UK, Q1B; R292UK, Q7B; R313UK, Q8B; R347UK, Q7B; R361UK, Q7B; R367UK, Q2B.

The oppressive character of the present becomes even more pronounced and the evaluation of all individual and more specific social, cultural, and political developments is framed in the general lack of prospects. Subsequently, one comes to judgments that emphasize the futility of human endeavour and place global development on a path towards doom.

This spiral-like process itself often resists deliberate control any ultimately eclipses the possibility to engage in positively charged cognitive evaluations and judgements:

> I can't think about anything positive just negative thoughts. I only think about my own problems and they keep going round and round my head with no let up and no escape. (R28UK, Q7B).

The entrapment in this negative spiral of thinking can as in the passage above centre around the current difficulties and emotional distress one is experiencing, which may exacerbate the prevailing feelings of hopelessness and the suffering associated with depression and thereby place one in a vicious cycle of negatively charged experience, which is both associated and magnified by engaging in negative evaluations and contemplation:

> When I am depressed it builds and builds from a low moment that triggers something that then accelerates through a thinking process that is eternally negative that links one bad thought/experience to the next until you try and shake yourself out of it. (R60UK, Q1B)

In many cases, this spiralling cognitive style, moreover, might culminate in a chaos of (negatively charged) thoughts and thereby strongly interfere with the performance of any other cognitive activity as illustrated by this response to the DDQ UK:

> It [depression] completely disorganises my thoughts. I can't concentrate on things I try and concentrate on (usually uni work) and yet my head is filled with so many thoughts I can't ever sleep. Just hundreds and hundreds of thoughts whirling around in my head, with no function or order. It's complete chaos. (R14UK, Q7B)

The general trend towards negative focus and evaluations, inability to disengage from (aspects of) the current situation, and the repetitive circular and automatic character of thinking reported by individuals suffering depression manifest the background orientation of loss of existential hope. The world is disclosed as robbed of prospects and this occasions a radical shift in significance that centres around the impossibility of change of the current predicament. Respectively, one feels trapped in the present condition, which makes its negative aspects more strongly pronounced and the failure to envision change triggers automatic associations of negative cognitions that are processed in a repetitive and circular manner.

6. Being Suicidal

According to the American Association of Suicidology (2004), "depression is the psychiatric diagnosis most commonly associated with suicide". Commonly, the focus in the research on suicidal ideation has shifted to its conception in terms of a cognitive construct accompanied by the respective attitudes, desires, wishes, and evaluations or estimations (for instance as exemplified by the items in the Scale for Suicide Ideation (Beck, Kovacs, and Weissman 1979)). First-person reports by individuals suffering from depression frequently include descriptions of the experience of being suicidal that are not restricted or even sometimes do not include the explicit reference to thinking about suicide or planning such. What some of these illustrate is rather that feeling suicidal is a different way of being that constitutes the background of all experience, thought, and action (Benson et al. 2013) as illustrated by this passage, in which William Styron recollects the profound change in his surroundings that he encountered when being suicidal:

> [M]any of the artifacts of my house had become potential devices for my own destruction: the attic rafters (and an outside maple or two) a means to hang myself, the garage a place to inhale carbon monoxide, the bathtub a vessel to receive the flow from my opened arteries. The kitchen knives in their drawers had but one purpose for me. Death by heart attack seemed particularly inviting, absolving me as it would from active responsibility, and I had toyed with the idea of self-induced pneumonia […]. Nor had I overlooked an ostensible accident […] by walking in front of a truck on the highway nearby. (Styron 1990, 52-53)

For Styron, in this new situation mundane objects are associated with radically different patterns of significance – rather than continuing to be significant in the context of his common engagements with the world (for instance in the course of everyday life), now they are encountered as offering only possibilities to end one's life. This though is not the result of a formerly contemplated plan to commit suicide. In contrast, by encountering these in this manner, one seems to become aware that what one strives at is death. This radical shift itself is a new way of finding oneself in the world, against the background of which all affective experience, thought, and action changes accordingly (Benson et al. 2013). As such, it is experienced at the bodily level as well and suicidal feelings can be characterized as bodily experiences that restructure the experience of self, world, and others (Benson et al. 2013, 40). Being or becoming suicidal is, thus, "[…] a reorientation of the whole of one's existence rather than simply a wish to die by one's own hand" (Benson et al. 2013, 41). The majority of descriptions of feeling suicidal and being subjected to suicidal ideation in an explicit form frequently relate these experiences to the general loss of hope that makes the current

predicament seem unchangeable and permanent[91]. Thus, those inhabiting a background orientation of being suicidal are reoriented towards "bringing an intolerable mode of existence to an end" (Benson et al. 2013, 41). In what follows, I am going to engage in an examination of the different ways of being suicidal that are described in first-person testimonies. Thereby, I am also going to examine how the failure of anticipating a significant and better future establishes the background of being suicidal.

The descriptions of depressive experience provided in response to the DDQ UK and published testimonies point towards some differences in the experience of being suicidal that can help distinguish between two ways of being suicidal and the associated structural changes. Although all descriptions of the experience of being suicidal refer to a wish to stop living, for some death presents itself as alleviation or relief (1), while for others it is the punishment for (alleged) shortcomings, flaws, and transgressions (2). In the former cases (1) described by 46 (37.7%) of the respondents to the DDQ UK, the lack of prospects in particular can come in two variants: while for some it is limited to the failure of the future to offer any prospects for change (1.1), for others it can be more closely associated with an anticipated personal failure to induce or deploy such (1.2).

In instances of (1.1), the failure to anticipate a significant future and the associated feelings of pointless existence make one ask the question whether this life is worth living as the meaning of one's practical projects has disappeared. For 35 (28.69%) of the respondents to the DDQ UK the current predicament becomes unbearable in terms of its utter lack of meaning and purpose and can be escaped in only one way – by ending it. One's life has been transformed into a burden, which has to be endured rather than lived as pointed out by this respondent the DDQ UK[92] (Crafton 2009, 3-4; Hatfield 2008, 235, 244-245, 246; Smith 1999, 18-19; Solomon 2001, 71; Styron 1989, 26-27; Wurtzel 1995, 11, 107, 233, 293-294, 316 similarly describe this orientation towards suicide):

[91] Traditionally, the research on suicidal ideation has focused on its relationship to hopelessness (Beck, Steer, Beck, and Newman 1993). Both suicidal ideation and hopelessness have been conceptualized and studied mainly as reflective attitudes and cognitive constructs that one adopts. Unlike these approaches, it is important to emphasize here, I am viewing both the loss of hope and being suicidal as closely related background orientations that exceed particular attitudes and cognitive constructs. Individual attitudes such as beliefs that particular hopes will not be fulfilled, desires and wishes, such as those to stop living or to die by one's own hand can, thus, be seen as individual reflective manifestations of the background orientations of loss of hope and being suicidal rather than as the respective phenomena in their entirety.

[92] The two excerpts to follow were administered the code *No relief from suffering*. Responses describing experiences of being suicidal with an emphasis on the lack of meaning, suffering, and absence of prospects for change are: R14UK, Q8B; R16UK, Q1B; R23UK, Q1B; R28UK, Q1B, Q8; R30UK, Q1B, Q8B; R54UK, Q8B; R65UK, Q1B; R66UK, Q8B; R105UK, Q7B; R106UK, Q8B; R107UK, Q8B; R112UK, Q1B; R113UK, Q8B; R117UK, Q1B; R118UK, Q4B; R128UK, Q8B; R133UK, Q8B; R143UK, Q8B; R157UK, Q1B, Q8B; R168UK, Q1B; R186UK, Q8B; R192UK, Q1B, Q8B; R228UK, Q8B; R239UK, Q8B; R240UK, Q8B; R253UK, Q8B; R269UK, Q8B; R271UK, Q8B; R282UK, Q8B; R307UK, QB; R325UK, Q8B; R341UK, Q8B; R361UK, Q8B; R367UK, Q1B; R371UK, Q8B.

> I see life as meaningless and long to exit so I don't have to deal with it any more. (R66UK, Q8B)

The lack of meaning of the practical endeavours that make up life has disappeared and this transforms existence into a chore, which has to be dealt with. As discussed in the previous section, there is no anticipation of a fulfilment of current practical endeavours and in its absence these have lost their meaning and purpose. This frames the present in terms of its futility so that life becomes merely meaningless and pointless existence.

Life can also seem not worth living specifically in terms of the suffering that one has to endure. The current predicament is characterized not only by finding oneself in a world that is threatening and insecure or overwhelming and increasingly demanding but also fails to offer any prospects for change. We can conceive of this mode of being as established by the combination of the orientations of insecurity and threat and hopelessness and despair described in the previous section. Accordingly, one's current existence in a world of doom and threat is both intolerable and potentially permanent, so that death appears as the only option to escape it as described by this respondent to the DDQ UK:

> When I am depressed I want to die. I want to go to sleep and never ever wake up. When I am depressed the world seems such an awful place I no longer wish to be a part of it. (R14UK, Q8B)

While in these cases the impossibility of a change or relief is associated with the possibilities offered by the world, to others (e.g. Wurtzel 1995, 228, 237, 258) it might be experienced as closely related to how they themselves lead their lives (1.2). For them, both the current predicament is the result of (alleged) personal failures and there is no possibility for a significant or better future as they fail to procure or make use of such as described in 10 (8.2%) responses to the DDQ UK:[93]

> I almost always feel suicidal for at least some of the time when I am feeling depressed. My life feels hopeless, as if there's no point in continuing because I'm never going to get better or be able to change. (R47UK, Q8B)

Life, here, is again experienced as hopeless, but not because it lacks meaning in general or will never change, but rather because one fails to have a life of meaning and hope. In contrast to the former instance of feeling suicidal, here, one identifies oneself as 'never able to change', it is not the world or life that is not amenable to change but the individual herself as explicitly described by some of the respondents to the DDQ UK:

> It makes me doubt whether life is worth it. Everything seems pointless, it seems like there is no hope left. When I'm not depressed I have ambitions, but

[93] The two excerpts to follow were administered the code *I am failing at life*. Further passages, which describe experiences of being suicidal that emphasize the sense of lack of prospects for change as tied to personal shortcomings or failures and received this code are: R21UK, Q1B; R24UK, Q1B; R47UK, Q1B; R53UK, Q8; R85UK, Q1B; R89UK, Q1B; R129UK, Q7B; Q145UK, Q8B; R228UK, Q1B; R311UK, Q8B.

> when I am it feels like there's no point in trying because I'll just fail anyway. (R292UK, Q8B)

Accordingly, many of these who described the experienced lack of prospects as related to their failures emphasized also feelings of diminished self-worth revolving around (alleged) shortcomings and failures in life.

The wish to escape the unbearable mode of existence that the respondents describe can be experienced as a specific motivational pull occasioned by the intolerable suffering one is subjected to. The only possibility that can be envisioned is that of death and the only action the world affords is killing oneself. Respectively one can feel pre-reflectively drawn or enticed by this possibility without entertaining the respective attitude 'I wish to kill myself':[94]

> […] you can't bare the pain of the feelings, you feel tempted to end the suffering – however this is not a calculated decision (to end the suffering), it is a feeling as though its a natural next step to take […]. I have stood on an edge of a pavement and felt like stepping out in front of a car. (R117UK, Q1B)

The wish to commit suicide can also be experienced in the form of explicit desires accompanied in some cases by detailed and elaborate plans of the possible ways to do this that result of conscious deliberation and consideration.

> All I think about is killing myself and go on websites for people who have committed suicide and inspire me, then plan my own. (R28UK, Q1B)

Thoughts of suicide are often experienced as intrusive, automatic, and pre-occupying. They frequently lack a particular trigger and their regulation can resist conscious effort, especially during severe depressive episodes[95]. During milder episodes, although not constantly present and reflectively experienced, feelings of being suicidal and explicit thoughts of suicide might still be present in a more diffuse and vague form that can come to the foreground of experience without a specific event that makes one feel as that death is the only possibility:

> Suicidal feelings that whilst not in my worst states of depression, are pushed to the back of my mind (but still there), linger in every waking thought. There does not have to be ANYTHING I am upset about to make me feel as if death is the only option. (R367UK, Q1B)

While in both (1.1) and (1.2) the major underlying structural change is the experience of possibility, in particular the lack of enticement, which disturbs one's common disposition to hope for a significant or better future, the resulting intolerable predicament can prompt escaping it along different lines. For some, although the world is devoid of any possibilities for change and one cannot hope for a significantly different future (and respectively

[94] The five excerpts to follow were administered the code *No relief from suffering*.

[95] This, of course, does not indicate that feeling suicidal and explicit suicidal ideation cannot be intervened on or regulated but frequently due to their lack of a specific triggering event and their pre-intentional and pre-reflective character, they can in some cases resist the commonly deployed strategies for the regulation of affect (for a detailed discussion of regulatory strategies for moods and existential feelings see Stephan 2012).

alleviation from the current suffering), the current predicament can prompt one to 'create' a possibility for relief by ending one's life. In this case, at least a partial ability to act in the world and experience oneself as an agent is required (Ratcliffe 2015, 114). This, some of the respondents to the DDQ UK respectively describe as an explicit wish or desire to commit suicide, which is then a self-induced relief from the current suffering:

> Sleep is the best way out, to close everything down, but you can't sleep. This then leads to thoughts of self-harm/suicide as a way to switch off. Not distressing thoughts, more matter of fact, it's the only way, thoughts. (R112UK, Q1B)

Suicide in such a case is seen as an action originating from the agent herself in response to the lack of other possibilities for bringing about a change in the world.

In other cases, death might be conceived as the sole possibility that the world offers. The loss of hope and experiences of meaninglessness are so overwhelming that the current predicament of suffering and pain are not only experienced as ever-lasting but also one cannot entertain the possibility of acting in any way to end this unbearable mode of existence. Death, in these cases, is on the one hand the only option to end it and on the other not actively brought on by oneself but rather as a possibility the world offers. In such cases, one might passively wish for death in contrast to wishing to die by one's own hand as the action of committing a suicide is not conceivable. Respectively, one can "want it [life] to end, just go to sleep and let the mess go away" (R143UK, Q8B), etc. without an explicit reference to committing suicide but in line with a general orientation towards irrevocably escaping the present.

Another pattern (2) of being suicidal that can be observed in depression presents death as a punishment and not as the only way to escape an unbearable predicament (Fuchs 2002). The characteristic strong feelings of guilt and tendencies towards self-blame[96] can make death appear as the only suitable punishment for one's failures and shortcomings. Some respondents refer to experiencing themselves as inherently flawed or inferior and as feeling morally responsible for being this way. This is manifested especially with respect to others (e.g. family, close friends, etc.), who the individual suffering from depression frequently feels to have wronged. In many cases, the inferior self is conceived as a burden to others, which not only creates further distance between one and others, but also in extreme

[96] The feelings of diminished self-worth and a general background orientation of deep guilt described by many individuals suffering from depression are grounded in disturbances in fundamental intersubjectivity, which are going to be the subject of Chapter 5 "Loss of Intersubjectivity and Social Isolation: Loneliness, Shame, and Guilt".

cases may present the death by suicide as the only suitable punishment that will in addition also relieve others as described in the passages below:[97]

> I feel useless, worthless and feel everyone would be better off without me in their lives. I often have suicidal thoughts. (R20UK, Q1B)

The characteristic feelings of guilt and tendencies towards self-blame, I am going to suggest later, are rooted in disturbances of intersubjectivity that result in the breakdown of basic trust in oneself and others. The general lack of security that results from it can be manifested in feelings of threat and anxiety, of being inferior to others and flawed and of being a burden to others. The pattern of relating to others changes radically and is characterized by avoidance, feeling left out and abandoned, blamed or even threatened by others and by carrying the responsibility for (alleged) faults and shortcomings that impact others.

7. Conclusion

Commonly, our experience of embeddedness in life is characterized by a sense of active immersion in various everyday projects and endeavours. Life, and the various activities that it encompasses are endowed with meaning and purpose and go along with an anticipation of their continuity and possible successful completion in the future. We, in other words, experience ourselves as active participants in life. In contrast to this commonly taken for granted orientation, which is the backdrop of our all our affective experiences, thoughts, and actions, testimonies by individuals suffering from depression frequently describe feeling as passive observers of the world and life, which merely revolve around them. Their predicament is characterized by lack of meaning and purpose and their lives have been transformed into the endurance of pointless suffering without the promise of alleviation or relief. In this chapter, I argued that we can understand this mode of existence characteristic of depression as originating from radical changes in the pre-reflective sense of what is possible for one. The experience of possibility, which makes our active engagements with the world possible is disturbed in depression specifically in view of how the world entices or moves one into action. Finding oneself in a realm devoid of individual significance, one also fails to encounter one's numerous (habitual) engagements as meaningful in any way. Feeling disengaged from the world in this manner, moreover, interferes with how we are disposed to anticipate the future to come. For the individual suffering from depression, it is essentially robbed of prospects for change and meaningfulness. This places one in an orientation of

[97] The excerpt to follow was administered the *I do not deserve living*. Responses describing envisioning death by suicide as a punishment for (alleged) transgressions are: R20UK, Q1B; R143UK, Q1B; R259UK, Q8B; R357UK, Q1B.

hopelessness, despair, insecurity, and meaninglessness that in many cases culminates in an existential background that presents death (by suicide) as the one and only means to escape the predicament of intolerable suffering. These background orientations, respectively, are manifested in a large variety of reflective affective experiences such as moods and emotions, bodily experiences, cognitive styles, and actions that are consistently reported by individuals suffering from depression in their first-person testimonies.

While it can be argued that these changes do not amount to a complete loss of the pre-reflective experience of possibility as the title of this chapter suggests, I would like to point out that what they amount to is the sense of possibility, which is relevant to understanding how we can engage and remain continuously engaged in *meaningful and significant* interactions. While (at least some of) the individuals suffering from depression might still encounter the world as offering possibilities for interaction and engagement, these seem to lack the significance, appeal, or pull, which pre-reflectively moves one to engage in them. And thereby transform the world into one of individualized *impossibility,* i.e. of engagements appearing impossible for one in terms of their significance. Active engagements with the world can appear impossible in further ways as well in depression. And indeed the next common theme across first-person accounts of depression is that of *not being able* to actively engage in the world. While the sense of loss of possibility presented is with what we might call a 'passive' aspect of active engagements, in this latter case, one finds it impossible to interact with the world on the basis of the depletion of one's own abilities. The experience of abilities, I am going to suggest in the next chapter, is an essential component of one's experience of agency and its disturbance, similarly to that of the experience of possibility, establishes a radically mode of existence characterized by different background orientations.

4. Loss of Ability and Agency

Further changes in the experience of embeddedness in active engagements with the world reported by individuals suffering from depression highlight how they experience themselves as agents specifically in terms of what they are able to do. Here, I am going to examine these and argue that in depression, the (experienced) loss of abilities compromises one's sense of agency[98], so that ultimately one can pursue one's everyday endeavours only with great strain and effort. The testimonies of depressive experience suggest that we can distinguish between two broad kinds of abilities that are diminished or lost in depression: (1) skills that we deploy for the performance of routine activities and (2) capacities required for non-routine actions. In the case of (1), individuals suffering from depression experience routine activities as effortful and demanding and are moved to perform them mainly or solely by their normative significance instead of automatically engaging with them in the respective situations that solicit the particular activities. In what follows, I am going to argue that in these cases disturbances of embodiment are at the core of the sense of inability. These disturbances make the effortless and automatic performance of a wide range of routine activities appear beyond one's powers. Nonetheless, individuals suffering from depression still do carry them out and I am going to propose that instead of being moved at a pre-refelctive bodily level to do this, they engage with these activities on the basis of their instrumentall role in everyday life. This can, furthermore, be understood as resulting from an identification with various practical conceptions of oneself. In the case of (2), the performance of (at least some) non-routine activities can be described as impossible, beyond one's powers, etc. One feels not able to perform them in terms of one's declining capacities like concentration, memory, language, etc. or experiences one's performance as insufficient, inefficient, or flawed.

The phenomenology of agency is usually discussed in terms of the experience of ownership and authorship of action and control over the action during its course (e.g. Bayne 2006, 2008; Marcel 2003; Pacherie 2008; see also Gallagher 2012 on a detailed discussion of the various aspects of the sense of agency across different disciplines). The sense of agency is usually conceived as comprising the experience of control over the production and course

[98] It is important to note here that the experience of ability is not all there is to experiencing oneself as an agent but only one aspect of it. As my focus here is motivated by studying how experience changes in depression and this is the aspect of what it feels like to be an agent that individuals suffering from depression consistently describe (as suggested in the previous chapter (p. 85), a passive component of being engaged with the world or being an agent is part of the experience of experience of possibility. Here, I focus on an 'active' component of agency, which moreover, is identified in testimonies as originating from the subject.

of one's actions, of forming prior intentions to perform a particular action, of pre-reflectively or reflectively anticipating the course and outcome of actions, of the experience of effort in acting so as to produce a particular impact in the world. When individuals suffering from depression describe how they find themselves in the world, they report of radical alterations in experiencing themselves as agents and respectively actively engaging with the world[99] mainly in terms of what they are able to do and how they are able to perform specific activities. They feel tired and exhausted, everyday activities are insurmountable challenges. At work, some might feel incapable of doing their job up to specific standards and consider their performance as insufficient. Upon starting the day, everything appears difficult and unmanageable and everyday life is too much to cope with. In the course of acting, even simple tasks are tiring, one frequently makes mistakes and has to leave things unfinished. To examine these changes in detail and how they can illuminate further aspects of the experience of agency, I adopt a broad concept of agency that focuses on a general sense of being an agent and a sense of agency qua acting that captures the experience of agency prior to engaging in actions and activities and during the course of these. This encompassing notion of agency is inspired by how we experience and describe changes in the sense and the exercise of one's agency. We can feel generally able to act or to perform particular actions. For instance, not being able to drive, I do not experience myself as an agent with respect to the activity of driving a car, the possibility for action offered by a motor vehicle is not present for me. To someone else, driving would be a routine task, the most common way of getting from one place to another, so that she is an expert in driving and does this automatically when in a car and desiring or intending to go to a particular destination. A novice driver also feels able to drive, but for her driving is more complex, it is not a routine but requires a greater portion of her concentration, she has to focus on the traffic and the respective regulations so as to decide which actions to perform. When engaged in the task of driving, both drivers experience themselves in different ways, though. While the former automatically shifts gears, stops at red lights, etc., the latter has to observe the traffic and attend to traffic

[99] In line with Shaun Gallagher (2007, 347) I consider the experience of agency to be necessary for being an agent and acting: "In its proper sense, I understand agency to depend on the agent's consciousness of agency. That is, if someone or something causes something to happen, that person or thing is not an agent (even if they might be a cause) if they do not know in some way that they have caused it to happen. A hurricane may cause the electric system to fail, but we would not attribute agency to the hurricane in what I take to be the normal use of the term. The kind of conscious knowledge involved in agency does not have to be of a very high order; it could be simply a matter of a very thin phenomenal awareness, and in most cases it is just that". Disturbances in agency, in how one performs various actions and activities, thus, are commonly manifestations of how one experiences oneself as an agent – feeling not able to perform a particular action discloses this action as beyond one's powers or means and respectively one is less likely to perform it, might need an explicit normative reason to perform it, engages with it in a radically different way, etc. Similarly, for instance, if the experience of ownership of one's action is altered, one might fail to feel as an agent of the respective action.

regulations, press he pedal to break at a red traffic light, press the gas to go when it turns green, etc. And for doing this, she has to focus, remember which pedal is the gas, etc. during the course of the action. In this way one has agentive experiences in terms of acting in a particular way – automatically and skilfully in the former case and in the latter by exercising specific capacities. In what follows, I am first going to elaborate on this broad conception of agency and then examine how the changes in the sense of ability in depression highlight additional aspects of the experience of agency.

1. Agency in Depression

Throughout this work, it is important to emphasize that it is developed first and foremost on the basis of experiences described in first-person testimonies of depression. Consequently, I focus on studying what individuals suffering from depression describe as impairments or disturbances of agency. Their testimonies most notably include descriptions of how they fail to act, fail to be motivated, to motivate themselves, feel weak and powerless, how the tasks of daily living and professional life have become excruciatingly difficult and overwhelming but still demand from one to perform them. In order to better understand these reports, I not only attempt to preserve short distance from the actual description, but also to adopt a range of the distinctions, highlights, and emphases their authors introduce. What these reports point towards is that being an agent and experiencing oneself as one is not exhausted by the experience of oneself while acting or being in control over the course of one's actions, or producing intentional and goal-directed movements. Rather, being and experiencing oneself as an agent encompasses also different modes or ways of encountering various actions and tasks, a sense of one's abilities, an experience of how these are deployed, of the performance and successful completion of the tasks of daily living and professional life. To reflect this, I operate with a *first-person motivated notion of the experience of agency* that encompasses two main aspects: (AG1) a fundamental pre-reflective sense of agenthood, of *being an agent* and (AG2) a sense of oneself as an agent, a sense of *oneself acting* that comes in terms of acting in the world.

The insights gained from first-person reports suggest that individuals suffering from depression both experience themselves as agents and experience themselves as acting in a radically different manner with respect to their sense of ability in particular. When describing how their sense of agency and actual interactions with the world change during depressive episodes, they most commonly refer to the disabling character of the illness, of themselves not being able to perform particular actions, of various activities becoming more effortful

and demanding, of not being able to function or cope with life. In their descriptions of how their abilities have changed, they seem to refer to *two broad types of abilities*. For instance, most striking disturbance in agency for some are the following:

> *It [depression] either stops me from doing things or makes simple things harder*. Most noticeable are routine actions, which are normally performed without any thought, e.g. getting ready in the morning. It is something I used to do easily without thinking about it.
>
> Once depression took hold it all became very complicated. My partner would run the bath, and remind me to get out of bed and get in it. Once in there I really wasn't sure what I should be doing. It would take me a while to think that *I should wash my hair and that in order to do that I would need shampoo* and then I would have to look around and find the shampoo, then open the bottle and use it.
>
> It took a lot of effort to think through all of that which made me tired.
>
> I once had an idea that I should write down step by step all I needed to do to and laminate it to make things easier but I struggled to work it all out so I never managed to complete it. (R350UK, Q5B; emphasis added)

The author of this passage presents us with one of the most detailed and vivid descriptions of how everyday routine activities change in depression. She feels not able to perform even some of the simplest and most automated ones such as showering. This is in a striking contrast to the ease or rather lack of effort, strain, and deliberation that commonly accompanies taking a shower in the morning. It is just something that we do, we do not need a reason to do it and we do not need to attend to how we do it. Respectively, everything we encounter in the context of taking a shower is experienced (and used) skilfully so as to achieve our goal – the shampoo bottle is simply grasped and squeezed, the water is turned on, and so on as this is the course of the activity and the significance of these entities is determined by their relevance to the current activity. In depression, it seems that one has lost this skilful and habitual interaction as illustrated by this passage[100]. It is important to note here that the experience and performance of routine activities that I am going to focus on in

[100] Andrew Solomon (2001, 52-53) describes in a similar way his failure to perform routine activities in this eloquent passage: "I kept running through the individual steps in my mind: you turn and put your feet on the floor; you stand; you walk from here to the bathroom; you open the bathroom door; you walk to the edge of the tub; you turn on the water; you step under the water; you rub yourself with soap; you rinse; you step out; you dry yourself; you walk back to the bed. Twelve steps, which sounded to me as onerous as a tour through the stations of the cross. But I knew, logically, that showers were easy, that for years I had taken a shower every day and that I had done it so quickly and so matter-of-factly that it had not even warranted a comment. I knew that those twelve steps were really quite manageable. I knew that I could even get someone else to help me with some of them. I would have a few seconds of relief contemplating that thought. Someone else could open the bathroom door. I knew I could probably manage two or three steps, so with all the force in my body I would sit up; I would turn and put my feet on the floor; and I would feel so incapacitated and so frightened that I would roll over and lie facedown, my feet still on the floor. I would sometimes start to cry again, weeping not only because of what I could not do, but because the fact that I could not do it seemed so idiotic to me."

the first part of this chapter is manifested in various ways that I am going to examine in detail in the sections to follow.

One can also feel unable to act or perform particular activities in another way as well, as described in this passage:

> I become increasingly indecisive and lack concentration, which leads to a lack of motivation as I don't feel I can do my job properly […] (R246UK, Q5B)

Although this second response to the DDQ UK might at first glance describe similar difficulties with performing various activities, the emphasis on the loss of certain capacities, such as motivation and concentration, required for doing these activities, I would like to suggest, points towards a further aspect of feeling and being an agent. With respect to the different lives we live and accordingly the various interactions, activities, and practices we are engaged with, we develop individual sets of abilities some of which make us experts in particular fields or tasks. While most of us might be skilled experts in doing the dishes, making coffee, climbing the stairs, not all of us are skilled drivers. The latter group, driving and other activities, require the deployment of specific capacities, it is not done automatically like doing the dishes, for instance. The second passage introduced above describes changes in the experience and performance of activities of this type. Here, I am going to suggest, one's sense of agency and respectively agentive performance are altered in a different manner – what is lost is not skilled expertise but particular capacities that impact the quality of one's performance and might for some be associated with negative self-interpretation. The difference between the two aspects of the experience of ability and agency, I propose, does not lie in the nature of activities alone, but rather in the types of abilities they require and respectively how they are performed.

When we experience ourselves as agents, we feel up to the respective action in question (Hans Bernhard Schmid (2011) calls the sense of ability a 'feeling up to it' and here I adopt from him the term 'feeling up to performing an action or to acting'), our sense of agency is framed by our sense of ability. In his insightful analysis of the experience of agency, Hans Bernhard Schmid (2011, 230) argues that the sense of ability is "the most fundamental existential feeling" that grounds further existential feelings. Similarly to an existential feeling, I suggest, the sense of ability shapes how we encounter particular situations – to the novice driver, driving is straining, demanding, and overwhelming and requires the deployment of particular capacities; to the expert driver, it is automatically performed, she does not feel the need to focus on the traffic, to press the pedal to brake in certain situations, and to turn the blinker onwhen taking a left or right turn but automatically simply performs these. The sense of ability, thereby, establishes a general background orientation that is manifested in action,

thought, and behaviour. In this chapter, I am going to examine how the changes in (the sense of) ability impact the (sense of) agency in depression. The different changes in ability in depression illuminate additional aspects of agency that are altered in depression, namely what moves us to act or why we act, and how we act or evaluate our performance.

The two broad kinds of abilities I am going to focus on as described in first-person reports are skills deployed for the performance of routine tasks and general and specific capacities required for the performance of more complex, non-routine tasks. In the case of the former (AB1), what is most frequently reported is the increasingly demanding and effortful nature of routine tasks that is, as I am going to show, expressive of disturbances in skilful engagement or everyday coping (e.g. Merleau-Ponty 1945/2002; Dreyfus undated). The otherwise automatically performed routine actions such as common household chores, morning routine like brushing one's teeth and taking a shower deploy particular skills and acquire a habitual nature so that the situations calling for them are experienced as soliciting them and they are performed in an automatic and pre-reflective manner. In depression, disturbances in embodiment disrupt these skills and impede on automatic and pre-reflective performance of routine actions. They might still be performed as reported by the respondents to the DDQ UK, but one is moved to engage with them in a radically different manner: while prior to the onset of the illness, various everyday situations automatically solicited routine actions, now one is acutely aware of the necessity to perform them so as to maintain or at least attempt to maintain everyday life. Routine actions have now become duties that compel one to act rather than pre-reflectively meaningful automatically performed actions that did not require any reflection, deliberation, and effort. The reports of individuals suffering from depression describing how the way they experience and perform actions that used to have a routine character has changed illuminates, as suggested above, two main types of motivations significance – a fundamental bodily-affective one embodied by skills and solicitations and normative or practical one that is commonly attached to duties and obligations.

When describing how the decline in abilities impacts the sense of agency and actual performance in cases of non-routine more complex actions, I am going to suggest, individuals suffering from depression refer to change in capacities (AB2). We are not experts in all actions we perform, we are often faced with novel activities or some of such complexity that require reflection, deliberation, and explicit planning of both the resources necessary for completing them and how we will achieve this. For instance, in writing this text I may not have to deliberate on how my fingers move on the keyboard but I have to sometimes at least deliberately focus on what I want to convey and very carefully think about choosing the

words I am going to use in conveying it. While my immersion in typing might be reliant on my skills and expertise, the task of writing itself (and expressing myself) is not automatically performed. This latter case, I am going to suggest, requires the deployment of some capacities rather than of skills. Although both skills and capacities enable one to act, to perform particular actions, and are fundamental to one's sense of agency and active engagement with the world, they play a different role in one's agency and one's experience of it. In what is to follow, I am going to engage in an analysis of the disturbance of capacities in depression and argue that incapacitation is a further aspect of the disturbance of agency in depression.

2. Routine activities: Skills, Solicitations, and Normative Significance

Our everyday life is filled to a great extend with activities[101], which we perform without the need for explicit deliberation upon their course, utility, goal and attention to how they are executed. Instances of such activities extend from walking down the street on our way to work, locking the door when leaving the apartment, to more complex but still routine activities such as our morning routine, making coffee or tea, preparing a favourite meal, etc. All these activities, despite the difference in their complexity, are experienced in a similar manner – we rarely if ever have to reflect on their role in our everyday life, on how they aid us in attaining a goal we are set upon, on what individual actions they involve, and how these have to be executed. We are *experts* in these actions, they provide structure to how we go about our day and we feel automatically drawn into performing them as for instance in the case of our usual morning routine. Upon the sound of your alarm clock, you open your eyes and subsequently rise from bed (even after snoozing and enjoying ten more minutes under the covers). Without pondering upon what to do next, you head to the bathroom where you brush your teeth and take a shower. In doing these actions, you do not need to think about

[101] When using the term 'activities', I refer to instances of acting that comprise several different patterns of actions (motor acts or movements) that are goal-directed and intentional. For instance, the activity of making coffee encompasses a large number of individual actions such as entering the kitchen, turning the coffee machine on, filling it with water and coffee powder, etc. All these individual actions are aimed at a specific goal that is part of the goal of the activity of making coffee. When we talk about our abilities and our sense of what we are able to do, we commonly refer to the activity. For example, the respondents to the DDQ UK described routine activities as beyond their abilities – getting ready for work is too effortful and they have to deliberate about how to do it. The loss of skills makes the activity appear beyond their abilities. When I talk about skills here, I refer to a specific way of performing individual actions that make up (routine) activities. The experience and deployment of skills when acting provides one with a sense of what one is able to do in particular with respect to routine activities.
When discussing the changes in one's capacities and how it impacts the experience of ability and agency in the section to follow, I similarly use the term 'activities' to refer to the more complex patterns of acting that might comprise different actions. Here, activities commonly do not possess a routine character and one is frequently aware of the actions they encompass and the capacities required for performing them.

how or why to perform them. You proceed to produce them, they are called for by situation without the need to form an intention to engage with them. In fact, trying to reason about their utility or the sequence of the actions they encompass, you might find yourself not sure how to proceed and asking yourself what the exact actions involved are. Heading out of the bathroom, you proceed to making coffee, breakfast, and getting dressed in the same manner without the need to plan what to do first, how to perform the complex sequences of movements involved in the actions that are comprised by this activity. It is this class of routine actions and the abilities they require that I am going to focus on here in order to examine different aspects of human agency and how it is disturbed in depression.

2.1. Routine Activities and Skills

The central role of routine actions has been recognized by Merelau-Ponty (1945/2002) and Dreyfus (undated) who examine them in detail in their work. According to Merleau-Ponty, skills are gained through practice, which familiarizes the agent with the particular activity (Romdehn-Romluc 2011, 107). When acquiring a particular skill, for instance, how to ride a bicycle, one first has to be explicitly aware of particular affordances offered by the world that warrant specific action – the pedals are for pressing, one's hands have to be placed on the handle bars, etc. For instance, Dreyfus (undated, 1-7) distinguishes among the following stages of skill acquisition: (1) decomposition of the task (activity) into context-free elements that are the basis for the rules for how to perform the action; (2) new situational aspects are included in dealing with the particular case at hand; (3) adopting a perspective, which determines what elements of the situation are relevant for engaging with it and being affectively involved in the situation; (4) the involved agent has to still perform a choice of strategies how to achieve the set goals; and (5) the agent has a vast repertoire of situational discriminations and sees immediately what has to be done and how it can be done. Ultimately, upon frequent practice, the agent becomes more and more familiar with the patterns of motor activity that are appropriate in the specific situation, so that the entities encountered in the context of routine situations also afford and solicit different actions. With an increase in expertise, then, the bicycle becomes soothing to tbe ridden, rather than something to be sat on or balanced when in motion, the handlebars are for navigating rather than for being firmly held onto, whereby this happens without the need for reflective deliberation, or any intention to perform these individual actions that are part of the activity of riding a bicycle. What the bicycle solicits is part of how it is perceived, it calls for action in the moment one perceives it within the respective situation. Being an expert in riding a bicycle, thus, enables automatic unreflective deployment of the object in question so that both our activities (e.g.

riding a bicycle) and the actions (e.g. sitting on the bicycle, grasping the handles, pressing the pedals, etc.) that make them up are experienced as flowing from us as an automatic, appropriate, and optimal response to the particular situation at hand. So, with respect to routine activities in particular, we develop particular skills that enable our pre-reflective engagement with the respective situation in a specific manner – we are, for instance skilled coffee makers and upon waking up, as part of our morning routine, we automatically head to the kitchen and make a cup of coffee as the situation calls for this, the situation of getting ready in the morning is perceived as soliciting this particular activity. Skills, it has been suggested are embodied patterns of responding to action-relevant aspects of particular situations and thereby foundational for human agency (e.g. Romdenh-Romluc 2013; DeLancey 2006). The (everyday) skills that we develop are rarely if ever reflected on, especially prior to a routine activity, rather they make it possible that we perform routine activities in this automatic manner. So, we experience ourselves as up to a routine task, as able to perform it, when we experience the situation as potentially *soliciting* it usually dependent on a larger situational context. Skills, thus establish a sense of motivational significance that presents different situations as calling for specific activities.

The routine activities that make up most of our everyday lives require the development and subsequent deployment of skills. For instance, how one holds a toothbrush, the sequence of movements involved in the actual brushing of one's teeth, etc. are all (motor) skills, which we automatically deploy every time we perform this routine action. These actions have become deeply habituated so that whenever we encounter a situation characterized by a set of particular features, we automatically engage with it in this way[102]. Thereby, upon waking up in the morning, we do not need to deliberate how to hold the toothbrush, for us, the experts in brushing our teeth, this action is solicited by the world and we automatically carry it out. Routine tasks are also normatively significant – although they are not experienced as normatively binding (for instance as duties that have to be performed), they are to be carried out, we are moved to carry them out in a pre-reflective manner by what we might call 'the sheer force of habit'. Indeed, when acquiring many of these routine actions, we are frequently explicitly told that they are to be done for a particular reason. In this manner, we teach young children that they have to brush their teeth so as to avoid cavities, that they have to close and lock the door to the apartment so that no one can

[102] Examples for motor skills or habits often include such specific to sports – a particular kick in football, a swing of the bat at baseball, etc. Here, I am going to focus on less specific everyday routine actions, which are also habitual in this manner. Unlike sports skills, these routine actions are not subjected to specific evaluative standards that sports skills might in many cases be. Sports skills are not subjected to normative significance – although they might be experienced as the right thing to do in a particular situation, they cannot assume the character of duties (as for instance instances of household chores we might perform automatically).

come in, etc. Thus, routine or habitual tasks are also pre-reflectively normative and instrumental in achieving a certain end.

The habitual nature of routine activities does not imply that we are also always positively enticed into performing them or never find ourselves avoiding doing them. We have all too often been too tired to get up right after the hearing the alarm clock and head off to the bathroom, to do the dishes right after dinner, to dust on a sunny and warm Saturday, and this has happened for various reasons. In many of these cases, we might have had to deliberately remind ourselves of their practical significance and instrumental role in our everyday lives, which then move us to act. Although this might sometimes happen, it is commonly the case for only a limited number of routine actions and only in some specific situations.

Routine activities are encountered in a radically different manner by individuals suffering from depression. First, they are experienced as effortful and demanding – showering has become difficult, getting out of bed is the hardest thing, doing the dishes seems impossible. These, formerly automatically performed activities are now beyond one's means, they are overwhelming and daunting. But they are also encountered as compelling – one has to shower in the morning, one has to brush one's teeth or do the dishes. Commonly, being experts in everyday routine activities, we do not experience them as normatively binding. Being skilled tooth-brushers, we are automatically moved to brush our teeth in the morning, we do not feel that we must do this for a particular reason. In depression, I am going to suggest in what follows, the loss of skills places one in a predicament of absent pre-reflective motivational significance that is reflected in solicitations. What moves individuals suffering from depression to act in these cases is reflective normative significance, which is commonly implicated in practical deliberation. Not feeling able to perform routine activities, they respectively experience the situations that commonly solicited these as presenting them with obligations to act. I am going to suggest that severe disturbance of embodiment disrupts one's skilful pre-reflective automatic engagement with the world, which is replaced by acting merely on the basis of practical deliberation. In doing this, I am going to, first, discuss how we are moved to act by solicitations. Then, I am going to briefly present some aspects of normative or practical reason that are relevant to agency as developed by Christine Korsgaard (2008, 2009, 2014). Finally, I am going to discuss in detail the disturbances of embodiment, how they are implicated in the loss of skills and failure of solicitation.

2.2. Motivational Significance: Solicitations and Normative Significance

For the purposes of studying the complex and multi-facetted experience of depression, I suggest to distinguish between two instances of significance – one that is rather general and associated with the experience of possibilities and is not directly motivational; and another, which directly moves one to act either by means of pre-reflective solicitations or by presenting particular actions as normatively binding. The former, termed individual significance and introduced in the previous chapter, provides one with the basis of potential ways to engage with the world, without having a soliciting aspect that moves one to perform a particular (routine) action. For instance, a bicycle offers the possibility of transportation to someone who is aware of the practice of riding a bicycle and possesses the respective bodily and motor characteristics that are required for riding a bicycle. Even if this someone is a professional cyclist, though, she might not be solicited to ride a bicycle directly upon perceiving one. Rather, when speaking about individual possibility, what we have in mind is what potential interactions an object or a situation offers, without directly moving one to act. As introduced in the previous chapters these can also be characterized by an enticing aspect, which invites rather than solicits one into active engagement.

In contrast, the latter type of significance, motivational significance, is in the basis of our experience of ourselves as conscious and intentional agents who produce particular actions in response to the world in (e.g. in response to pre-reflective solicitations in the case of automatically executed routine actions) or normative requirements (e.g. in the case of duties and practical reasoning). By viewing individual significance and motivational significance as distinct, I aim at capturing the complexity of changes in experience in depression as description in first-person reports frequently refer to changes that come in different forms to the foreground of experience. For instance, the changes discussed in the previous chapter are commonly experienced and described in terms of how changes independent of the individual transform how she finds herself in the world. Changes in motivational significance, in contrast, are experienced and described as originating from the individual – she is the one who fails to act, who feels normatively bound to perform certain activities, or lacking a motivational drive. In the latter cases, what has changed is how we experience ourselves as agents, as the originators of our actions, which are aimed at producing a particular impact on the world.

In sum, the difference between the two, especially with respect to depression, can be seen as originating from the distinction between enticements and solicitations. Although specific activities, such as routine ones, are experienced by skilled agents as soliciting action, they do not appear as enticing. The enticing aspect of individual significance in the experience

of possibilities discussed in the previous chapter differs from the soliciting aspect I am focusing on here in several respects. First, solicitations require the possession of skills, while enticements have a more general character of individual significance within the context of one's practical endeavours. While I might be solicited to engage in the activity of coffee making as part of my morning routine, the possibility to make coffee itself is not experienced as having any enticing appeal. In contrast, while I might be enticed by the possibility to ride a bike, I might not be solicited to do so as I am not a skilled cyclist. Second, while both solicitations and enticements both move us to act pre-reflectively, when engaging in activities the possibility for which was enticing, we might not perform these automatically and without the need for reflection or awareness of their course. And third, enticing possibilities also commonly have are affectively experienced as, for instance the pleasure or enjoyment associated with various activities, while solicitations lack this affective framing.

By moving us to perform a particular action, in particular such that has a routine character, motivational significance presents particular situations as (a) affording certain interactions in view of how different species engage in the respective life forms and behave[103] as suggested by Merleau-Ponty, for instance:

> In so far as I have hands, feet, a body, I sustain around me intentions which are not dependent on my decisions and which affect my surroundings in a way which I do not choose. These intentions are general in a double sense: firstly in the sense that they constitute a system in which all possible objects are simultaneously included; if the mountain appears high and upright, the tree appears small and sloping; and furthermore in the sense that they are not simply mine, they originate from other than myself, and I am not surprised to find them in all psycho-physical subjects organized as I am. (Merleau-Ponty 1945/2002, 511)

Motivational significance is first and foremost experienced at the level of the lived body (b). What makes us act resonates at the level of the lived body and sets it in motion. Our actions are characterized by a form of bodily or motor intentionality[104], by disclosing the world in terms of the unity of our lived body. We encounter the world by means of the body-subjects we are and the unity of our body is that, which gives structure to the world that makes objects and entities appear small, large, climbable, etc. (cf. Merleau-Ponty 1945/2002, 510-511). So, actions, on this view, are intentional in a fundamental background bodily sense, which captures how we as body-subjects perceive, experience, and act in the world. The particular

[103] For instance, according to Merleau-Ponty, the purposes of individual actions that we produce can be seen as originating from the more basic purposes of the particular type of autonomous organisms we are (see Delancey 2006, 371 on a discussion of Merleau-Ponty's notion of behaviour).

[104] It is similar to what Merleau-Ponty introduces as 'motor intentionality' (for a detailed discussion of the concept of motor intentionality and how it differs from a rather reflective concept of intentionality, see Dorrance Kelly 2002).

practical projects we are engaged in (c) are also implicated in what appears motivationally significant or soliciting a particular action. Routine actions, although performed automatically, are goal-directed and instrumental in achieving a particular end and have through repeated practice become habitual. Brushing one's teeth is both performed for a particular reason and to achieve a certain goal – we consider dental health important and it can be achieved by engaging in these specific actions. But frequent practice has turned it into an automatically performed routine, which incorporates both the goal it is aimed at and the reason it is performed for. We rarely produce (meaningful) actions that are not part of a larger-scale practical endeavour with a specific aim or purpose that provides individual actions with their respective goals. Accordingly, although we are not constantly aware of the reasons and goals of our actions, especially those that have become routine, they are essentially goal-directed and aimed at producing a certain impact in the world. Thus, the motivational significance we encounter in the world is also based on what exactly we intend doing (d), what our "express intention" (Merleau-Ponty 1945/2002, 511) to act is, which determines what action we are going to produce and includes a pre-reflective anticipation of the impact on the world it is likely to produce.

As discussed in the previous sub-section, we experience various everyday situations as soliciting particular actions, without the need to consciously reflect on how to act (Romdenh-Romluc 2013, 107, 201). Whenever we encounter such everyday situations, what we experience is how they call us to engage with them, how they move us at a pre-reflective (bodily) level to engage with them. Solicitations are, on this reading, embodied experiences of the pull towards particular interactions that are felt as produced in response to (aspects of) situations, which 'call' for action. On such accounts, agency is exemplarily introduced as the exercise of particular expertise without the need for reflective or conscious deliberation (or the internal representation of the environment) on the course of one's actions (Dreyfus undated). Consider, or instance, the following situation: You are comfortably seated in your favourite armchair, enjoying a good book. You notice that you have already finished the tea you had prepared but still feel like having some more. So, you set your mind to making some tea. Within the context of this project, various entities become relevant in certain respects and call for particular actions. First, you get up from the armchair, you leave the book down and head to the kitchen. You do not have to deliberate on this, the whole sequence of actions is aimed at making tea, which provides all individual acts with their goal-directedness. Once in the kitchen, you perceive every relevant entity as calling for a particular action: the box with tea leaves is to be grasped, taken down from the shelf, opened; the teapot is to be taken out of the cupboard, filled with water, put on the stove; the switches for the stove are to be

turned on, etc. This routine activity is experienced as both solicited by the world and as produced by the agent to achieve a certain goal. Prior to engaging with it and during its performance, the agent also feels able to perform it – when noticing that one's cup is empty and feeling having some more tea, one feels up to the task of making more tea and respectively automatically engages with this activity. Being a skilled tea-maker, one does not need to engage in deliberate instrumental reasoning like "What can or should be used to make tea?" for example. If one were not a skilled tea maker, one would first have to ask oneself the question about how to make tea and encounter the teapot as an instrument or means to boiling water only subsequently. Skills, thereby, make solicitations possible, which present particular situations as normatively binding without the need for deliberate instrumental reasoning.

In some cases of developing routines, the normatively binding character of activities such as household chores is not explicitly experienced. Consider, for instance, cases in which you out of sheer habit clean the table and do all the dishes right after dinner. To perform it, we do not need to refer to a particular reason such as one has to clean the table and do the dishes right after dinner. Rather, the situation of finishing dinner is experienced as calling for this activity. Of course, many times, we might not feel enticed or drawn to doing it, but if this were a routine that is established on the basis of our skills, we would also not experience it as an obligation or a duty. Rather, through frequent practice, one has developed embodied abilities, skills, that enable the perception of the respective situation as pre-reflectively normatively binding. Although, we might very often be not enthusiastic or explicitly motivated to do household chores as doing the dishes, they rarely appear as burdensome duties that have to be adhered to.

Without a doubt, we do not perform routine tasks always in this manner. Sometimes they seem easier and more welcoming, other times we need to explicitly motivate ourselves or to be motivated by others to accomplish these. When tired after a long working day, doing the dishes right after dinner might appear effortful, unpleasant, or even burdensome. So, we might have to motivate ourselves explicitly to do it, but commonly even in such cases, this loss of solicitation of routine situations is not associated with suffering and emotional pain. So, in the optimal case of being engaged with the world in by performing routine or habitual activities, we on the one hand are rarely if ever aware of their normatively binding significance, and on the other, are moved to perform them at a fundamental bodily level of skilful action that does not require any (physical) effort but rather automatically proceeds from the agent.

In their responses to the DDQ UK, 56 (45.90%) of the participants in the survey report of finding themselves in a background orientation that transforms formerly effortless and automatically carried out activites into demanding and effortful challenges. Although, they might not feel up to performing these activities, they frequently report of engaging with them but in a markedly different manner. For instance, for ten (8.2%) of the respondents routine activities and tasks are encountered as beyond them but still engaged with only because one feels they must perform the, i.e. these are somehow normatively binding as for instance in this passage:

> I struggle immensely to do every day tasks, even getting washed is a major chore. I have to try and push myself to do things that I feel I must. Guilty helps me to achieve the little that I do.[105] (R66UK, Q5B)

For as many as 25 (20.49%) of the respondents to the DDQ UK, the loss of solicitations culminates in abandoning or failing to perform everyday tasks (see also Lewis 2002, 28; Smith 1999, 18; Sedgwick 2007, 8; Wurtzel 1995, 208 who report of such experiences):

> I find it very difficult to perform every day tasks such as housework. Consequently, my house is a mess and I often leave the washing up for days on end. I have a stack of clothes that need washing. I don't bathe as regularly. When I need to go shopping, I tend to put it off until I have no food left in the house.[106] (R129UK, Q5B)

Instead of encountering routine everyday situations as soliciting one to perform particular actions, they are now experienced as beyond one's abilities. Even failing to automatically engage with them, one still recognizes their central role in everyday life, though. They seem to have become obligations that one has to do – one becomes acutely aware of their normatively binding significance. Normative requirements of a distinct sort seem to have replaced automatic and pre-reflective solicitations in cases of their disturbance and still move one to perform routine actions despite radical changes in how one feels drawn to do these.

Failing to be solicited or moved to perform routine actions, individuals suffering from depression still face the necessity to act, to carry out their everyday chores, shower, brush their teeth, make tea, cook dinner, etc. Formerly automatically executed, these routine aspects of one's immersion and embededdness in everyday life are transformed into burdensome duties compelling one to act. Instead of soliciting one to perform routine

[105] This passage was administered the code *Chores have to be done*. Further responses that described the compelling nature of routine tasks are: R17UK, Q5B; R66UK, Q5B; R117UK, Q6B; R130UK, Q5B; R166UK, Q4B; R171UK, Q5B; R200UK, Q5B; R253UK, Q5B; R269UK, Q5B; R270UK, Q5B.

[106] This passage was administered the code *Postponing routine tasks*. Responses that describe this phenomenon are: R21UK, Q5B; R28UK, Q5B; R41UK, Q5B; R97UK, Q5B; R107UK, Q5B; R117UK, Q5B; R129UK, Q5B; R130UK, Q5B; R134UK, Q5B; R155UK, Q5B; R166UK, Q1B, Q5B; R171UK, Q5B; R189UK, Q5B; R192UK, Q5B; R218UK, Q5B; R219UK, Q8B; R231UK, Q5B; R253UK, Q5B; R259UK, Q5B; R270UK, Q5B; R291UK, Q5B; R323UK, Q5B; R341UK, Q5B; R347UK, Q5B; R357UK, Q5B.

actions, the world is disclosed solely in terms of the normative significance attributed to particular situations that call for the respective actions. Indeed, in rationalist traditions, agency is viewed as mainly, if not exclusively, established by practical reason, which through processes of deliberation and reflection moves one to act. When deliberating about acting, one attempts to answer the question about what is more desirable to do or what one ought to do (Wallace 2014, 1). Actions, here, are responses to reasons that move one to perform them in a particular "practical predicament" (Wallace 2014, 2). Then, finding oneself facing the sink full with dirty dishes, one has to choose between doing them and not doing them. In deciding, one weighs reasons for both actions in a process of deliberation. And most commonly, in doing this, one deploys practical rationality. Practical rationality, in a nutshell, is one of the substantive norms of practical reason and instructs the agent to take the means that are necessary for achieving a particular end (Wallace 2014, 6-7). In this case, doing the dishes might be conceived as the means to a particular end, namely adhering to standards for how a household is run, so doing them is an action worth performing for the sake of this end. Normative significance, thus, moves one to act by taking the means to a desired or valued end.

One account of normative agency of particular interest here that I am going to examine is that developed by Christine Korsgaard (1996, 2009). In what follows, I am going to suggest that it can account for the way individuals suffering from depression are moved to perform routine actions in the absence of solicitations. When our habitual engagements with the world by means of routine actions break down, we are transformed into a different kind of agent, one that is not immersed in one's everyday life but one that has to make oneself perform the actions that make it up. And in trying to motivate oneself to perform these formerly pre-reflectively and automatically carried out routine actions, one attempts to still be the kind of agent one was, to carry out with one's everyday life the way one used to by responding to the normative significance different everyday situations have for one.

According to Korsgaard (1996, 2009), we respond to normative significance that is derived from reasons and obligations. Reasons and obligations, in turn, originate from one's conception of practical identity. Practical identity can be "understood as a description under which you value yourself, a description under which you find your life to be worth living and your actions to be worth undertaking" (Korsgaard 1996, 101). When failing to perform routine activities, we might find ourselves in a markedly different situation, in which we do not feel drawn to perform the activities that came naturally to us. To some, it might even appear as if they are losing their identity, that they have become a different person, one who

fails to structure her day in the way one used to.[107] By losing this agentive identity and trying to retain it in the same time, we might present various routine activities as obligations, which compel us to act as threats to one's practical identity gives rise to obligations (Korsgaard 1996, 102) that are experienced as normatively binding. In order to illustrate how the loss of skills and respectively solicitations places one in a reflectively normatively binding predicament, I am fist going to introduce one account of agency that focuses on normative reason. Then, I am going to engage in a detailed examination of the loss of skills and solicitations in depression and how they impact agency.

According to Korsgaard's account of self-constitution and agency, we are moved to act in the following way:

> […] along comes an incentive, […] a representation of a certain object as pleasant. Being aware of the workings of that incentive upon you, you have an inclination for the object. And that inclination takes the form of a proposal. So the inclination says: end-E would be very pleasant. So what about end-E? Doesn't it seem like an end worth pursuing? Now, what the will chooses, is strictly speaking, actions, so before the proposal is complete, we need to make a proposal for action. Instrumental reasoning determines that you could produce end-E by doing act-A. So the proposal is: that you should do act-A in order to produce the pleasant end-E. Now, if your will were heteronomous, and pleasure were a law to you, this is all you need to know, and you would straightaway do act-A in order to produce that pleasant end-E. But since you are autonomous, pleasure is not a law to you: nothing is a law to you except what you make a law for yourself. […] The proposal is that you should do act-A in order to achieve pleasant end-E. Since nothing is a law to you except what you make a law for yourself, you ask yourself whether you could take *that* to be your law. Your question is whether you can will the maxim of doing act-A in order to produce end-E as a universal law. (Korsgaard 2009, 153-154)

Being moved to act by practical reason comprises the following aspects: (1) recognizing a particular situation as presenting one with possibilities for achieving a certain normatively laden end-E (for instance because it is part of everyday life within the framework of a particular conception of practical identity it can present one with an affectively laden incentive to act as in the example above[108] or with different normative reasons); (2) conceiving of a particular action (frequently one that was automatically performed in these situations) as the means to achieving this normatively laden end; (3) deliberating on whether

[107] There are many cases, in which we do not perform routine activities anymore without this being related to radical or even pathological changes in agency and a loss of practical or agentive identity. In cases like these, we also do not feel unable to perform particular actions and are not subjected to the normative significance of the situation. What has happened, then, could be a change of practical projects for instance that respectively present the situation at hand as motivationally relevant in other respects.

[108] Although normative reason can still move one to act, especially in the cases or routine actions, it could be also argued that individuals suffering from depression lose their autonomy as they are not able to choose the principles that guide their actions. But focusing on disturbances of autonomy in this way comes short in accounting for the disturbances in automatically performed actions that we rarely if ever choose to perform upon deliberation.

you want to be moved to perform this action by the particular normativity of the end[109]. Thereby, one is both moved to perform a particular action and constitutes oneself within the framework of particular practical identities that present one with various patterns of significance and meaning. Acting, on this account, is (a) based on what ends specific conceptions of practical identity present as worth achieving and (b) a means to identifying with certain (aspects of) individual practical identities and the normative values that come along with these. So, actions in general can be conceived as instrumental in achieving a desired end, whereby their normative value can in some cases be experienced as that of compelling duties, which shape the respective conception of oneself.

So, failing to be solicited to perform one's morning routine, the individual suffering from depression might experience its normative pull in terms of attempting to remain engaged in everyday life. It acquires an explicitly normative character as opposed to the routine and habitual one that just moved one to perform a pre-reflectively meaningful action that a specific situation called for. Acting on the basis of normative significance alone might happen along the following lines: Upon waking up, one experiences the activity of getting up and getting ready for work as effortful and demanding, it is beyond one's abilities. But it has to be done – it is an essential part of everyday life. Subsequently, one feels *compelled to act*, in spite of not feeling up to it, of feeling unable to engage with this activity. Respectively, one engages with it because one *has to*, because it is important that one goes to work and in order to do this, one has to get up and get ready. All these actions are then performed with great effort and strain. So, with respect to the different aspects of the sense of agency and the sense of ability based on skills, one's sense of agency is disturbed prior to the performance of the action – one is not solicited to perform it but rather compelled to do it. During the course of the action, the experiences of bodily effort are both a manifestation of declining or lost skills and impact the experience of oneself as an agent.

When immersed in everyday interactions and engagements, we rarely if ever have to resort this particular sort of deliberation. Familiar everyday situations pre-reflectively solicit is to act, they are encountered as characterized by ends worth achieving by means of specific actions. In depression, as suggested by the first-person reports introduced above, everyday

[109] (3) will not be discussed in detail here. It can be taken to suggest that although individuals suffering from depression are in some cases still able to perform routine actions based solely on their normative significance, they nonetheless lack autonomy as they might be unwilling to identify themselves with the particular maxims that move them to act. The changes in volitional capacities require further examination and analysis and can be indicative of a general shift in how agency operates in depression, namely in terms of the adherence to rules, obligations, duties, etc. that can on the one hand replace solicitations and on the other can be taken as objective externally imposed regulations one has to follow as she might not be confident in the self-imposed maxims on her conduct.

situations can be encountered as compelling one to act for normative reasons. Respectively, routine tasks such as household chores, for example, *have* to be performed to achieve certain ends. These actions are not pre-reflectively meaningful aspects of aspects of everyday life that are called for by specific situations, but burdensome duties and chores. One fails to pre-reflectively respond to the significance these have and is moved by their normative practical value in everyday life. In these cases, one is guided merely by normative agency that is based on individual conceptions of practical identity. This breakdown of pre-reflective solicitation, which makes one act based merely on normative significance, I am going to suggest, is grounded in radical disturbances of embodiment that transform the lived body into a living one, which hinders pre-reflective automatic interaction and necessitates the deployment of practical reason.

3. Disturbed Performance of Routine Activities

Instead of being solicited into acting, individuals suffering from depression encounter the situations formerly soliciting routine actions as compelling and demanding specific actions that are aimed at reaching certain ends. What was pre-reflectively meaningful is now deliberately instrumental – the coffee machine is there to be filled with coffee powder, water, etc. rather than to solicit one to brew coffee when getting ready in the morning. One is not only aware of the individual actions, which routine activities comprise but also encounters the entities deployed in them explicitly in view of how they are to be deployed rather than in terms of what one can achieve by using them. Instead of skilful performance of routine activities, the descriptions of how individuals suffering from depression find themselves in the world and act resemble a process of skill or habit acquisition as for instanced described by Romdenh-Romluc:

> More often the environment is real, but the agent's activity is not habitual, and so he does not perceive his environment as requiring it. In such a case, the agent mentally represents the requirement for action to which he responds. Before I have learnt to drive, for example, I perceive the pedals as for-pressing, but I do not yet perceive one as for-braking. Instead, I mentally represent the pedal's function, to which I can then respond by appropriately braking. The way in which I represent my environment is a possible value for action that it may have. My capacity to go beyond the actual allows me to act with respect to this possible environment. (Romdehn-Romluc 2011, 107)

What happens in depression, thus, is similar to the loss of skills, which presents specific actions as performed for a particular reason, as means to achieve a certain end that one finds worth attaining. As Romdenh-Romluc (2006, 107) points out, when engaging with non-routine activities, the whole situation is experienced differently – one encounters the

individual entities in it as to be manipulated in a particular way so as to achieve a certain impact: the pedals are for pressing, which achieves the goal of stopping the car, etc. Similarly, in depression, many everyday formerly habitual situations are encountered as presenting one with particular ends that can be achieved by means of certain actions. For instance, when experiencing getting up and getting ready for work as overwhelming and effortful, but still compelling, the individual actions one performs are means to achieve the desired or required end rather than smoothly proceeding automatic engagements with the world. Accordingly, the various entities in the situation at hand are not encountered in the same manner as when one is automatically solicited to perform the particular action – the shower has to be turned on so that one can shower, the shampoo bottle has to be pressed, the toothbrush to be held in one's hand, etc[110]. So, in the case of the loss of skills necessary for the performance of routine actions in depression, some of the everyday objects we encounter might have lost their pre-reflective soliciting aspect, in which they are commonly disclosed to us.

Here, one could argue that the changes in the experience and execution of routine tasks is not the loss of particular skills but rather the experience of unfamiliar environments that one has not yet learned how to deal with. Although depression indeed is characterized by radical changes in how one finds oneself in the world, I think that this line of argumentation on the one hand runs the danger of trivializing the quality of changes in experience in depression by viewing them as a failure of adjustment to newly-developed existential situations, and, on the other hand, might suggest viewing depression as a disorder of the acquisition of (motor) skills, which would be an oversimplification that fails to capture the encompassing nature of changes in experience and functioning characteristic of the illness. Moreover, in the descriptions of the experience of everyday routines and how these are executed, individuals suffering from depression seem to be aware of losing something, losing a kind of expertise, which made it possible for them to be drawn or moved into action without the exercise of effort or the need of deliberation over purpose, course, etc. of the individual actions carried out.

Being solicited to perform a routine action, one feels moved to act at a fundamental bodily-affective level, which both prepares one's body for the particular solicitations and

[110] In cases of everyday routine actions, the loss of skills and failure of solicitations that present one with the need for instrumental reasoning might be even more striking. Commonly, we not only perform these automatically but they are also so frequently practiced that, unlike the skills necessary for driving, one does not recall the process of acquiring them, how they were performed before that, and how one came to perform them in this particular habitual way. This is also reflected in our commonsense or everyday conception of skills as a sort of special abilities that one develops upon practice. Here, I use the term 'skills' to refer to both special abilities such as driving, riding a bicycle, operating a specific machine, and rather mundane abilities to perform the activities of everyday life such as getting ready in the morning, making coffee, cooking, carrying out particular household chores, etc.

shapes how the world and respectively the task in question are experienced. Routine activities in general are made possible by the essentially embodied experience and interaction with the world. Being moved by the world at such a fundamental pre-reflective level requires an experience of the own body primarily in terms of medium of perception and interaction, a lived body, which discloses the world in a particular manner. The loss of skills in depression can be understood as related to radical changes in embodiment, which revolve mainly around a transformation of the lived body into a living body, of the medium of perception and interaction into an object that hinders habitual interactions (see Fuchs 2002, 2005 on a review of the changes in embodiment in psychopathology in general and depression in particular). In the chapter "Loss of Possibility", I already addressed some aspects of the disturbance of embodiment in depression, in particular how the experienced of loss of possibility is expressed in bodily feelings. Here, I would like to focus on the other pole of the meaningful world disclosure performed by the lived body, namely how changes in bodily experience are manifested in world disclosure, which is characterized by a failure of enticement into habitual interactions. The own body in depression is frequently experienced as heavy, rigid, weak, failing, etc. It becomes a burden rather than a medium, it does not provide one with the necessary vitality and potentiation to interact with the world. To a failing, rigid body, routine tasks appear effortful and insurmountable.

3.1. The Failing body: Disturbances in Embodiment

The experience of depression is characterized by a multitude of changes in bodily experience, which shape how the world is disclosed to one. The lived body or body schema[111], as introduced in Chapter 3 "Loss of possibility" is the medium of perception and interaction with the world is the background of world disclosure. It is not the object of experience itself but rather shapes all experiences the subject undergoes. Consequently, all changes pertaining to the own body, for instance to its physical state, disclose the world in a different manner. The experience of agency in terms of skills and solicitations in the focus of this chapter is

[111] Some authors (e.g. Merleau-Ponty, Gallagher, etc.) deploy the notion of body schema and body image when distinguishing between pre-reflective and pre-conscious experience of the body as the medium of interaction and perception (lived body) and the conscious experience of the own body as the object of perception (living body). For the purposes of the discussion here, the terms 'body schema' and 'lived body' and respectively 'body image' and 'living body' will be used synonymously when addressing changes in bodily experience and agency. The term 'body schema', whenever deployed here, is used to illustrate more clearly and vividly the implicit, schematic, yet integrated and Gestalt-like aspect of the experience of the own body as a lived body and to acknowledge the fact that the current discussion is present in the literature under the headline of 'body schema and body image'. For a detailed discussion of the distinction between the two modes of bodily experience and how they have been deployed in empirical research and theoretical considerations across different disciplines, see Gallagher (1986).

essentially embodied. In the most general sense, our particular embodiment discloses what various entities in the world afford (Merleau-Ponty 1945/2002, 511) in view of how entities can be deployed, manipulated, etc. given our particular bodily characteristics. In this way, a pen might afford holding in one's hand, letting go, etc., a chair can be sat on, leaned on, grasped and lifted, etc. In view of individual practical projects, particular actions, such as holding a pen in one's right hand when writing a letter and picking it up with one's left hand and letting it go when packing it in one's handbag, are solicited. Routine actions, it has been suggested, operate at the level of the body schema (Gallagher 1986, 551) that integrates the body and organizes it in specific ways in its relationships with the environment (Gallagher 1986, 51). It encompasses the lived, non-conscious performance of interactions with the world without the need to represent or conceptualize these as requiring the exercise of specific bodily capacities and abilities. The own body here remain anonymous and abstract, it is that through which one experiences the world and not a body that one owns and has to manipulated so as to interact with the world (Gallagher 1986, 552). Intact embodiment enables this background unified structure of world disclosure that presents the world as a realm of interaction and meaning. The living body, or the body image, in contrast, is the object of conscious experience, the explicit awareness of possessing a body that we deploy when acting in the world. In what follows, I am going to examine how various changes in bodily experience transform the lived body to a living body, replace the body schema with a body image, and interfere with routine interactions with the world. In contrast to the changes in bodily experience and alterations of the lived body discussed in the previous chapter, my focus here will be on how alterations in the functions and respectively experience of the own body shape world disclosure[112]. This, of course, does not imply that the changes in the world, such as the loss of possibility do not indirectly impact our agency. Finding herself in a world devoid of possibilities, the subject is also not enticed into action as there is nothing significant that might potentially have motivational significance. The changes in agency I am going to focus on here, in particular those pertaining to bodily experience, foreground how we experience our actions and how we act, how we experience ourselves as agents who are both moved by the world and strive for causing a change in the world with their actions. Along these lines, how the world moves me to act is essentially influenced by how I experience the world through my body, how my body shapes what the world entices me to do.

[112] Merleau-Ponty (1945/2002, 95) has dedicated substantial attention to such changes especially in view of for instance specific changes in bodily constitution. In his iconic example of losing a limb, the environment continues to solicit habitual interactions, which are now not possible anymore due to the absence of the limb. The changes in world disclosure I have in mind here are of a more encompassing nature – the whole body is experienced as consisting of "regions of silence" (Merleau-Ponty 1945/2002, 95) that hinder spontaneous and effortless engagement with the world.

The changes in bodily experience in depression revolve around the main thread of a corporealization of the lived body (Fuchs 2005). From medium of perception, it becomes a burden, an obstruction that has to be overcome. Instead of being immersed in various interactions in the course of pursuing different practical projects based on what the world moves one to do, the body has to be utilized for the purposes of interacting with the world. It is not that which automatically immerses one into acting in habitual situations. It not only becomes obvious in the experience of its diminished vitality, heaviness, and potential lack of reliability[113] but also impacts how individual routine tasks in particular are experienced and performed. Here, I am going to suggest that the corporealization of the lived body disturbs skilful engagement by presenting the body as an object of experience rather than the medium of action. The corporealization of the lived body, thereby, establishes two background orientations: that of the resistant body found in 89 (72.95%) of the studied responses and that of the ailing body that was described by 54 (44.26%) of the respondents to the DDQ UK.

3.1.1. The Resistant Body

The lived body is first and foremost experienced as endowed with vital powers. It is an active instrument of perception and interaction, a living organism, which inhabits the world by means of actively relating to it. Commonly, we feel endowed with energy and physical potential, which disclose the world as potentially soliciting various actions. This provides us with the basis of engaging in any kind of (physical) activity. Changes to the experience of vitality such as overwhelming feelings of physical exhaustion or tiredness provide one with a radically different background against which any physical action demands more effort. The lack of vital powers, similarly to sensations of pain and general physical discomfort, are not merely causes that impact our experience of agency. Rather, they are fundamental aspects of how we find ourselves in the world (Merleau-Ponty 1945/2002, 512). In depression, the lived body is drained of energy and vital potential and feels "very tired and uncomfortable[114]" (R8,

[113] Havi Carel (2013a) introduces the concept of bodily doubt, which refers to cases of physical illness characterized by the failure of bodily functions that disclose the own body is potentially unreliable.

[114] This and the four excerpts to follow were administered the code *Lack of vital powers*. Responses describing the experience of diminished vital powers (such as instances of tiredness, exhaustion, feeling drained, etc.) are: R8UK, Q4B; R17UK, Q2B, Q4B, Q5B; R20UK, Q4B; R21UK, Q4B; R22UK, Q4B; R24UK, Q4B; R28UK, Q1B, 4B, 5B; R37UK, Q4B; R38UK, Q1B; R41UK, Q4B; R49UK, Q1B, 4B, 5B; R53UK, Q4B, Q5B; R54UK, Q4B; R65UK, Q4B; R66UK, Q1B, Q4B; R80UK, Q4B; R85UK, Q4B, Q7B; R89UK, Q4B; R93UK, Q1B; R97UK, Q4B; R105UK, Q1B, Q4B; R109UK, Q5B; R110UK, Q4B; R112UK, Q4B; R115UK, Q4B, Q5B; R117UK, Q4B, Q5B; R128UK, Q1B, Q4B; R130UK, Q1B, Q4B; R133UK, Q4B; R145UK, Q4B; R147UK, Q4B; R150UK, Q4B; R153UK, Q4B; R154UK, Q4B, Q5B; R155UK, Q4B; R157UK, Q4B; R160UK, Q4B; R161UK, Q1B, Q4B; R162UK, Q4B; R166UK, Q4B, Q6B; R171UK, Q1B, Q4B; R180UK, Q4B; R186UK, Q4B; R192UK, Q1B, Q4B; R199UK, Q44B; R200UK, Q1B, Q4B; R218UK, Q4B; R225UK, Q4B; R231UK,

Q4B) as reported by 71 (58.2%) of the respondents to the DDQ UK (see also Crafton 2009, XVI; Hatfield 2008, 243, 253; Lewis 2002, 79; Smith 1999, 7-8; Thompson 1995, 3, and Wurtzel 1995, 156 who describe experiences of exhaustion and lack of vital powers). These feelings of diminished vital potential are foregrounded as sensations of tiredness and exhaustion, which in many cases are inexplicable as they are not related to any particular activity:

> I experienced massive exhaustion, where my body wouldn't co-operate, as though I'd been very physically active for a long period and needed to rest. (R17UK, Q4B)

The fatigued body fails to provide one with the potential for acting and thus relating to the world. Against this background of declining or exhausted vitality, the world and one's interactions with it present a challenge, which for some might appear insurmountable:

> [My body feels] Tired – really, really tired – the stairs in my house seem like a mountain. (R147UK, Q4B)

The massive tiredness or exhaustion that characterizes how the body is experienced now transform even the simplest routine activities into tasks, which demand effort and have to be executed rather than merely being effortlessly immersed in. Even walking, a prototypical pre-reflectively and automatically executed routine motor action becomes apparent in terms of the strain it requires from the depleted body-object:

> [My body feels] tired and lethargic – too much effort needed to do the simple task of walking. (R308UK, Q4B)

We have all experienced instances of similar physical exhaustion that presented the last few steps to the bed as beyond our powers and are familiar with short-term or non-permanent transformations of this sort. What individuals suffering from depression describe is the overwhelming and all-encompassing nature of such changes – the lack of vital powers is not mere tiredness, it is rather a general orientation of loss of vital potential for any kind of activity. Accordingly, to some all activities might now appear effortful and overwhelming:

> Start to constantly feel tired, body almost feels heavy and even the slightest activity becomes a great burden to complete. (R331UK, Q4B)

The body drained of energy becomes apparent as it stands in the way of pursuing satisfaction of one's basic urges and drives. Here, the lived body is corporealized (Fuchs 2005) in terms of the changes pertaining to its vital state rather than in terms of changes in how the appears that were discussed in the previous chapter.

Q4B; R237UK, Q1B, Q4B; R240UK, Q4B; R246UK, Q4B; R253UK, Q4B; R271UK, Q4B; R282UK, Q4B; R288UK, Q4B; R291UK, Q4B; R292UK, Q4B; R308UK, Q4B; R311UK, Q1B; R311UK, Q4B; R316UK, Q1B; R323UK, Q4B; R331UK, Q4B; R341UK, Q1B, Q4B; R343UK, Q4B; R347UK, Q1B; R355UK, Q4B; R357UK, Q1B, Q4B; R366UK, Q1B, Q4B; R367UK, Q1B, Q4B; R371UK, Q1B.

In depression, the lived body becomes an object of experience, "loses the lightness, fluidity, and mobility […] and turns into a heavy, solid body that puts up resistance to the subject's intentions and impulses. Its materiality, density, and weight, otherwise suspended and unnoticed in everyday performance, now come to the fore and are felt painfully" (Fuchs 2005, 99). The own body is experienced as a heavy weight that has to be dragged around and prevents the interactions with the world as described by 45 (36.89%) of the respondents to the DDQ UK[115] and some authors of memoirs (Hatfield 2008, 243 and Thompson 1995, 57):

> Lethargic, like it's full of lead. My legs felt heavy all the time […]
>
> I think a lot of people have this impression that depression is a purely mental illness, and I can't explain it but it totally affects you physically as well and your body just goes into meltdown mode. (R22UK, Q4B)

The corporealization of the lived body, which disturbs the pre-reflective engagement with the world is not exhausted by sensations of fatigue, tiredness and heaviness. The own body becomes an obstacle rather than a medium of perception and interaction for 27 (22.13%) of the respondents to the DDQ UK in terms of its failure of excitability and various other functions, which we are commonly not reflectively aware of as pointed out here (also reported by Danquah 1998, 57; Hatfield 2008, 246; Lewis 2002, 1-2; Solomon 2001, 50, and Styron 1989, 43):

> My body feels like it isn't my own, that it is controlled by the depression. (R240UK, Q4B)[116]

For some, the radical changes in bodily experience make it become "ugly, grey, old." (R150UK, Q4B), "vulnerable and hollow" (R312UK, Q4B). The body devoid of its function of a medium of interaction feels old, unreliable, and useless as it resists the attempts of the agent to set it on a course towards action.

The living body, thus, occupies the foreground of experience and precludes automatic solicitations into routine activities. The heavy, drained, and unreliable body makes

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[115] The passage to follow were administered the code *Heavy body*. Passages, which describe feelings of bodily heaviness are: R14UK, Q4B; R20UK, Q4B; R21UK, Q4B; R22UK, Q4B; R40UK, Q4B; R49UK, Q4B; R60UK, Q4B; R97UK, Q4B; R107UK, Q4B; R110UK, Q4B; R112UK, Q4B; R118UK, Q4B; R129UK, Q4B; R130UK, Q4B; R134UK, Q4B; R137UK, Q4B; R143UK, Q4B; R150UK, Q4B; R153UK, Q4B; R154UK, Q4B; R166UK, Q4B; R168UK, Q4B; R190UK, Q4B; R199UK, Q4B; R200UK, Q4B; R224UK, Q4B; R225UK, Q4B; R231UK, Q1B, Q4B; R237UK, Q4B; R239UK, Q4B; R246UK, Q4B; R253UK, Q1B, Q4B; R259UK, Q4B; R271UK, Q4B; R288UK, Q4B; R291UK, Q4B; R303UK, Q4B; R311UK, Q4B; R312UK, Q4B; R331UK, Q4B; R341UK, Q4B; R343UK, Q4B; R347UK, Q4B; R350UK, Q4B; R367UK, Q4B.

[116] This passage was administered the code *Unreliable body*. The responses, which describe various feelings of loss of bodily function and excitability are: R21UK, Q4B; R22UK, Q4B; R38UK, Q4B; R40UK, Q4B; R54UK, Q4B; R80UK, Q4B; R93UK, Q4B; R110UK, Q4B; R130UK, Q4B; R134UK, Q4B; R150UK, Q4B; R157UK, Q4B; R166UK, Q4B; R168UK, Q4B; R192UK, Q1B; R199UK, Q4B; R200UK, Q4B; R240UK, Q4B; R246UK, Q4B; R253UK, Q4B; R271UK, Q4B; R285UK, Q4B; R303UK, Q4B; R311UK, Q4B; R312UK, Q4B; R323UK, Q4B; R355UK, Q4B.

automatic skilful interaction impossible as it discloses routine everyday situations as effortful tasks, which demand specific capacities and physical exertion.

3.1.2. The Ailing Body

The living body can come to the foreground of experience and be transformed into a living body in terms of various somatic complaints that disintegrate its unity and turn it into an object of experience. We are commonly actively immersed in various practical projects or individual (routine) tasks without realizing that the processes in physical body run smoothly to make this possible. In this way, the (relatively) healthy body provides with a somewhat steady background of reliable functioning, against which various entities solicit different actions and gain a further aspect of their (embodied) significance. For instance, for the heavy smoker the four flights of stairs are tiring, as they make her dizzy and short of breath. When climbing them, she becomes aware of her tightening chest and heavy breathing. For the person down with the flu and running a high fever, it is challenge to drag one's exhausted and weak body out of bed to make some tea or get a glass of water. In depression, I am going to suggest a wide range of physical complaints otherwise commonly associated with various somatic illnesses[117] in a similar manner impact how one finds oneself in the world as an agent in terms of the corporealization of the lived body. I am going to suggest that the various physical ailments in depression transform the lived body into a living body mainly in terms of (1) loss of embodiment and the foregorunded experience of bodily functions we are otherwise not aware of, and (2) the loss of bodily confidence, which is part of the background of our meaningful interactions with the world.

Going about our everyday lives and performing routine tasks, our body is experienced as essentially integrated and unified. It is not a mere collection of body parts and organs that stand in a particular relation to each other, have various functions, and contribute to different abilities or affordances, but rather a meaningful unity that is solicited to perform a particular activity. For instance, we go about the task of making tea in terms of the unified bodies we are. The individual actions implicated in making tea are not experienced as requiring the deployment of specific body parts and motor abilities. We frequently become aware of the essential unity of our body especially in routine everyday situations when it disintegrates even temporarily. After suffering an injury to one's arm, one might still set off to prepare tea in the habitual manner and only upon failing to lift the teapot notice that for

[117] Ratcliffe et al. (2013) engage in a detailed discussion of the various somatic complainta reported by depressed individuals and compare these to the experience of purely somatic illnesses such as the flu.

lifting the teapot one needs one's arm. Prior to this, the teapot used to be something to make tea in, now it becomes something to be opened, lifted, etc. by using one's arm. Thus, in cases of bodily malfunction these individual (motor) requirements become apparent. The own body comes to the foreground of experience as an object, which impedes routine interaction, as suggested by Havi Carel (2013, 31):

> It is only when something goes wrong with the body that we begin to notice it. Our attention is drawn to the malfunctioning body part and suddenly it becomes the focus of our attention, rather than the invisible background of our activities. The harmony between the biological and the lived body is disrupted and the difference between the two becomes noticeable.

This disintegration of the unity of the lived body makes it explicit, turns it into an object of reflection, which has to be deployed, similarly to a tool to perform a task. And 54 (44.26%) of the respondets to the DDQ UK report of various physical ailments that move their body to the foreground of experience and disturb its unity (Brampton 2008, 34, 91, 251; Lewis 2002, 10, 12; Malai Ali 2007, 21, 22; Styron 1989, 43; Thompson 1995, 3, 34 also provide descriptions of various somatic complaints)[118]:

> Leaden. Often an all over physical aching. Can be literally painful to move. (R137UK, Q4B)

The conspicuous body part stands in the way of acting, it has to be manipulated to perform a simple task, which now against this background is effortful and laborious. The body becomes explicit qua its failure to perform as it used to. We suddenly realize that the individual body parts, which formed a meaningful unity, carry out different functions and thereby might for the first time become painfully aware of how bodies work and enable us to act in the world. Qua failing to do what it used to before, the body becomes the object of experience and thereby also apparent as the means for acting.

The ailing body, plagued by pains and aches, is not a reliable means of interaction. Our sense of bodily confidence in the continued functioning of our bodies is essential to agency, especially with respect to the actions that we perform automatically and without deliberation and reflection. The increasing sense of bodily doubt (Carel, 2013; Carel 2013a)

[118] The two excerpts to follow were administered the code *Physical ailments*. Responses describing the experience of various somatic complaints such as pains and aches, symptoms of somatic illness, etc. are: R14UK, Q4B; R16UK, Q4B; R17UK, Q1B, Q4B; R20UK, Q4B; R21UK, Q4B; R24UK, Q4B; R30UK, Q4B; R37UK, Q4B; R41UK, Q4B; R47UK, Q4B; R53UK, Q1B, Q4B; R54UK, Q4B; R60UK, Q4B; R65UK, Q4B; R66UK, Q4B; R85UK, Q4B; R89UK, Q4B; R97UK, Q4B; R105UK, Q1B, Q4B; R106UK, Q4B; R110UK, Q4B; R115UK, Q4B; R117UK, Q4B; R118UK, Q4B; R130UK, Q4B; R134UK, Q4B; R137UK, Q4B; R150UK, Q4B; R154UK, Q5B; R155UK, Q4B; R162UK, Q4B, Q7B; R166UK, Q4B; R168UK, Q4B; R180UK, Q4B; R225UK, Q4B; R228UK, Q1B, Q4B; R231UK, Q4B; R239UK, Q1B, Q4B; R253UK, Q4B; R259UK, Q4B; R270UK, Q4B; R282UK, Q1; R292UK, Q4B; R303UK, Q4B; R307UK, Q4B; R312UK, Q4B, Q5B; R323UK, Q4B; R325UK, Q1B, Q4B; R331UK, Q4B; R334UK, Q4B; R343UK, Q4B; R352UK, Q4B; R361UK, Q4B; R366UK, Q4B; R367UK, Q4B.

is established by the disintegration and disturbance of our embodiment, which impact its pre-reflectively experienced functions and capacities and one becomes aware of one's bodily vulnerability:

> I feel a dull pain in the front of my body from my neck down to my stomach. It is sometimes so painful that all I can do is curl up. My body also feels very heavy. (R239UK, Q4B)

The world of the subject plagues by an illness, it has been suggested, is transformed into an "unnhomeike being-in-the-world" (Svenaeus 2013). While entities were formerly encountered as soliciting specific interaction in particular situations, the ailing body now has transformed even the most familiar of these into objects that one has to manipulate in a particular manner. Familiar routine activities have now become daunting against the background of the disintegration of the painfully experienced body.

The corporealized body discloses the world as requiring one to deploy it or to overcome it at the price of great physical strain and effort to execute various tasks. What used to pre-reflectively move the lived body to act now prompts the utilization of the objective body as the means to achieve a certain end that one has set upon. The various disturbances in embodiment reviewed above transform how the world is experienced in particular in terms of how one engages with it – the simplest and most routine actions are now effortful, require the deliberate manipulation of the objective body, etc. In what follows, I will examine in more detail the changes in the experience and performance of routine tasks that against the background of the failing body have become effortful and demanding and can be executed only after deliberation prompted by their normative significance.

3.2. Lost Skills

Against the background of the failing body, routine tasks and activities become demanding, tiring, and effortful. The lived body, which disclosed various everyday situations as automatically soliciting meaningful interactions, now appears as an impediment to active engagement. Experienced in terms of its failure to enable acting, to cooperate with the subject, primarily in terms of its heaviness and disintegration, it stands between the subject and the world instead of being the medium of world disclosure and interaction. Situations, which formerly automatically solicited actions now require conscious and deliberate strain and the exercise of physical effort. One suddenly becomes painfully aware that one *has to* hold the cup of tea and the physical strain required for doing this, that *one has to* fill the kettle with water when desiring a cup of tea. The individual actions and movements realizing this also for what seems like the first time come to one's awareness. Formerly, the lived body

merely performed these as integral parts of various tasks such as enjoying a nice cup of one's favourite tea, going to bed, etc. Now, even pleasant and preferred activities are straining against the background of the failing and 33 (27.05%) of the respondents to the DDQ UK explicitly describe a large variety of activities and actions as effortful, straining, demanding, and difficult (Danquah 1998, 27, 141; Lewis 2002, xi, 13, 130; Smith 1999, 6-7; Solomon 2001, 49, 52-55, 61; Wurtzel 1995, 251, 260 also describe the increasingly effortful and demanding nature of routine activities)[119]*:*

> Everything feels 1000 times harder to do. To get out of bed, hold a cup of tea, it's all such an effort. (R14UK, Q4B)

Routine activities such as having a cup of tea are now experienced as comprising individual patterns of effortful movements or motor acts. Formerly, one simply set out to enjoy a nice cup of tea without the explicit realization of how to go about doing it or of the physical strain of its individual motor acts and movements patterns. Now, the individual automatic motor skills or actions are explicitly present in one's consciousness – to have a cup of tea, one has to hold the cup in one's hand, lift it to one's mouth, etc. Suddenly, the radically altered body presents not only the activity at hand as effortful but also breaks down the meaningful unified actions into individual movements oriented towards achieving a particular end – if one is to have a cup of tea, one has to hold the cup in one's hand, lift one's hand, etc. The soliciting aspect of highly practiced routine actions has now become a deliberate instrumental reasoning as described in this passage:

> Everything seems 10 times harder. I had to do everything in such tiny steps. Just the simple task of getting out of bed or leaving a building would be a huge deal. I would have to tell myself "first get into a sitting position. Then we'll worry about the rest of it afterwards." (R22UK, Q2B)

The performance of these effortful and straining actions has to be learned again, the routine situations do not solicit the meaningful embodied patterns of motor activity but are experienced as requiring the deliberate manipulation of the object body so as to achieve a certain required end. In some severe cases, individuals suffering from depression even report of having forgotten how to perform simple routine activities and relying on explicit instructions as to how to accomplish particular tasks as described above.

[119] The emphasized passage and the two responses to follow were administered the code *Körper and effort*. Responses that described the experience of increased bodily effort required for routine tasks in particular against the background of radical disturbances in embodiment are: R14UK, Q4B; R20UK, Q1B; R22UK, Q2B, Q5B; R47UK, Q5B; R53UK, Q5B; R65UK, Q5B; R89UK, Q5B; R105UK, Q5B; R117UK, Q5B; R118UK, Q5B; R124UK, Q5B; R133UK, Q5B; R137UK, Q5B; R147UK, Q5B; R150UK, Q5B; R154UK, Q5B; R162UK, Q1B, Q4B; R166UK, Q5B; R169UK, Q5B; R171UK, Q5B; R190UK, Q1B; R192UK, Q2B; R199UK, Q5B; R200UK, Q1B; R224UK, Q1B, Q5B; R225UK, Q5B; R240UK, Q2B; R246UK, Q5B; R270UK, Q4B; R308UK, Q4B, Q5B; R350UK, Q4B; R367UK, Q1B; R371UK, Q5B.

Although many everyday situations might fail to solicit the particular formerly automatically performed actions, they are still recognized as occasions prompting particular actions and thereby cannot be said to lose all their motivational significance. Upon waking up, one still recognizes that the day is to be started by performing one's morning routine as part of everyday life. Similarly, household chores are also recognized as significant parts of everyday life that have to be completed. By experiencing these routine tasks as compelling or requesting accomplishment, individuals suffering from depression find themselves in an everyday life characterized and structured by duties and obligations that move them to act merely on the basis of their normative or practical significance that can be derived from one's (autonomous) choice to pursue a certain end (Korsgaard 2008, 27). Upon encountering everyday situations that used to be routines but now seem challenging and effortful, the individual suffering from depression reflects on this change – what used to automatic is not anymore, what used to be mundane and required no effort, is now hard, complex, and intricate, lacks meaning and purpose, but still has to be done as it is essential to everyday life as one used to know it. So, it is one's duty to perform or at least try to perform these actions in spite of not being enticed to do so.

Seeing the normative significance of everyday activities in terms of their compelling or obligatory status can be more apparent in the case of household chores and how one performs these. If one used to be the person who cleaned the table and did the dishes just like that right after dinner, not being automatically solicited to do this might be on the one hand a significant difference in how one finds oneself in the world as an agent, and on the other akin to a loss of part of one's habitual way of being, of one's identity or conception of oneself. Although, others might have to be reminded to do this so that the dirty dishes do not lie around the next day or two and turn one's house into a mess, for this person, this was never done as a means to achieve a certain end – it was just the natural thing to do. In depression, this might radically change, not being automatically moved to do the dishes and seeing them lying around, one recognizes that they have to be done, but now they have to be done as to reach a certain end – keeping house, having clean dishes, etc. In contrast to prior to the illness, one has to force oneself to perform such duties at home. So, (at least) some routine activities that are experienced as effortful, demanding, and overwhelming can still be performed as means to achieve a certain end presented by a particular conception of practical identity. For instance, although cooking dinner for one's children might appear impossible against the background of a feeble and resistant body, one feels compelled to do it as part of being a (good) mother. Instead of being automatically engaged in routine actions, one is forced or necessitated to act so that ultimately everyday life is structured along a range

of duties that demand to be performed rather. Everyday situations are experienced as necessitating rather than soliciting actions by presenting one with a range of normatively loaded requirements as described in this passage[120]:

> My living becomes mechanical, based on necessities to be done. Children need to be fed. Plates need to be washed. School clothes need to be clean. Everything else in life is put on hold. (R117UK, Q6B)

Everyday life, as described in the passage above, revolves around necessities – only that, which is necessary is to be performed as against the background of the failing body these both require more effort and strain and fail to solicit automatic effortless engagement. Their still present normative significance, which is now the sole motivational factor, is a remnant of one's former habitual engagement and respective practical identity. Here, specifically the practical identity of being a mother, among other possible and actual such, presents these activities as such that have to be done. Describing the differences in how one finds oneself in the world as an agent as revolving around the compelling obligatory normative significance of routine activities places the major alteration in the realm of how one is moved to perform these, why one engages with everyday routines. For the author of the passage above, what has changed is that clothes need to be washed, children need to be fed and this is what makes her carry out these activities. The lost skills that made the experience of these situations as soliciting the particular activities and their subsequent automatic performance is now replaced by the normative force of obligation, which presents them as instrumental in achieving a particular end.

In some cases, one might also postpone or abandon the performance of routine actions and everyday chores as one might fail to respond to the normative significance as described in this response to the DDQ UK[121]:

> I try to force myself through them [routine tasks and everyday activities]. I can either force myself to be with people, or force myself to work, or force myself to go to class, but not all three at once. The house becomes a wreck and everything slowly deteriorates. Food moulds in the fridge. (R130UK, Q5B)

In some of these cases of failure to perform routine actions and everyday chores, these are the ones that one can rely on others' support for (a partner, a family member, etc.) or such that are aimed at the subject only like personal grooming, etc. Respectively, they might be neglected as either someone else can perform them in the case of failure of automatic solicitation and overwhelming demand or they lose their normative significance as they are related only to oneself:

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[120] The passages to follow were administered the code *Chores have to be done.*

[121] The excerpt to follow was administered the code *Postponing routine tasks.* Lewis 2002, 28; Smith 1999, 18; Wurtzel 1995, 208 also report of abandoning or postponing various everyday activities.

> I worked very hard to ensure that it didn't interfere with my routine – I didn't take any time off work, I tried to make it to the gym etc. but in some ways I think it would've been more sensible if I'd not tried so hard to pretend everything was 'normal'. […] The thought of small tasks like washing-up seemed enormous, and unfortunately for my partner I stopped doing housework. I could get away with that at home because he knew what my situation was […]. (R21UK, Q5B)

The normative significance of routine actions, thus, can also be related to the strong social stigmatization of mental illness that prompts tendencies towards pretence and continued forced engagement with everyday life in an attempt to conceal one's suffering. As one strives to maintain everyday life at least partly so as to conceal changes in how one finds oneself in the world, exactly the routine tasks that have outward manifestation or might benefit others acquire a strong normative character. In contrast, the ones that are concerned only with one's private everyday life might be neglected to a large extend.

Against the background of disturbed embodiment, one encounters situations of everyday life as characterized by normative significance, which replaces the pre-reflective automatic engagement with routine actions based on pre-reflective solicitations. Despite the failure of solicitations and the disturbances of the performance of routine tasks, one engages in everyday life based on the normative significance attributed to everyday tasks that is related to particular conceptions of practical identity. In this way, one finds oneself facing an everyday life comprised of duties that has replaced the former pre-reflective meaningful engagement. The described instances of disturbed agency in the case of routine actions in particular suggest that higher-order volitional capacities might be deployed as a compensatory strategy when automatic pre-reflective engagement fails. But the first-person reports of individuals suffering from depression strongly suggest that in these cases they feel compelled and necessitated to act, they have to overcome themselves, etc., which indicates a disintegration of agency that might be expressive of radical changes in volitional capacities as well. What might be severely disturbed in such cases could be one's capacity to choose autonomously which (aspects of) different practical identities one endorses and potentially subsequently through practice incorporates and embodies (for instance in patterns of solicitations in the case of routine actions).

4. The Sense of Ability and the Sense of Agency

As introduced at the beginning of the chapter, the *first-person motivated notion of agency* I am concerned with here encompasses at a fundamental level the experience of oneself as an agent in isolation from particular action (AG1). Acting and finding oneself in the world as

an agent includes this basic sense of oneself as "[…] causally effective over time" (Marcel 2003, 51[122]) or in other words as having the potential to produce some causal impact on the world. The sense of agency also encompasses the experience of oneself acting, the experience of oneself as an agent while performing a particular action (AG2). Both aspects of the sense of agency are related to the experience of one's ability, of feeling up to performing a certain action (AB). With respect to the performance of routine activities, the specific skills we develop through frequent practice (AB1) present particular situations as soliciting the appropriate actions as discussed in the previous section. With respect to our sense of being an agent prior to acting (AG1), AB1 provides us with a sense of being the potential subject of solicitations when finding oneself in specific situations. It is not necessary here that the solicitations lead the agent all the way to performing the action, but rather that certain situations are perceived[123] as potentially soliciting particular actions so as to produce a certain impact on the world. For instance, someone who generally cleans up the table right after dinner, when entering a dining room and seeing the empty dishes still on the table, perceives the table as not cleaned up. This does not directly translate into a solicitation to perform the activity, but can potentially, depending on further aspects of the particular situation, do so. If this is the dinner table at one's own home that she did not clean up because one was seeing her guests out, the situation will solicit one to clean up the table right away upon witnessing it after returning to the dining room. In contrast, if the same person witnesses the same situation at a friend's house upon coming over for a movie night, she will perceive the situation as one of untidiness or disorderliness but not as one that solicits her to perform the particular activity.

On this broad notion of agency, we also experience ourselves as agents qua performing particular actions (AG2). Various components such as experiences of effort[124]

[122] Anthony Marcel (2003, 51) calls this sense of agency a long-term sense of agency. In my view, what is distinctive and crucial about this aspect of our sense of agency is not its duration (as suggested by the label 'long-term') but rather its fundamental yet encompassing character – it is not limited to the experience of oneself at instances of acting but is the background sense of potentially being able to act that underlies acting and the ocurrent sense of oneself acting.

[123] Tim Bayne (2011) argues that the experience of agency is a perceptual phenomenon, which is consistent with the discussion of the skilful aspects of agency. It is important to emphasize here that I do not wish to claim that all experiences of agency have this perceptual character but rather that solicitations to perform routine activities based on the possession of skills are akin to perceptions of specific situations as possessing (motivational) significance that pre-reflectively moves one to act. A detailed discussion whether agency is exhausted by such phenomena is beyond the scope of this work. The distinction between routine activities, solicitations, and skills and non-routine activities and capacities in this chapter is based on reports of radical alterations in experience, thought, and behaviour that can be indiscernible in non-pathological or non-altered cases.

[124] Experiences of effort are, according to some (e.g. Bayne and Levy 2006, 57) an essential aspect of the experience of agency. For them, the term 'effort' refers to "[...] the experience of needing to invest energy and will-power in our actions" brought about by the "[t]he world's resistance to our actions, coupled with our limited success in changing it". Conceived in this way, the sense of effort is not an unpleasant or negative experience but can accompany a wide range of intact and unaltered experiences of agency and instances of

and control, the formation of different intentions to act, etc. of the occurrent sense of agency (Marcel 2003, 51) are often in the focus of research (e.g. Bayne 2008, 2011; Bayne and Levy 2006; Pacherie 2007, 2008.). When engaged in routine actions (AB1), their automatic performance in response to particular features of certain situations provides us with an experience of being immersed in action that establishes our immediate sense of agency qua being involved in pre-reflectively meaningful actions aimed at achieving a particular goal. When encountering and perceiving particular situations as soliciting specific routine activities, such as for instance taking a shower in the morning, the embodied nature of our ability to shower is reflected in the automatic performance of this activity. Being solicited to shower as part of our morning routine, the ability to shower is pre-reflectively experienced as a background that enables us to perceive the situation as one, which calls for showering. So, with respect to routine actions, the pre-reflective sense of ability (AB1)[125] makes it possible for us to automatically engage with a particular situation in a respective manner and be immersed in its course.

But in some cases, before performing a specific activity, we experience ourselves as agents (AG1) and up to it in terms of possessing specific capacities required for its performance (AB2). For instance, I might not experience myself as an agent in a situation that requires me to conduct a conversation in French, as I do not speak the language. This situation to me might even not seem as prompting a particular action as it is beyond my capacities to engage with it and I might even avoid it if there is the slightest chance of being necessitated into performing the action it requires. So, if you consider this example, during a visit in France, I might frequent only places where I am aware that English is spoken and avoid places where no one speaks English, as they do not present me with any possibilities for acting. Thereby, a sense of agency rooted in the capacities at my disposal shapes how possibilities for actions are experienced. In some cases, in which alternative means for achieving the goal of the prompted action are present, I might experience these situations as requiring a further type of action. For instance, if I have someone to interpret and translate with me on my visit in France, I am going to engage in conversations in French that she makes possible by conversing with her as well. So, what the situation of visiting a local family

acting. The experience of effort that was discussed in the previous section, in contrast, is painfully felt as (physical) strain or resistance when acting.

[125] This is commonly a pre-reflective sense of being able to perform a particular routine action. We do not reflectively experience ourselves as being able to make coffee, but when desiring a cup of coffee, we deploy the coffee maker in the respective manner. If we, for instance, were to use a coffee machine we are not familiar with, we might have to deliberate on the individual steps involved in the process and appreciate the resources necessary for this. Also, if some general situation-specific conditions change, we might find ourselves engaging in a deliberate estimation of the capacities or conditions required for performing the action (for example, if unbeknownst to us someone unplugged the coffee machine our, so that it is not starting we might start checking if the power is down, etc. upon pressing the on switch several times without success).

restaurant where only French is spoken prompts is for me to engage with the waiters through my companion. In cases of incapacitation (due to a loss of capacity that one used to have or due to the absence of a capacity as it was never acquired or developed), it is not necessary that I do not experience myself as an agent anymore with respect to all situations. What changes is rather what situations are action-relevant for me. Moreover, once engaged in an activity (AG2) that requires certain capacities, I might fail to feel as agent if the course of it I lack the capacities or have insufficient such for its successful performance. While this might not rob me entirely of a sense of being an agent established qua acting, I might fail to feel as particular type of agent, namely one who is able to perform specific activities up to a particular standard.

As mentioned at the beginning of this chapter, individuals suffering from depression are subjected to disturbances in agency (AG1 and AG2), as they do not feel up to specific activities in terms of lacking the respective capacities required for their performance. In such cases, one frequently does not feel up to a certain standard of functioning or performance as for instances in cases of non-routine activities (like at least some of those in the professional sphere) that are commonly associated with particular evaluative standards. These activities, at least some of the respondents to the DDQ UK and authors of memoirs encounter as difficult or impossible and they respectively perform them poorly or fail to perform them. Routine activities, as already discussed, on the other hand, appear as effortful and performed with great difficulty or even abandoned, but in the descriptions of how one encounters and performs them, their authors emphasize the disturbance of automatic performance and the instrumental and normative character formerly routine activities and actions have obtained. These distinct focuses, I suggest, highlight two important aspects of the sense of ability and agency – on the one hand, that the normative or practical value or significance of various activities can be incorporated and embodied in skilful practice, and that agency and ability are subjected to evaluative standards as well.

When describing the instances of feeling not up to different non-routine activities, the respondents to the DDQ UK refer to their *failure* to perform in a particular way, they feel incapacitated, or acting appears impossible. It is not the case that specific activities have become apparent qua their difficulty or effort, but rather that one is not up to a (particular level of) performance that one used to achieve prior to the illness. Unlike perceiving situations as soliciting routine activities, here the activity in question is disclosed against the background of the capacities it requires and frequently so with respect to specific evaluative standards. One and the same activity can on this reading be encountered as routine by some (and as prompted by solicitations and automatically performed) and as requiring certain

capacities based on individual expertise. For example, the novice driver, who is not skilled at driving yet, experiences driving as deploying various capacities. She (is aware that she) has to pay close attention to the traffic and to the respective traffic regulations. When perceiving a traffic light turning red, she is supposed to stop and wait for it to turn green. When it turns green, she is supposed to press the gas pedal, etc. So, the activity of driving is disclosed to her in terms of the individual actions that make it up and the respective capacities required for performing them. She needs to be concentrated, to recall how to start the car after stopping at a red traffic light, when to switch gears, to see well and clearly, to press, push, and pull with hands and feet. Being capable of doing these provides one with a sense of ability, the ability to perform a specific activity in a particular way. Thus, to be able to drive, to the novice driver is made of being capable of attending, recalling, etc. Consequently, to be able to drive well, one needs capacities such as eye-sight, concentration, memory recall and the like. A skilled and experienced driver, in contrast, experiences the different situations in the process of driving as soliciting skills rather than requiring capacities – the red light is perceived simply as the signal 'stop', the green light is the signal 'go', she does not press the gas or the brake, she simply stats and stops, etc[126]. In what follows, I am going to examine in detail the experience of ability in terms of the capacities required for the performance of different activities and their alterations in depression. I am going to suggest that the disturbances of agency in these cases illustrate its evaluative component – what has changed for individuals suffering from depression is how they perform, how they function, how they cope or come to terms with life.

5. (Declining) Capacities and the Sense of Ability

First-person accounts of depressive experience frequently refer to the loss of a wide variety of capacities that one recognizes as essential for performing particular actions. One's concentration is very often severely impaired, which may interfere with performance at the workplace, memory is also deficient, so both recalling and memorizing new information is difficult, etc. General capacities like these, and more specific ones present some individuals suffering from depression with a sense of inability, which shapes how they encounter and perform various activities. Prior to engaging with a particular activity, one is not an expert at

[126] Driving is generally considered a specific ability that is acquired through practice and is respectively institutionally acknowledged. When claiming that one *can* drive, one can refer to the general ability to drive that is acknowledged by possessing a driver's license. It can also refer to the high level of expertise that is more akin to instances of being a good driver, which are in many cases related to the routine character of driver. In this case, we would identify the 'can' in 'I can drive' with skills and solicitations rather than with ability as in the former sense.

in the sense discussed in the previous sections, one is at least pre-reflectively aware of what capacities are necessary for its performance. The novice driver, for example, although being able to drive, still has to actively attend to traffic and traffic regulations. Moreover, when stopping at a red traffic light, she has to redirect her attention to the pedals and the gears when the green light comes. She is aware of the need to redirect her attention in these cases in the same way as one is aware of the need to speak a particular language, say Spanish, when opening an original edition of "One hundred years of solitude" with the intention of reading it. Upon engaging with activities of this type, one anticipates what they require and how these requirements stand against one's capacities. The capacities one possesses are tacitly compared to what the intended or desired action requires and this provides one with a general appreciation of how much one is up to the action in question, in how far one can perform it. So, activities, which are not performed automatically and might even require deliberation and planning, are encountered against the background of one's capacities[127].

In depression, the sense of declining capacities directly impacts how one experiences oneself as an agent and the background orientation of incapacitation was described by 63 (51.64%) of the respondents to the DDQ UK. Various activities have not only become more demanding against this background but even prior to engaging with these, one might feel a robbed of a general agentive capacity, of the ability to act at all in terms of a radical decline in specific or general capacities (AG1). Moreover, these references to the disturbed (experience of) agency qua incapacitation frequently explicitly refer to specific or implied evaluative standards of functioning. For instance, for 40 respondents (32.79%) to the DDQ UK the background of incapacitation is expressed in reflective experiences to being robbed of agency, so that they are unable to successfully engage with the tasks of daily living (e.g. Danquah 1998, 89; Hatfield 2008, 240, 243, 251; Lewis 2002, 7, 11; Smith 1999, 8, 10, 184; Solomon 2001, 88-89; Styron 1989, 13-14, 17, 45; Wurtzel 1995, 184-185, 221-222, 277-278 refer to disturbances of agency in terms of declining capacities):[128]

[127] The term 'capacities' generally refers to a broad range of rather disparate capacities such as memory, attention, hearing, sight, concentration. This is also mirrored in the responses to the DDQ UK that describe loss of concentration, inability to focus or concentrate, difficulty recalling and memorizing information, a general confusion of thought. Here, I am not focusing in detail on the discussion of the different capacities that are impaired in depression, to what degree they are impaired, and whether there is a (causal) explanation of their impairment (for instance, some respondents wrote that they cannot concentrate on completing different tasks due to the enormous emotional anguish they were experiencing) as what is of relevance for the experience of agency is the sense of ability based on the experience of one's capacities. It is also important to note that what is usually identified as capacities throughout the responses are general cognitive powers such as memory, attention, language, etc. This does not mean that the term 'capacity' in general is reserved only for these. In conditions that affect the motor system, one's experience of agency is disturbed by one's diminished motor capacity.

[128] The three excerpts to follow were administered the code *I cannot function*. Responses describing the experience of a failure to function in the same manner as prior to the illness are: R14UK, Q5B; R16UK, Q5B; R17UK, Q5B; R37UK, Q5B; R47UK, Q1B; R53UK, Q1B; R54UK, Q5B; R61UK, Q7B; R69UK, Q5B, Q8B; R84UK,

> It stops me dead. I can't deal with decisions. I can't work. I can't drive because I can't focus enough. I don't know what I'm supposed to be doing. Can't think what I want to eat, don't realise I'm thirsty. I just stop. I spend hours staring at the tv but have no idea what I've been watching... I just don't process my surroundings. (R192UK, Q5B)

Moreover, frequently the descriptions of the experience of agency in terms of declining of lost capacities also include explicit mention of evaluative standards for the quality of one's performance. Respectively, rather than finding these activities effortful, straining, or demanding, one feels "totally debilitated" and not able to "function" either at work or at home in a "normal" manner" (R219UK, Q5B). In some cases, though, one might not feel moved to perform a particular task or engage with a certain activity as described here:

> I do not go out. I do not make plans to do nice things. I just want to do nothing at all. (R291UK, Q5B)

Motivation itself can be understood as one of our basic capacities, particularly in cases of non-routine and nont automatically performed actions such as the ones described above. Thus, having lost motivation and not wanting to engage with a range of different activities as described above results in a general passivity of behaviour, which can be likened to a failure to function (in a normal manner) as well.

What changes radically for the individuals suffering from depression is how they perform these actions and what agents they are. The decline in their capacities not only impacts how they encounter various actions prior to performing them, but also how successfully they engage with these. While performing an action or engaging with an activity, we experience both in how far we are able to doing this as intended or desired and receive evidence for our success in acting. For instance, lacking concentration after a long tiring day at work, we sit down with a favourite book to relax. We start reading but soon notice that after finishing two pages, we cannot tell what has happened in the plot. Although we managed to engage with the activity in question and might have even felt up to it prior to starting to read, we are not successful in reading, we fail to perform the activity of reading with respect to the standards for it, namely to acquire information about changes in the plot. Thus, based on evidence we can also acquire a sense of our capacities – in this case, that our concentration is diminished beyond the level required for reading a book successfully, so that we can say "I cannot read right now" based on our experience with the activity at this moment (AG2). Similarly, 22 (18.03%) of the respondents to the DDQ UK describe how

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Q5B; R106UK, Q5B; R110UK, Q5B; R124UK, Q5B; R133UK, Q5B; R134UK, Q7B; R147UK, Q7B; R153UK, Q5B; R154UK, Q1B; R157UK, Q5B; R160UK, Q5B; R168UK, Q5B; R186UK, Q5B, Q7B; R192UK, Q5B; R195UK, Q5B; R212UK, Q7B; R219UK, Q5B, Q8B; R228UK, Q5B; R231UK, Q4B, Q5B; R240UK, Q5B; R270UK, Q7B; R271UK, Q5B; R282UK, Q5B; R288UK, Q5B; R291UK, Q5B, Q7B; R323UK, Q1B; R352UK, Q5B; R355UK, Q5B; R360UK, Q7B; R361UK, Q5B; R370UK, Q5B, Q7B.

their declining capacities interfere with the course or successful performance of different actions and activities and they feel not able to act in this manner anymore[129] (see also Styron 1989, 12, 45; Wurtzel 1995, 251):

> At its worst I cannot concentrate.
>
> I'm a teacher and found myself in the position where a student would ask me to look at their work with a question for me.
>
> I'd look and instantly forget the question or what I was looking at.
>
> Decisions are impossible. (R343UK, Q5B)

First-person reports of individuals suffering from depression illuminate a further aspect of the sense of ability, of the experience of 'I can do A, which requires capacities A, B, and C'. When describing how they find themselves in the world as agents and respectively act, frequently their sense of ability is closely bound to their (sense of) capacity (AB2). When encountering various situations that prompt one to act, or intending to perform a particular action, these are disclosed against the background of what capacities are required for their performance. In depression, such tasks are frequently encountered as beyond one's means, one feels not able to perform them (in the same way as prior to the illness) anymore, or not up to them mainly against the background of lost or diminished capacities. Diminished or lost capacities establish a sense of what one is able to do both prior to performing particular actions (AG1) and in the course of acting (AG2). Encountering the different actions and activities of daily living against the background of diminishing concentration, for instance, attending project meeting, keeping up with the discussions and contributing to them, is experienced as beyond one's means. On the other hand, when already participating in the meeting, the failure to follow the thread of the discussion, to recall what suggestions were just made, etc. provides one with a sense of having failed to efficiently and successfully perform especially as compared to periods prior to the illness, when these activities were not demanding, straining, and too complex. Experiencing one's capacities as diminishing and also witnessing one's declining performance in different contexts in particular of actions or activities that are not habitual or routine, one experience oneself as not able to act in the respective contexts. The sense of declining capacities and the experiential evidence for these obtained during one's performance establish one aspect of the sense of agency that is central to the experience and exercise of agency.

[129] This passage was administered the code *Diminished performance*. Responses that describe the loss of capacities and a failure to meet certain standards of performance (sometimes accompanied by negative self-evaluations) are: R20UK, Q5B; R47UK, Q5B; R89UK, Q7B; R93UK, Q5B; R134UK, Q5B; R166UK, Q5B; R180UK, Q2B, Q5B; R190UK, Q7B; R212UK, Q5B; R237UK, Q5B; R246UK, Q5B; R259UK, Q5B; R269UK, Q8B; R282UK, Q7B; R303UK, Q5B; R311UK, Q5B; R312UK, Q5B; R316UK, Q5B; R323UK, Q5B; R325UK, Q5B; R343UK, Q5B, Q7B; R367UK, Q5B.

The sense of ability commonly expressed by utterance like 'I can' plays a crucial role in the experience of agency. The individuals suffering from depression frequently describe their active engagements with the world as characterized by a strongly diminished or depleted ability – everyday activities have become effortful and demanding; one also does not feel able to perform non-routine actions and activities anymore as one cannot concentrate well, recall or memorize information, etc. In both cases, one would refer to the changes in one's sense of agency in terms of loss of ability to engage with specific activities. Ultimately, against the background of loss of skills or incapacitation, one often feels as if not able to deal with the requirements of everyday life – everything is too effortful and straining and performs poorly. Consequently, everyday life is merely just too much to cope with and at least of those suffering from depression describe the (experienced) loss of ability in terms of a desire to avoid dealing with life and its requirements and strains as reported by 11 (9.02%) respondents to the DDQ UK[130]:

> When I'm depressed I feel as though [life] is really difficult […] Everything feels too much to cope with. There have been times when it feels too much to do anything. (R93UK, Q8B)

While for some this experience is most poignant in terms of their failure to meet the seemingly ever-increasing demands of everyday life, for others it is most cleaerly present in the experience of lack or motivation, anxiety, or reluctance to meet these. For them, the tasks of life appaear daunting against the background of their declining (sense of) ability, so that they strongly deire to avoid having to deal with them as for instance described in this passage:

> first time – difficult to get out of bed in morning, insomnia made it difficult to concentrate at school, when did sleep, overslept, was late for school.
>
> second time – very difficult to get out of bed in morning, just wanted to sleep so didn't have to face life, could sleep for hours on end.
> brain didn't seem to function correctly, couldn't think properly, interferred with university coursework. (R218UK, Q5B)

The sense of ability, it has been suggested has been neglected in the study of agency (Schmid 2011, 216). In the study of pathology in particular, the focus has been mainly on the experience of ownership or authorship and control of one's actions and thoughts for instance in schizophrenia, addiction, and some neurological conditions. First-person reports of

[130] The two passages to follow were administered the code *Unable to deal with life*. Responses describing a disturbed agenthood in terms of loss capacities and the associated experience of not being able to deal with life are: R17UK, Q5B; R20UK, Q1B; R22UK, Q1B; R38UK, Q5B; R66UK, Q1B; R93UK, Q1B, Q8B; R162UK, Q5B; R190UK, Q5B; R218UK, Q5B; R292UK, Q5B; R361UK, Q8B.

depressive experience as discussed throughout this chapter indicate that one might fail to experience oneself as an agent prior to the performance of actions and activities (AG1) and when performing them (AG2) in terms of her experience of ability (AB). These reports indicate that one can feel unable in two ways: By becoming painfully aware of the effortful and demanding character of routine activities that were formerly automatically performed; and by lacking the capacities required to perform non-routine tasks that might generally require deliberation and reflection. In the former case (AB1), what is lost is the pre-reflective experience of situations as soliciting specific responses so that one fails to skilfully engage with these. In the latter case (AB2), diminished capacities present different activities as beyond one's powers and impossible. Both aspects integrate to a unified sense of ability of feeling up to particular actions that shapes how the world is experienced.

6. Changes in Temporal Experience and Agency

Being one of the major structures of experience, the sense of agency; like the experience of possibility, establishes a background pre-reflective sense of temporal flow. And alterations in the experience of time related to changes in agency and ability were reported by 45 (36.86%) of the respondents to the DDQ UK. Being actively engaged with the world, one commonly experiences time as a pro-active orientation towards the future, where current endeavours are realized and satisfied. Experiencing oneself as an agent prior to acting (AG1) and while acting (AG2) establish the synthesis of past, present, and future in terms of the active pursuit of drives, urges, and desires that motivate one's practical projects and individual actions and activities. When experiencing oneself as an agent (AG1), one is oriented towards the future in terms of the potential ways one can causally impact the state of the world. Thus, the future appears as relevant or significant in terms of the realization of practical projects. For instance, when experiencing oneself as an agent in general, one pre-reflectively anticipates the future as time, in which one can causally impact the world in various ways. Temporal flow is experienced in terms of the practical projects we are engaged in, of the particular routine and non-routine actions that structure our everyday life. Time, it might be suggested, gains significance in terms of acting in the world – similarly, the different portions of the day are characterized by distinct groups of activities: one's early morning is dedicated to getting ready and getting to work. The working day is filled with various routine and non-routine tasks and in the evening one engages in re-creational activity (ideally). So, anticipating a future moment is at least partly determined by how it is relevant to acting in the world. Accordingly, the radically disturbed sense of agency that individuals suffering from

depression report of is for some manifested in experiences of loss of significance of time or temporal flow. Feeling not able to actively engage with the world and subsequently in some cases failing to do this, whether and how time passes is of no relevance. As one does not feel up to performing the actions and activities that structure the passage of time, so that past, future, and present barely matter or become irrelevant as described by 16 (13.11%) of the respondents to the DDQ UK[131]:

> I don't tend to have any track of time when I'm depressed. My wife writes me lists so I remember to do things at certain times.
>
> When not depressed I am very punctual, and always know what needs doing and when. (R157UK, Q6B)

The experience of oneself as an agent in the course of an action (AG2) establishes a further aspect of the experience of temporal flow, namely its duration. As we experience time based on our active engagements with the world, how these unfold and progress towards their satisfaction presents us with a sense of how the present moment transforms into the future, how the not-yet of future satisfaction of practical projects becomes the now of successful action. The loss of ability (both AB1 and AB2) make acting more difficult, actions are more effortful, straining, demanding, etc. and take longer as one does not have all required skills and capacities at one's disposal or these are not available at the same level of functionality. So, for example, getting ready in the morning, now requires deliberation on how to go about the process of showering and making coffee, which turns the morning into an endless moment of not-yet-ready-to-leave-the-flat. The future becomes apparent in terms of one's failure to 'reach' it by performing the activities that characterize the transition from present to future. All actions (seem to) take forever when performed as reported by 19 (15.57%) of the respondents to the DDQ UK[132] (Lewis (2002, 14) also describes the experience of time slowing down specifically in terms of the duration of activities):

> It seems as though time moves slower, as though I can't do things or that it takes forever. It's like watching things at one tenth speed, or experience them as such. (R118UK, Q6B)

As nearly all (if not even all) actions and activities take much longer than usual, one is also acutely aware of the progress of time or suddenly realizes it. It seems to one that the day is over too soon, before one has managed to perform everything one had originally planned or

[131] The passage to follow was administered the code *Time is irrelevant*. Responses that describe the experience of time as insignificant or irrelevant are: R51UK, Q6B; R54UK, Q6B; R112UK, Q6B; R115UK, Q6B; R155UK, Q6B; R157UK, Q2B, Q6B; R162UK, Q6B; R168UK, Q6B; R186UK, Q6B; R192UK, Q6B; R218UK, Q6B; R219UK, Q6B; R237UK, Q6B; R271UK, Q6B; R308UK, Q6B; R357UK, Q6B.

[132] The passage to follow was administered the code *Everything takes forever*. Responses that describe the experience of slowed temporal flow in particular when performing different actions and activities are: R38UK, Q6B; R49UK, Q5B; R53UK, Q5B; R89UK, Q5B; R93UK, Q6B; R118UK, Q6B; R166UK, Q6B; R168UK, Q6B; R171UK, Q6B; R190UK, Q5B; R192UK, Q6B; R237UK, Q6B; R240UK, Q6B; R253UK, Q5B; R269UK, Q4B; R285UK, Q5B; R288UK, Q5B; R312UK, Q5B; R370UK, Q6B.

extended. In these cases, the present is suddenly transformed into an already-here future that comes along with a host of actions and activities that have to be performed as well as described by 17 (13.93%) of the respondents to the DDQ UK[133]:

> Time before I am due to do something such as attend university or fulfil another responsibility, goes extremely fast. (R367UK, Q6B)

Against the background of disturbed agency, the pre-reflective awareness of implicit time is transformed into the reflective experience of the transformation of present to future. On the one hand, the impaired or forced engagement with activities in the present discloses the future as time of their delayed realization. As the agent has to invest more physical and mental effort into their performance, they appear to take longer and respectively the transformation of present into future is delayed. On the other hand, to some the disturbances in agency are manifested in reflective experiences of a particular future period approaching at a quicker pace. Spending more time to perform various activities, the present seems to become the future that is characterized by the anticipation of further active engagements. The general disturbance of one's agentive experience and the associated passivity might in some cases rob time of its significance. As one does not feel moved to act and fails to act, the flow of time is irrelevant against the background of loss of strive for active engagement.

7. Conclusion

The sense of ability commonly expressed by utterance like 'I can' plays a crucial role in the experience of agency. The individuals suffering from depression frequently describe their active engagements with the world as characterized by a strongly diminished or depleted ability – everyday activities such as brushing one's teeth, taking a shower, making coffee or cooking a favourite meal, cleaning one's house, etc. have become effortful and demanding; one also does not feel able to perform non-routine actions and activities anymore as one cannot concentrate well, recall or memorize information, etc. In both cases, one would refer to the changes in one's sense of agency in terms of loss of ability to engage with specific activities. The sense of ability, it has been suggested has been neglected in the study of agency (Schmid 2011, 216). In the study of pathology in particular, the focus has been mainly on the experience of ownership or authorship and control of one's actions and thoughts for instance in schizophrenia, addiction, and some neurological conditions. First-person reports of

[133] The passage to follow was administered the code *Running out of time*. Responses that describe the experience of a sudden transition of present to future and time pressure associated with it are: R14UK, Q6B; R30UK, Q6B; R53UK, Q6B; R60UK, Q6B; R66UK, Q6B; R117UK, Q6B; R130UK, Q6B; R134UK, Q6B; R160UK, Q6B; R171UK, Q1B, Q6B; R192UK, Q6B; R200UK, Q6B; R270UK, Q6B; R303UK, Q6B; R308UK, Q5B; R355UK, Q6B; R367UK, Q6B.

depressive experience as discussed throughout this chapter indicate that one might fail to experience oneself as an agent prior to the performance of actions and activities (AG1) and when performing them (AG2) in terms of her experience of ability (AB). These reports indicate that one can feel unable in two ways: By becoming painfully aware of the effortful and demanding character of routine activities that were formerly automatically performed; and by lacking the capacities required to perform non-routine tasks that might generally require deliberation and reflection. In the former case (AB1), what is lost is the pre-reflective experience of situations as soliciting specific responses so that one fails to skilfully engage with these. In the latter case (AB2), diminished capacities present different activities as beyond one's powers and impossible. Both aspects integrate to a unified sense of ability of feeling up to particular actions that shapes how the world is experienced.

Moreover, the experience of two broad kinds of abilities and the changes it undergoes in depression highlight two important aspects of agency that are central to understanding the reflective manifestations of both the experience of agency and alterations in it. On the one hand, with respect to skilful engagement, we automatically both engage and perform these – situations are pre-reflectively experienced as soliciting these and when engaged in them we do not need to reflect or deliberate on their course as well. But as discussed in this chapter, when our skills are disturbed and respectively we do not feel up to performing routine activities, their normative significance remains the sole factor that can move us to engage in them. Respectively, the experience of ability broadly conceived also includes a component of normativity that, particularly in the cases of routine actions, is experienced as solicitations to act.

The second kind of abilities that were the in focus of this chapter are commonly conceived and experienced as required for the performance of various actions and activities that go along with specific implicit or explicit standards of (successful) performance. In this case, experiencing oneself as an agent includes an anticipation and appreciation of both what is required by the task prior to performing it and the experience of one's own performance during the course of the action. Here, again individuals suffering from depression describe their experience of not being able to do various things – they are not able to function, they make mistakes, they cannot perform their professional obligations, etc. What these cases have in common, is that the loss of capacities impedes on how one performs these actions, on what kind of agent one is with respect to these specific actions – one becomes a bad teacher as one fails to attend to the request of their students, for instance. This aspect of the sense of ability, the experience of capacity, highlights another frequently neglected feature of

(the sense of) agency, namely that of its evaluative character and how this relates to how we conceive of ourselves.

So, our sense of ability is the synthesis of our experience of skills (AB1) and capacities (AB2). It shapes how we find ourselves in the world in terms of both being an agent (AG1) and acting (AG2) and encompasses the normative aspects of what moves us to action and how we (we are able to) perform our actions. Experiencing oneself as an agent, thus, encompasses not only a sense of what one is able to do but also of why and how one performs particular actions and how one's performance measures up to certain evaluative standards. These respective normative and evaluative aspects that are described in reports by individuals suffering from depression require further detailed examination in particular with respect to their potential role in therapeutic measures and conceptualizations of depression.

5. Loss of Intersubjectivity and Social Isolation: Loneliness, Shame, and Guilt

In the last two chapters, I focused on how we relate to the world by means of the (1) possibilities the *world* offers and also by means of (2) (the experience of) *our ability to engage with the world*. Another consistent theme in first-person testimonies of depression is that the world their authors find themselves in is not shared with *other* people (e.g. Dorothy Rowe (1987, 7-8) also identifies isolation as a common theme of descriptions of experiencing and living with depression). Sharing a world with others, I am going to suggest in line with phenomenological approaches (e.g. van den Berg 1972/2013; Gallagher, 2001; Fuchs 2015, 2014; Mertens 2011; Ratcliffe 2015; Ratcliffe, Rudell, and Smith 2014; Zahavi 2012), structures how we find ourselves in the world by establishing shared patterns of significance and meaning and engaging in interpersonal interactions. In doing this, I am first going to examine fundamental aspects of sharing a world with other *subjects*, which is the basis of complex interpersonal engagement that characterize our social life.

First-person reports of depressive experience describe an orientation of disconnectedness and alienation from a world shared with others in terms of a loss of a shared perspective and a radical disturbance of intersubjective interactions. The failure to share a world with others transforms it into a realm of solitary existence, in which the gap between oneself and others cannot be bridged and one is confined to a position of being observed and observing others. Occupying a position of intersubjective isolation as opposed to being immersed in second-person interactions, one becomes painfully aware of being a detached self observed by others. Coupled with the (experienced) loss of abilities, this isolation establishes a background orientation of depressive shame and guilt.

Various disturbances of intersubjectivity are at the core of different psychopathological conditions such as for instance schizophrenia (e.g. Fuchs 2015a; Pienkos 2015) and autism (e.g. Gallagher 2004; Fuchs 2015). Unlike these conditions characterized by the experienced loss of common or shared reality, the failure to experience others and oneself as persons (Ratcliffe 2015, 206), and the lack of access to others' subjectivity, what changes in depression is the experience of being related to others. While others are still experienced as subjects and persons, they appear strikingly different from one in terms of their subjective perspective on reality and the world. Subsequently, they present one with a lack of understanding and a sense of fundamental disconnectedness. Naturally, against this

background, one feels lonely, isolated, and not understood, craves re-connecting, or is not moved or enticed to (attempt to) interact with others as described in memoirs and, for instance, in these responses to the DDQ UK:

> My feelings are that no one understands or cares and that is why I am alone. (R323UK, Q1B)
>
> Yes. It seems like everyone is having an amazing time and you're the one missing out. It's so easy to beat yourself up and think there's something wrong with you. It feels like no one else has ever experienced anything like this before, like you're all on your own. (R22UK, Q3B)

Feelings of guilt and shame establish an unbridgeable gap between oneself and others, as well. In these cases, the tacit background of self-awareness reflected in how the world is experienced is replaced by a focus on the own self that appears as inherently flawed and deficient and to some (potentially) harmful to other people:

> feel I am a burden and that the world would be better without me. (R271UK, Q2B)
>
> I feel they [other people] are all achieving something and I am not. (R66UK, Q3B)

These experiences, I am going to suggest, are the result of the failure to establish a second-person perspective. Thereby, one's common tacit self-awareness is replaced by the third-personal experience of one.

Moreover, secondary social isolation or disconnectedness resulting from the social stigmatization of mental illness in general and depression in particular both further reinforces these experiences and directly disturbs one's (moral) agency and personhood and is expressed in experiences of loneliness, shame, and guilt similar or even identical to those associated with underlying changes in intersubjective experience. as reported by authors of depression memoirs and respondents to the DDQ UK. By emphasizing this aspect, I would like to draw attention to the need to study the phenomenology, (social) structure, and impact of stigmatization in particular in view of how it can additionally aggravate and compound experiences of depression. In particular here, I am going to suggest that the examination of wide-spread narratives, which impact how we understand depression and engage with those afflicted with it prevalent in different groups (e.g. individuals suffering from depression, non-depressed individuals, and medical and mental health experts) can inform such study and help in identifying oppressive and detrimental master narratives that impact one's (moral) agency and experience of personhood.

1. An Intersubjectively Shared World

Our everyday life and active engagements with the world are rarely if ever experienced and conceived in isolation from others – we collaborate with others in the course of joint projects, we interact with them within the framework of various social practices, etc. When we encounter others in various settings we first and foremost experience them as creatures endowed with subjective experience, which makes active engagements of this kind possible. But, in particular, when engaged in face-to-face interactions and joint projects with them, their subjective perspective on the world is experienced as shared with one's own, which establishes a background of belonging to a world of shared meaning. I am going to propose that this background of sharedness of subjective experience establishes a fundamental sense of relatedness, which is the basis of experience and interactions in social contexts. In doing this, I am, first, going to review how we come to experience others as subjects endowed with individual yet shared subjectivity from the point of view of phenomenology. In line with Gallagher (2001; 2004; 2008; 2009), Fuchs (2013, 2015), and Zahavi (2011), I am going to propose that in interacting with others we adopt a (shared) second-perspective, which makes the co-constitution and ultimately the sense of inhabiting a shared world possible. In depression, the disturbance of a second-person perspective places one in a position of solitary detached observation instead of embeddedness in a shared world.

1.1. Shared Individual Subjectivity

Intersubjective interactions are commonly viewed as based on an empathic understanding of others in the form of conceptual theoretical knowledge (e.g. Baron Cohen, Leslie and Frith 1985), simulation (e.g. Shanton and Goldman 2010), or embodied pre-conceptual understanding of others (Gallagher 2001, 2008). The discussion I am embarking upon here is not going to argue for the nature of the processes involved in intersubjective interactions, the developmental pathway of the capacities required for them, and the implications of developmental disturbances as traditionally discussed in the field of social cognition[134]. Individuals suffering from depression do indeed describe a radically altered way of experiencing and engaging with others but these are not based on disturbances in the understanding or simulation of other minds. Unlike in cases of autism and schizophrenia (e.g. Gallagher, 2004; Fuchs 2015; Fuchs 2015a; Pienkos 2015; Ratcliffe 2015; Ratcliffe et al.

[134] See Barlassina and Gordon (2017) for a detailed overview of the simulationist view of mind reading and folk psychology, Currie (1996) for a discussion of theory-theory, simulation theory, and disturbances of mindreading in autism; Goldman (1992) on a defence of a simulationist view of mindreading; Gallagher (2001) on a critical discussion of theory-theory and simulation theory and an overview of a perceptual account of social cognition; and Gallagher (2004) on a discussion of interpersonal impairments in autism.

2014), the changes in depression do not disrupt the possibility of experiencing others as minded, conscious, and intentional creatures. While others are still encountered as subjects, I am going to propose here, the fundamental bond or connection to them one used to have has been severed, so that they now appear alienated, unfamiliar, and lacking understanding.

The majority of the studies of intersubjectivity and social cognition do not traditionally focus on qualitative changes of this kind (notable exceptions are Ratcliffe et al. 2014; Ratcliffe 2015a; Earnshaw 2011; Fuchs 2014) and the debates revolve mainly around the nature of the access we have to other minds, the capabilities required for successful interaction with others, and their development in (early) childhood. Phenomenological inquiry into intersubjectivity, on the contrary, offers detailed and insightful analysis of the qualitative nature and structure of the experience of others, the interactions with them, and how others impact the mode of finding oneself in the world. As suggested by van den Berg (1972/2013, 65-71) how we experience the world changes with respect to whom we experience it together with and radical changes in experiencing and interacting with others are at the core of psychopathology in general (van den Berg 1972/2013, 103-124). The co-constitutive role others play in how we experience the world is also something we are familiar with in the absence of pathological changes as well. Consider, for instance, this case of a radical transformation of the situation one is in, which occurs upon interacting with another person. You are at a lively dinner party with nice food and music. The atmosphere there is very relaxed and welcoming, although you do not know many of the other guests. When seated, you enter a conversation with the guest sitting next to you and it quickly moves to the discussion of current social and political developments. But then you find out that your conversational partner espouses social and political views radically different from your own. The perspective she has is not merely unreasonable, unjustified, and morally questionable, but rather completely alien to you so that you suddenly have the feeling to be talking about different worlds. Subsequently, a feeling of alienation and disconnectedness settles upon you – you feel completely unrelated to your conversational partner, feel misunderstood, and also fail to comprehend how and why she espouses these values. How you can proceed interacting with her is puzzling to you – if she sees the current social and political events in this way that radically differs from your perspective, how can you establish any 'common ground' with her. You hesitate, wish to avoid further puzzling and annoying exchanges and are not interested in conversing with her. But this incident can also transform how the formerly enjoyable party appears to you. You suddenly become aware of the crowd of chit-chatting people surrounding you and at once, they appear loud and annoying. You do not feel part of this crowd anymore – this formerly pleasant occasion has turned into a gathering of loud-

speaking and laughing strangers. The noises they produce are too loud and what they say does not reach you. You start feeling as a detached observer of a crowd of random strangers.

Here, the occasional interaction with a chance encounter has transformed your world from one of embeddedness to one of alienation and disconnectedness. By encountering this radically different foreign perspective, you seem to have lost a sense of sharing the meaning of the events you were talking about. What this example illustrates is that on the one hand interacting with others can influence the basic sense of finding oneself in the world and on the other that even in the absence of a conscious realization or expectation of shared perspective, in this case shared political and social values and beliefs, we engage in interactions with others by anticipating at least basic similarities in how we experience the world. Thereby, prior to entering the conversation, you encountered the person sitting next to you at the dinner table (and the others at the party) as a potential conversational partner – as capable of conversing, as possibly interested in conversing about specific topics, as capable of comprehending what you are saying, as inhabiting the same reality, and as possibly sharing at least to some extend[135] a subjective perspective on the world. But upon encountering her radically different views, this background was disturbed – you could not find a 'common ground', which both made further interactions impossible or undesirable and transformed a background of sharedness and relatedness into one of alienation and disconnection. Fundamental intersubjectivity[136], I propose, is the general background orientation of basic relatedness to others in terms of a shared subjective perspective on the world[137], which here was shattered by encountering a radically different and irreconcilable

[135] Of course, we do not always expect others to have a subjective perspective on the world that is identical with ours. Rather, what we share in a common subjective perspective are fundamental patterns of meaning and significance – that the entity I call a 'table' is also a table for you, that at least some of our values are shared (for example moral values). I think that radically different social and political views illustrate exactly this aspect of 'induced' alienation upon encountering that how we conceive of political and social events for instance has nothing in common with what the other. Subsequently, we realize that we cannot establish a common perspective.

[136] Here, I prefer to use the more specific term 'fundamental intersubjectivity' instead of the more frequently deployed 'intersubjectivity' for several reasons. First, as indicated at the beginning of this chapter, I propose to distinguish between two aspects of how we experience and engage with others, namely as subjects and as persons. I will elucidate the difference between the intersubjective and the interpersonal in detail in Section 3.1 of this chapter. Second, the term 'primary intersubjectivity' (Threvarthen 1979 as in Gallagher and Zahavi 2012, 208-210) is commonly adopted in recent phenomenological accounts. As I am going to engage in a brief discussion of the development of (fundamental) intersubjectivity, I am going to review it in what follows shortly. In a nutshell, primary intersubjectivity captures the perception of others' intentions and feelings in their bodily, posture, facial expression, movements, etc. (Gallagher and Zahavi 2012, 208-210). Similarly to primary intersubjectivity, what I refer to as 'fundamental intersubjectivity' is the embodied and enactive experience of others as creatures endowed with specific subjectivity, which is individual yet common across subjects. Thereby, my emphasis lies on the experience of commonality or similarity of the individual subjectivity rather than on its particular contents.

[137] Alfred Schutz (1976, 24-27) refers to the shared aspect of individual subjectivity a ""pure" we-relation". It presents others as sharing a subjective perspective on reality, in particular when they are present in the same context or situation as one is. Fundamental intersubjectivity, similarly to the direct we-relation establishes a background of shared 'objective' reality, which enables practical interactions with others: "I am inclined […] to

foreign subjective perspective. Sharing a (subjective) perspective with others, thus, makes the co-constitution of meaning in the course of interacting with others possible.

Participatory sense-making (Gallagher 2009) or the co-constitution of meaning in intersubjective interactions occurs from a second-perspective, which is characteristic for our engagements with others (Fuchs 2013a). Being engaged in face-to-face interactions, the counterparts establish a common (pragmatic) situation, which presents (at least) this local context as shared. Respectively, in the course of active engagement, they establish patterns of shared meaning, which ground a *shared* second-person perspective of commonality. Engaging with the other within a shared second-person perspective establishes a perspectival 'we', which alternates between my experience of the other as a 'you' and the other's experience of me as a 'you'. Thereby, we are also pre-reflectively aware the other's behaviour as essentially meaningful, expressive, and goal-directed and of being perceived by the other in this way. In second-person interactions with other subjects, we co-experience the specific situation (Fuchs 2013a, 657). The current situation is experienced not only as real by both of us but also as having the same patterns of (pragmatic) significance. Going back to our dinner-party example, we approached the guest sitting next to us within the framework of shared yet individual subjectivity, which presented for instance current social and political events first and foremost as a potential topic. But upon engaging in a detailed conversation, we were struck by our failure to maintain the agreement or commonality of the particular significance these have. The shared second-person perspective of a 'we' that came along with the anticipation of shared meaning was suddenly shattered – event A is for you a breach of fundamental human rights, while for your conversational partner it is an appropriate means for establishing security. Subsequently, you are not part of a shared 'we' any longer – your conversational partner became a detached and unrelated subject who seems to be 'living in a different world'. Thereby, (a) the background experience of sharing a subjective perspective with the other was disturbed and (b) further active engagements were obstructed as the result of a breakdown of the second-person perspective primary for intersubjective interactions.

In depression, I am going to suggest, a shared second-person perspective breaks down, which renders intersubjective and interpersonal interactions impossible. Finding

assign to fellow human beings a world which corresponds to the world as I experience it myself. In the We-relation I do so with infinitely greater confidence because […] the world within the reach of my fellow-man coincides with mine. I may not only assume that the table in front of me is the same table which is in front of you but also that your experiences of this table correspond to mine. […] The community of environment and the sharing of experiences in the We-relation bestows upon the world within the reach of our experience its intersubjective, social character. It is not my environment nor your environment nor even the two added; it is an intersubjective world within the reach of our common experience. In this common experience the intersubjective character of the world in general both originates and is continuously confirmed" (Schutz 1976, 31).

themselves in a radically different world, individuals suffering with depression fail to establish or maintain a second-perspective of shared subjective experience with others, which culminates in feelings of loneliness, tendencies towards isolation, irritability and anger, shame, and guilt. In developing my proposal, I am, first, going to examine existing phenomenological accounts of intersubjectivity and the primacy of a second-person perspective. Then, I am going to explain how fundamental intersubjectivity as the tacit background of relatedness and familiarity with other subjects is established by engaging in a shared second-person perspective, which presents other subjects as the bearers of shared yet individual subjectivity. In the next section, I am going to present the alterations it undergoes in depression as described in first-person accounts of the disorder.

1.2. Shared Subjectivity and the Second-person Perspective

It has been suggested that, from an early age we perceive others as creatures endowed with a special sort of mental life, which makes interacting with them in particular ways possible (Gallagher 2001; Gallagher 2008; Gallagher and Hutto 2008; Gallagher and Zahavi 2012; Zahavi 2011;). Although one does not have the same sort of access to the inner life of others, we are frequently somewhat familiar with how others feel, what they think, what they intend, and the like especially for the purposes of interacting with them[138]. This pre-theoretical and pre-reflective understanding is made possible by the development of various capacities. At an initial stage of primary intersubjectivity (Trevarthen 1979), infants possess „embodied, sensory-motor (emotion-informed) capabilities that enable us to perceive the intentions of others" (Gallagher 2004, 209). The innate or early developing capacities like gaze-following, perception of goal-related movements, of meaning and emotion in movement and bodily posture underlie this pre-theoretical knowledge of others as intentional, goal-directed subjects (Gallagher 2001, 90).

In a subsequent developmental step, beginning around the first year (Gallagher 2004, 209), infants develop secondary intersubjectivity, which enables them "to perceive others as intentional agents whose actions and mutual interactions are purposeful in pragmatic contexts. In the course of cooperative actions, they also experience themselves as being perceived as intentional agents by others, in a common social space that gradually assumes a

[138] The access we have to others' subjectivity differs greatly from that we have to ours. Although we might share a common perspective, we can never enjoy the same access to the other's subjective experience, so that the second-person perspective always comes in a first-personal mode of direct experience. This eliminability of the first-person access to (inter-)subjective experience has been acknowledged by Merleau-Ponty as well and termed 'local solipsism' (for an insightful review of variations in phenomenological accounts of intersubjectivity, see Koo 2016).

symbolic structure" (Fuchs 2015, 194). By expanding intersubjective interactions and including objects in them, infants come to enter the realm of shared meaning in particular in pragmatic contexts (Fuchs 2015, 194; Gallagher 2004, 207; Gallagher and Zahavi 2012, 210-211).

In addition, tertiary intersubjectivity enables the anticipation and detection of potential individual differences across individual subjective perspectives and thereby makes a transition between a first-person 'I', a third-person 'he' or 'she', and second-person 'you' or 'we' possible. By being able to adopt a meta-perspective on oneself and the other, intersubjective experience and interactions move between an ego-centric and an allo-centric perspective without losing one's self-awareness in a shared second-person perspective, for instance (Fuchs 2015, 195). Narrative competence also plays a crucial role here. By being exposed to narratives, we come to understand and inhabit a world of common meaning. In narratives we encounter others, their subjective experience, mental life, and how they act in the context of various pragmatic circumstances (Gallagher and Zahavi 2012, 215). Consequently, in cases of disruptions of shared meaning such as in psychosis (Ratcliffe 2015) narrative competence is also severely compromised (e.g. Gallagher 2007; Saavedra, Cubero, and Crawford 2009).

Encountering others as the bearers of individual yet shared subjectivity is at the basis of face-to-face interactions within the framework of a shared second-person perspective, which characterize our everyday life. The second-person perspective, according to Fuchs (2013a, 658) is "the intersubjective, participant or co-experiencing perspective, referring to situations of reciprocal interaction that are characterized by some form of mutual relatedness and coupling of the partners". Thus, within a shared second-perspective, others are encountered as co-creators of the patterns of meaning in the world. In terms of the specific interaction one is engaged in and with respect to the particular pragmatic contexts, for instance, various entities acquire shared significance. In contrast, the first- and third-person perspectives are the isolated stances of respectively individual isolated subjective experience and detached observation of others (Fuchs 2013a, 658). Thomas Fuchs (2013a, 658-661) further distinguishes between implicit and explicit modes of each of the three perspectives. The former is a basic pre-reflective awareness of oneself and of the other and the latter is an explicit understanding of perspectives as such. The awareness of different perspectives as such makes it possible to dissociate from a disturbed second-perspective and revert to a first- or third-person one. If you consider the example from the previous sub-section, the background of fundamental intersubjectivity presented the other as a bearer of shared yet individual subjectivity. So, against this background, you engaged in a conversation with her

within a second-person perspective of co-experiencing and face-to-face active engagement. But in the course of the conversation, it became apparent to you that you fail to establish common patterns of meaning in the shared situation – while you reacted with indignation to the recent political manipulations, she considered these appropriate measures that had to be taken. Subsequently, the shared second-person perspective on this event, which framed your interaction, was disturbed. In dismay, you retreat to observing, respectively, listening to, your conversational partner and feel alienated from her. The shared second-person perspective of immersed face-to-face interaction is then suddenly replaced by that of a detached observation and alienation. The background sense of fundamental intersubjective relatedness by means of sharing a common subjective perspective was thereby shattered by the encounter of a radically different perspective.

Fundamental intersubjectivity or the background of relatedness in terms of shared yet individual subjective perspective can be understood as the achievement of the development of primary, secondary, and tertiary subjectivity as it incorporates aspects of all three: (a) an experience of others as endowed with specific subjectivity, which is manifested in posture, facial expression, etc. Through the participation in intersubjective interactions in a wide range of pragmatic contexts, (b) others' actions are experienced as purposeful and meaningful, one enters the realm of shared (pragmatic) meaning and starts establishing a second-person perspective, in which the (pragmatic) significance of entities is shared by different subjects. In the final step of the development of fundamental intersubjectivity, (c) the ability to switch between a first-, second-, and third-person perspective enables implicit self-awareness in a shared second-person perspective and the anticipation of potential individual differences within a shared perspective. Thereby, when encountering others and interacting with them, we first and foremost experience them as the bearers of subjective experience, which we share, in particular with respect to pragmatic contexts.

In non-pathological instances, like the example we considered earlier, the background of sharing a yet individual perspective can be 'locally' restricted to specific realms or domains – in this case, you fail to agree on social and political issues. Although this establishes a background or disconnectedness and unrelatedness, you might upon observation from a third-person perspective discover similarities among you and your conversational partner in other domains, say your views on what works of literature you both find enjoyable. So, you can reconnect with the same person in particular in the context of engaging in small talk at the dinner table. But in some cases, you might be repeatedly or constantly confronted with radically different individual subjective perspective. If, for instance, at this dinner party there is a public talk about current social and political events

from a radically different perspective and everyone attending expressed their agreement with it, you would eventually feel unrelated and disconnected from everyone at the party.

In the section to follow, I am going to propose that the experiences of loneliness in the form of not being understood or cared for by others are expressive of a disturbed fundamental intersubjectivity, which establish a background orientation of interpersonal disconnectedness. This disturbance is brought about by experiencing others as the bearers of a radically different individual subjectivity, which precludes establishing a shared second-person perspective[139]. Failing to engage with others within a second-person perspective, moreover, one is confined to being a detached observer and the object of third-personal observation. This disembeddedness from a shared second-personal world, I am going to suggest, also directly alters one's self-awareness: instead of being tacitly self-aware in terms of being engaged in face-to-face second-personal interactions, one becomes explicitly aware of oneself in terms of being the object of others' subjective experience. This foreign third-personal self-awareness constitutes, I am going to propose, background orientations of depressive shame and guilt frequently described in the responses to the DDQ UK and memoirs of depression.

1.3. Habitual Trust

Matthew Ratcliffe (Ratcliffe 2015, 122-127; 201-229; Ratcliffe et al. 2014;) has recognized the central constitutive and developmental role of intersubjective and interpersonal interactions in psychopathology such as psychotic states (in schizophrenia) and depression as well. He argues (Ratcliffe 2015; Ratcliffe, 2015a) that intersubjective and interpersonal interactions play both a developmental and a constitutive role by establishing a background orientation of basic or habitual trust, which determines the possible experiences we are subjected to. Inhabiting an orientation of basic trust, we find ourselves in a reality shared with others who are experienced as "well-meaning and competent" (Ratcliffe 2015a, 177). Subsequently, we engage in particular interactions with them against this background of trust – we encounter

[139] It is important to note here that in these cases one does not fail to encounter others as subjects. While they are still experienced as conscious, intentional, and goal-directed beings, their perspective on the world differs radically from one's own. It is not the case that it is inaccessible, rather that one experiences it as radically different and fails to establish a sense of relatedness or sharedness. Depression, thereby, does not involve a deficit in mind-reading, which precludes the access to other minds. Rather it is characterized by a loss or fundamental relatedness to others, which is constituted by severe disturbances of second-person interactions. The world of the depressed is experienced as a solitary realm of suffering, which substantially differs from that of others. Against this background, others are encountered as unconcerned, lacking understanding, and distant. Respectively, at least some of the individuals suffering from depression report of actively avoiding interactions with them not because they fail to 'read their minds' but rather because they are encountered as bearers as foreign and radically different subjective perspective.

them first and foremost as (epistemically) reliable and not threatening. This orientation of basic trust is specific not only with respect to our interpersonal practices, though. Rather, both the formation of beliefs and their content are shaped by the style of interpersonal experience, which provide us with a sense of shared reality, knowledge, and practice (Ratcliffe 2015a, 177). Thus, our experience is co-constituted by our interactions with others and it can undergo radical alterations following prolonged isolation or traumatic experience (Guenther 2013; Ratcliffe 2015; Ratcliffe 2015a).

Depression in particular, according to Ratcliffe (2015, 201-229), is characterized by different variants of estrangement that restrict or even obliterate the possibilities to relate to others. He analyses the changes in the domain of intersubjective and interpersonal interactions in terms of the "lack of access to distinctively interpersonal kinds of possibility" (Ratcliffe 2015, 203), which are inseparable from how the world and the own self are experienced. The characteristic loss of self-transformative possibilities (Ratcliffe 2015, 218-229) not only establishes a background of disconnectedness but also transforms one's current situation into a permanent predicament that cannot potentially be subjected to any change[140]. Against a background of loss of habitual trust, relating to others, being exposed to their influence is not possible anymore, which culminates in the sense of an inescapable solitary predicament (Ratciffe 2015, 218-229). Subsequently, one either experiences others and the world in general as hostile and threatening, or is not enticed to engage in interactions with them. In both cases, the loss of self-transformative possibilities is acutely experienced.

While I agree with Ratcliffe (2015) that the world of depression is characterized by feelings of estrangement, I depart from his analysis of these in several significant respects. First, I conceive of the experience and interaction with others as one of the main aspects of establishing one's embeddedness in the world, namely by means of sharing it with others by establishing both fundamental and specific relations with them. Based on the descriptions of changes in how others are experienced and engaged with, I suggest that the alienation and disconnectedness reported in them occur in two main domains – at a fundamental level of

[140] Experiences of loss of prospects (for a significant future), I suggested in Chapter 3 "Loss of possibility", are manifestations of a background orientation of loss of hope. By adopting a wider notion of possibility and arguing for the constitutive role of intersubjective experiences and interactions in the experience of possibility, Ratcliffe (2015) can account for the experienced loss of relatedness to others as a loss of a particular class of possibilities, namely those to relate to others. My focus on the changes in the experience and interactions with others, while emphasizing their co-constitutive role in subjective experience, revolve around the loss of what can be identified as specifically intersubjective or distinctive of encountering subjects, namely a sense of sharing a common perspective on the world, of sharing subjective experience of the world. Focusing on this specific relation that shapes how we find ourselves in the world, it is characterized by alienation, lack of understanding and familiarity, and loss of security. These, of course, by adopting a wider notion of possibility, can be conceived as possibilities or lack of some kinds of such, which now determine affective experience, thought, and behaviour. In this form, though, they are not compatible with the considerations on a narrower notion of possibility and agency that were introduced in discussed in detail in Chapter 3 and Chapter 4.

finding oneself in an intersubjectively shared world; and a more complex level of specific (inter-)personal practices, which impact the experience and understanding of the own personhood, personal identity, and moral agency. Distinguishing between different ways to relate and engage with others, namely by being part of an intersubjectively and an interpersonally shared world, I, second, attempt to identify more complex effects of *social isolation*, which results from the stigmatization of mental illness in general and depression in particular. While this, undoubtedly, also shapes the possibilities for relating to others one experiences, it presents us with a complex socially and culturally induced *second-order disconnectedness* that is not only an effect of how individuals suffering with depression are oppressed or misunderstood oppressed or misunderstood, etc. but also closely resembles the phenomena of loss of trust (Rattcliffe 2015, 122-127; 218-229; 2015a) and loss of fundamental intersubjectivity. The phenomenology of this latter form of disconnectedness and the social and cultural mechanisms that realize it warrant further study and analysis and have the potential to inform applied measures that are targeted at the alleviation and prevention of stigmatization, oppression, and social isolation.

2. Loss of an Intersubjectively Shared World

The experiences of loss of fundamental relatedness in depression, I am going to suggest, are expressive of a radical disturbance of the background of sharedness of subjective perspective. While others are still encountered as intentional and goal-oriented subjects, they have become peculiarly distant and unrelated in terms of the radical differences between their perspective on the world and one's own. Against this background, the world is transformed into a realm of solitary existence populated by foreign and unrelated subjects who one fails to relate to. The loss of the sense of relatedness by means of a shared yet individual perspective makes establishing and sustaining a shared second-person perspective not possible anymore, which confines one to a position of detached contemplation and isolation.

2.1. A Predicament of Lonely Existence

As many as 59 (48.36%) responses to the DDQ UK describe a lonely and isolated way of finding oneself in the world that is manifested in various reflective experiences and action or behavioural tendencies. Commonly most of us most of the time encounter others as fellow-subjects who share a similar subjective perspective on the world as introduced above. This enables us to enter interactional patterns with them, which are characterized by a second-perspective of participatory sense-making. In depression, the experiences of loneliness and

isolation frequently refer to feeling not understood or cared for by others. Instead of related co-experiencers, others appear as having an essentially different perspective on the world, which makes understanding and engaging with the individual suffering from depression not possible anymore as described by 16 (13.11%) of the respondents to the DDQ UK:[141]

> When I am depressed the main emotion that I feel is loneliness. I feel like I have no one I can turn to, and this isolation makes me feel trapped. […] I feel lost and completely separate from the world, and it feels like no one has ever experienced what I'm going through before. (R292UK, Q1B)

The world of the depressed is one of torment and suffering – it is devoid of possibilities and prospects and she feels unable to carry out even the most basic tasks of everyday living. In this dark world of loss and inability, others, in contrast to the one afflicted with depression, still seem to be able to act, pursue their practical projects, and experience happiness and pleasure. To some, they are first and foremost encountered as finding themselves in a world of radically different patterns of meaning, which make this possible as for example this respondent to the DDQ writes:

> Somewhat. I will see them [others] laughing, my friends and family, and I just think 'How can they be so happy and carefree? (R51UK, Q3B)

Thereby, the second-person perspective one used to be engaged in when interacting with others is radically disturbed. Analogously to the example with the dinner party introduced at the beginning of this chapter, what and why others value appears incomprehensible and irreconcilable with the way of being of the depressed individual. Subsequently, others, instead of co-creators of shared meaning, and thus, potentially understanding how one finds herself in the world, now appear unable to comprehend one's suffering and (emotional torment):

> Everyone seems so annoyingly normal, happy, able to cope, unaware of the turmoil that is filling my room, my head, my life, my world. (R253UK, Q3B)

Responses to the DDQ UK like the one introduced above seem at first glance to attribute the failure to establish and maintain a shared second-person perspective explicitly and exclusively to the radical changes in experience in general associated with depression. Consequently, some might argue that as the world of anyone suffering from a long-term (mental) illness is radically altered and the experiences of loss of relatedness and connectedness I am concerned with here are not characteristic of depression but rather the 'by-products' or results of being afflicted with a serious illness, which radically transforms various aspects of one's experience and has a profound impact on one's life. Although,

[141] The three excerpts from the DDQ to follow were administered the code *Others do not understand*. Respondents describing experiences of loneliness and isolation in these terms are: R14UK, Q3B; R22UK, Q3B; R30UK, Q2B; R51UK, Q3B; R115UK, Q1B, Q3B; R118UK, Q3B; R137UK, Q3B; R153UK, Q3B; R169UK, Q3B; R186UK, Q3B; R253UK, Q3B; R288UK, Q1B; R292UK, Q1B; R323UK, Q1B; R334UK, Q3B; R366UK, Q3B. See also Wurtzel (1995, 15) for a description of similar experiences.

undoubtedly, experiences of social isolation and lack of understanding are associated with probably all long-term pathological conditions, the disturbances of fundamental intersubjectivity are integral to depression and differ radically from cases of loneliness and isolation associated with other disorders. The overall changes in experience during a depressive episode cannot be discerned from an 'intact', 'common' perspective on the world. While the individual suffering with depression is aware that the world has changed in terms of being subjected to a painful torment, this change is commonly not attributed to the disorder – the failure to relate to others in terms of establishing or maintaining a second-person perspective is an integral part of their illness experience. The world devoid of possibilities and the loss of ability in depression constitute a radically different way of finding oneself in the world, which cannot be shared with others to begin with. And this change is prior to experiences of more specific social disconnectedness, which are embedded in social, cultural, and personal aspects of illness experience. For instance, while in some conditions these might be related to restrictions imposed by the illness itself (for instance, if one requires pro-longed hospitalization, or is incapacitated and cannot participate in social life in the same way as prior to the illness, etc.) or by its social stigmatization, the first-person descriptions of depressive experience refer to others first and foremost as alien and disconnected. The radical transformations of the world of the depressed make it impossible to maintain and establish a very fundamental relatedness of experiencing a common world – others inhabit one of meaning of significance, a world offering prospects and hope, and they also are able to actively participate in it. Subsequently, they also respond (affectively) in a markedly different way – they can be happy, can make plans, enjoy themselves, etc. The individual suffering from depression, in contrast, cannot make sense of how and why they do it, they are utterly alien and distant in terms of how they find themselves in the world.

Isolation and loss of connectedness to others is both a symptom and a consequence of depression (Karp 1996, 26). Being not understood by others and avoided because one suffers from an illness others do not understand or misrepresent directly impacts further socially and culturally constructed aspects of self-understanding and -experience such as personhood, personal identity, and (moral) agency. Thereby, this form of social disconnectedness, is more akin to stigmatization and oppression rather than to a disturbance of fundamental pre-reflective relatedness. In Section 3 of this chapter, I am going to suggest that social isolation or second-order disconnectedness is based on misguided narratives of mental illness in general and depression in particular. Although it operates at a different level of experience and self-understanding, it can induce experiences of loneliness and alienation similar to the disturbances of fundamental intersubjectivity. These, I propose, are still in need

of detailed study both with respect to their phenomenology and social and cultural aspects and offer the potential for the construction of measures that can prevent or at least to some respects alleviate social isolation. And in doing this we can come one step closer to avoiding various harmful effects on self-understanding and experience.

The failure to engage with others from a second-person perspective can disclose in particular those one used to have a close relationship with (such as close friends, family members, loved ones, partners, etc.), as not concerned about one's well-being or emotionally invested as reported in 27 (22.13%) of the responses to the DDQ UK. Having formerly enjoyed a close relationship commonly characterised by emotional investment, interest, and well-meaning concern, the current alienation is most noticeable in terms of the absence of these intersubjective affections (see also Solomon 2001, 45 and Thompson 1995, 53 who repport of similar experiences):[142]

> They are, after a fashion. The closer the relationship, the less this is true for me.
>
> Typically people are more distant, less caring and generally more unpleasant when I'm depressed. (R307UK, Q3B)
>
> I could be surrounded by friends, which I was in reality, but still feel ridiculously lonely and like no one cared about me at all. (R22UK, Q2B)

Although some might be aware of the 'irrationality' or 'inadequacy' of this experience, during a depressive episode they are still succumbed by it and encounter close ones as lacking concern and not caring:

> Generally my friends don't seem different although sometimes I can doubt whether they really have my best interests at heart and whether they do actually care, which is quite irrational. (R334UK, Q3B)

The lack of 'common ground' or shared perspective can also be associated with a general retreat from interactions with others that are reported in 19 (15.57%) of the responses to the DDQ UK. In at least some of these cases, one describes experiences of not being moved or enticed to engage with others[143] as they fail to offer possibilities for relating to because one

[142] The three passages to follow were administered the code *Others do not care*. Passage describing the experience of others as not concerned with one or not caring about one are: R8UK, Q3B; R22UK, Q2B, Q3B; R24UK, Q3B; R41UK, Q3B; R51UK, Q2B; R61UK, Q3B; R65UK, Q2B, Q3B; R93UK, Q3B; R112UK, Q3B; R134UK, Q3B; R153UK, Q3B; R155UK, Q3B; R186UK, Q1B; R200UK, Q8B; R218UK, Q3B; R269UK, Q1B; R288UK, Q3B; R303UK, Q3B; R307UK, Q3B; R323UK, Q1B, Q2B, Q3B; R331UK, Q1B; R334UK, Q3B; R341UK, Q3B; R349UK, Q5B; R357UK, Q1B; R367UK, Q3B; R371UK, Q2B, Q3B.

[143] Ratcliffe (2015; Ratcliffe et al. 2014) considers the lack of enticement for engaging in intersubjective interactions as expressive of the loss of fundamental trust, which places one "[…] in a world from which the possibility of meaningful, progressive, goal-directed activity is absent" (Ratcliffe et al. 2014, 7). Respectively, one is not moved to interact with others as relating to them is experienced as not possible anymore. The loss of trust presents others as threatening and hostile, so one tends to avoid them and thereby further alienates oneself from them (Ratcliffe 2015, 221). The tendencies towards withdrawal and isolation in depression, I suggest, can be expressive of two major changes in how others are experienced. Here, I focus on the loss of sharedness and relatedness established by adopting a second-person perspective. In the section to follow, I am going to focus on the experiences of being subjected to social stigmatization that are associated with

radically differs from them and feels distant and alienated (Hatfield 2008, 234; Smith 1999, 146, and Wurtzel 1996, 96-97 also describe tendencies towards withdrawal from social interactions)[144]:

> Yes I do think some people do seem different when I'm depressed – it's harder to relate to them and they can seem a bit heartless because of this. (R313UK, Q3B)

Moreover, as they might appear also lacking understanding and concern for one, they are disclosed as not directly ill-meaning or threatening, but rather as essentially detached observers who fail to understand or be interested in establishing a relation or a common perspective with the individual suffering from depression. To some, withdrawing from the contact with others can be more closely related to their lack of support and understanding during depressive episodes in particular.

On some occasions, the lack of enticement for intersubjective interactions can transform these into burdensome duties. Nevertheless, not being actively sought out or approached by others can be related to feeling left out or neglected as explicitly pointed out by 4 (3.28%) of the respondents to the DDQ UK. Moreover, this general lack of interest in intersubjective interactions can in some cases be paired with a wish or desire to re-establish relatedness and reconnect with people. These opposing experiences capture one in a vicious cycle of deliberate isolation, acute loneliness, and a craving to establish one's belonging to a shared world by engaging with others. The conflicting tendencies might subsequently make one feel trapped and conflicted in particular with respect to intersubjective interactions as described in this passage (Danquah 1998, 253 and Wurtzel 1995, 107 also describe experiences of feeling left out, ignored, or rejected by others and a desire to re-establish relatedness with them):

> I can become very clingy and over-reliant on people, particularly my boyfriend, and fear that without him I'll somehow disappear[145].
>
> Seeing people becomes a huge chore, so I avoid friends, but then get upset when I'm not invited to things, feeling rejected and left out[146]. (R21UK, Q3B)

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disturbances of interpersonal practices and in some cases are closely associated with patterns of avoidance of interpersonal interactions.

[144] The excerpt to follow was administered the code *Avoiding others*. Responses describing tendencies towards withdrawing from interactions with others, avoiding social occasions based on a loss of fundamental intersubjectivity are: R21UK, Q3B; R22UK, Q1B; R47UK, Q3B; R84UK, Q3B; R105UK, Q1B; R115UK, Q6B; R124UK, Q5B; R145UK, Q3B; R147UK, Q3B; R157UK, Q1B; R162UK, Q3B; R186UK, Q1B; R218UK, Q3B; R219UK, Q3B; R308UK, Q3B, Q5B; R311UK, Q3B; R313UK, Q3B; R323UK, Q1B; R343UK, Q1B.

[145] This passage was administered the code *Craving contact*. Further passage, which describe the desire to interact with others are: R21UK, Q3B; R28UK, Q1B; R85UK, Q3B; R112UK, Q1B.

[146] This passage was administered the code *Avoiding others*.

The failure to establish a second-person perspective in particular when interacting with others can also be experienced as inability or diminished performance in social situations. Thus, at the prospect of such, one might feel not up to the task of interacting with others rather than not feeling enticed to do it as described by 7 (5.74%) of the respondents to the DDQ UK[147] and authors of memoirs (e.g. Styron 1989, 45;):

> unable to socailise
>
> not able to answer the phone
>
> only meet people out of my house so that I am in control (R115UK, Q1B)

In these cses, the radical disturbances of the tacit background of a shared perspective on the world makes the engagement in everyday social practices such as conversing with others at a social gathering, making appointments, meeting friends, etc. appear beyond one's means. Respectively one feels unable to automatically and effortlessly engage in these so that one subsequently either actively avoids social situations or in some cases interprets this inability as a character trait or personal characteristic:

> Started when I was very young. Didn't understand it. Never mentioned it to anyone. Believed myself to be anti social and just 'different'. When I felt bad at this time of my life I was very withdrawn, couldn't handle social situations, didn't want to talk to anyone, when I did talk to people I was smiley and positive. (R161UK, Q1B)

The disturbance of the second-person perspective transforms the world into a realm of solitary existence. One fails to feel related or connected to others who appear distant, uncaring, and not understanding. One feels observed by them rather than engaged in a meaningful interaction or adopts an observer position with respect to them. Shifting between an observed and observer perspective (Fuchs 2013a), one is not interested or feels unable to actively engage with others, which fosters active tendencies towards avoiding occasions for intersubjective interactions, withdrawal, and isolation from active social life. This intensifies the feelings of loneliness and disconnectedness further.

2.2. Anger, Impatience, and Irritability

When describing how others are experienced and engaged with, some of the responses to the DDQ UK refer to them as being (more) irritating and frustrating and of oneself reacting with less patience to them[148] and being angered either by a specific state of affairs, another

[147] The two passages to follow were administered the code *Inability to socialize*. Further excerpts describing the experience of not being able to interact with others are: R30UK, Q5B; R115UK, Q1B; R117UK, Q5B, Q7B; R161UK, Q1B; R212UK, Q5B; R224UK, Q1B; R361UK, Q5B.

[148] As established by Ratcliffe (2015, 29), published first-person accounts of the experience of depression include less if any descriptions of experiencing others as irritating, of being less patient with them, etc. (e.g. Solomon 2001, 47; Thompson 1995, 37, 56). Under the influence of what affective responses and attitudes

person, or without an apparent reason. Subsequently, one is also more likely to actively avoid possible interactions with others as these are irritating and straining. Failing to establish a shared second-person perspective, the foreign perspective is experienced not only as radically different but also as contrasting and opposing one's own and and this (seemingly) irreconcilable discrepancy may in some cases establish an orientation of hostility, anger and irritability that is described by 45 (36.89%) of the respondents to the DDQ UK in its various manifestations.

The individual suffering from depression who finds herself in a world devoid of significant possibilities for change is subjected to overwhelming feelings of despair, which colour her affective response to everything around her. To her, then, how others might lose specific hopes, for instance, can seem utterly incomprehensible and inappropriate because finding herself in a world devoid of all prospects makes others' hoping seem misguided or unjustified. Thus, others' radically different perspective on the world, which also provides the basis for their seemingly inappropriate or disproportionate affective experiences might for some be associated with a general irritability and impatience, which are described in 34 (27.87%) of the responses to the DDQ UK[149]:

> No but I have no patience for them and their pitiful bullshit, having dramas over the stupidest little things, if that's all their problems are they should think themselves lucky and shut the fuck up. (R89UK, Q3B)

Others seem to be concerned only or mainly with the trivial aspects of life rather than with what is essential according to the one afflicted with depression. Their pre-occupation with everyday matters does not seem reasonable or appropriate and this discrepancy can in some cases be experienced as frustrating but not infuriating discrepancy in contrast the response quoted above:

> I get a lot more irritated with them when I'm depressed, I can't be bothered to talk to them or be around them. Sometimes everything just seems really trivial. (R49UK, Q3B)

towards others are generally socially acceptable, one might tend to exclude descriptions of being hostile in one's interactions with others from an official published account. In contrast, anonymous reports such as the DDQ provide one with the possibility to report of such experiences. Thus, the increased frequency of descriptions of irritability and impatience in particular with respect to engaging with others in anonymous reports can reflect this discrepancy.

[149] The two passages to follow were administered the code *Impatience and irritability*. Further descriptions of experiences of being impatient and irritable when interacting with others are: R20UK, Q2B; R42UK, Q3B; R49UK, Q3B; R89UK, Q3B; R117UK, Q3B; R124UK, Q3B; R129UK, Q3B; R130UK, Q3B; R133UK, Q1B, Q3B; R134UK, Q2B; R143UK, Q2B; R150UK, Q3B; R157UK, Q7B; R160UK, Q1B; R161UK, Q1B, Q5B; R166UK, Q1B; R168UK, Q1B; R180UK, Q3B; R186UK, Q1B; R190UK, Q1B; R192UK, Q3B; R212UK, Q1B, Q3B; R228UK, Q1B; R237UK, Q1B, Q2B, Q3B, Q7B, Q8B; R239UK, Q3B; R259UK, Q2B; R269UK, Q3B; R270UK, Q1B; R323UK, Q3B; R334UK, Q1B; R343UK, Q1B, Q3B; R352UK, Q3B; R370UK, Q1B; R371UK, Q2B. These tendencies, particularly in the domain of social interactions, are only rarely reported in published autobiographical accounts so that only Danquah (1998, 186), Smith (1999, 57, 178), and Solomon (2001, 72) refer to being impatient or irritable with others.

Fourteen (11.48%) of the DDQ UK respondents and authors of memoirs also mentioned experiencing anger, often directed at others without any particular reason on the part of their interactional partners (Brampton 2008, 83; Crafton 2009, 6; Danquah 1998, 40; Solomon 2001, 47, and Thompson 1995, 37, 56 also describe reacting with anger or experiencing episodes of anger in their memoirs)[150]:

> I get angry with my partner and children for any reason yet really they are being themselves. I also find it hard to show kindness and emotion to them. (R42UK, Q3B)

While instances of increased irritability with others are described in more detail by referring to specific aspects meriting the affective response or the tendencies towards avoidance and isolation that might result from these, feelings of anger are usually only explicitly named and sometimes contrasted to an overall flattening or absence of affect as respectively in these responses:

> Generally very tearful, angry, tired and negative. Its a permanent battle of wills with myself. (R237UK, Q3B)
>
> veer from being completely numb to anger and hatred and self-hatred. (R61UK, Q1B)

These brief descriptions can on the one hand reflect the general trend towards avoiding the description of socially inacceptable affects (in particular directed at other people) and on the other the lack of detailed and rich vocabulary to picture affective experiences of this type in sufficient detail especially when those experiences appear not grounded or caused by anything in particular. Analogously to the experiences of irritation or frustration with others, anger can be understood as a manifestation of the radical difference in subjective experience, which in extreme cases can anger and infuriate one. Such instances appear to be especially poignant with respect to the overall diminished affective tone and the avoidance tendencies associated with the dominant negative affective responses such as sadness, despair, hopelessness, and the like. Being explicitly named usually with a single word and by many in their responses to the first question of the DDQ UK, anger is most probably a mood-like state, which crystallizes in reflective experiences of anger that might be unspecific, diffuse, and not directed at anything in particular. The constant encounter of radically different foreign subjectivity transforms the overall affective tone into one of dissatisfaction and anger, which is then not anymore limited only to intersubjective encounters. Rather, all aspects of one's being in the world are experienced as unsatisfactory, not conforming to how

[150] The three excerpts from the DDQ to follow were administered the code *Anger*. Responses, which describe feelings of anger in particular are: R21UK, Q1B, Q3B; R23UK, Q1B; R37UK, Q1B; R42UK, Q3B; R53UK, Q1B; R61UK, Q1B; R85UK, Q4B; R130UK, Q1B; R145UK, Q1B; R161UK, Q1B; R212UK, Q1B; R237UK, Q1B, Q3B; R307UK, Q1B; R334UK, Q1B.

one wishes or expects them to be, etc. This profound change in mood is nonetheless difficult to describe in particular due to its diffuse character and wide scope – one is angered both by everything and by nothing in particular.

Like the world of intersubjective interactions, the physical world is for some a realm of irritation and annoyance. At the level of bodily experience, the stimuli across various modalities are experienced with stronger intensity. Thereby, the physical world appears brighter, louder, busy, and generally perceptually overwhelming to 11 (9.02%) of the respondents to the DDQ UK and is often explicitly contrasted to a numbed perception of the physical world (see also Brampton 2008, 66, 82 and Danquah 1998, 28 who similarly describe a heightened perceptual sensitivity)[151]:

> My perception of sound and light was greater everything was too noisy or too bright. (R112UK, Q2B)
>
> It [the world] looks too sunny or too dull. (R110UK, Q2B)

The disturbance of the shared second-person perspective characteristic of active engagement with others in depression establishes a background or lack of relatedness and sharedness of subjectivity and significance. Thereby, the individual suffering with depression finds herself in isolation from others. They are encountered first and foremost as not understanding observers and are respectively observed in the course of (attempted) interactions. The radical differences in subjectivity or perspective also frequently elicit feelings of irritation and impatience, which additionally impact the engagement in social interactions. The disruption of the second-person perspective constitutes intersubjective disconnectedness in further respects as well. In what follows, I am going to suggest that by failing to participate in second-person interactions, one remains confined to the role of a detached object of observation and this radically alters one's self-awareness. The tacit self-awareness in terms of being embedded in an intersubjectively shared world is then replaced by a foreign third-personal perspective on the own self, which constitutes an orientation of shame and guilt frequently described by individuals suffering with depression. These in turn further alienate and distance one from others.

2.3. Disturbed Second-person Perspective and Self-awareness: The Disembedded Self

Although we are commonly immersed in a second-person perspective when interacting with others, we are also able to dissociate from it and adopt an observer role in particular in cases

[151] The passage to follow was administered the code *Perceptual hypersensitivity*. Further passages describing the increasing intensity of perceptual stimuli in different modalities are: R37UK, Q4B; R110UK, Q2B; R112UK, Q2B; R115UK, Q2B, Q7B; R117UK, Q5B; R134UK, Q2B; R143UK, Q2B; R166UK, Q5B; R186UK, Q1B; R259UK, Q2B; R334UK, Q1B.

of disrupted interactions (Fuchs 2013a). The development of capacities such as joint-attention, turn-taking, etc. enable engaging in face-to-face second-person interactions by entertaining explicit and implicit variants of first-, second-, and third-person perspective. Thereby, the almost constant and frequently effortless participation in complex patterns of engagements with others characteristic of everyday life is made possible. Being able to adopt a meta-perspective in particular with respect to specific patterns of relations with others makes it possible for us to come to terms with (some) discrepancies or disturbances of specific interactions as proposed by Fuchs (2013a, 659):

> [In the implicit second-person perspective] I perceive the other as a bodily, animate being, and I immediately perceive his intentions-in-action in the context of the meaningful situation. Moreover, I also experience myself as being looked at, attended to or addressed by the other. Thus, the 2PP includes my awareness of the other as well as my implicit awareness of his awareness of me. It means a primary inter-bodily relatedness or co-experiencing.
>
> Now in adopting an explicit 2PP or self–other metaperspective, I focus on the present interaction as such and direct my attention to it. This happens in particular when an irritation, misunderstanding or disturbance occurs, and I ask myself what is going on between us, in particular when a close relationship is concerned. In this case, I take a step back, so to speak, and try to grasp why the other said or did what he did, what he might be thinking or feeling, whether I said something wrong, what the state of our relationship is, etc. I might also attempt to transpose myself into the other, simulate to be in his or her position, to reason about his or her motives, search for his or her hidden intentions, etc. Thus, adopting a self–other metaperspective may include deliberately taking the other's perspective (explicit 3PP) as well as reflecting on myself (explicit 1PP).

In cases of loss of fundamental relatedness as in depression, the second-person perspective is not merely disrupted but rather rendered impossible. Others are encountered as the bearers of a fundamentally different perspective that makes it impossible to engage in a shared perspective of co-experiencing and co-constituting patterns of shared significance. Subsequently, one also ceases to be *tacitly* aware of both the other and oneself. The tacit self-awareness of being perceived by the other as a bodily animate being is lost and replaced by an explicit third-person perspective on oneself. Thereby, rather than reflecting on oneself from an explicit first-person perspective, one becomes self-aware only or mainly in terms of the other's third-person perspective on one's (disembedded) presence. This peculiar mode of explicit third-personal self-awareness, in particular in combination with the experienced loss of abilities presents one with a focus on the own deficient self, which establishes a background orientation of depressive shame. In the remainder of this section, I am going to propose that the disruption of the second-person perspective radically alters self-awareness as well and provides the basis for experiences of depressive shame and guilt.

2.3.1. The Deficient Self

Upon (1) the breakdown of the second-person perspective, one is confined to a solitary first-person perspective of detached observation and isolation. From this perspective, one loses the sense of tacit self-awareness established by the embeddedness in interactions with others as it is replaced by an acute awareness of (2) being an isolated entity. From this position of isolation and disembeddedness, the other can also be experienced only by means of detached observation. Consequently, (3) one feels encountered by the other as a detached entity that is the bearer of specific characteristics. This foreign third-personal perspective replaces the tacit second-personal self-awareness of embededness in a shared world and becomes (4) a peculiar form of experiencing oneself, which coupled with a severe disturbance of agency establishes an orientation of shame described by 71 (58.2%) of the respondents to the DDQ UK. In these cases, one not only becomes an entity of observation for the other but also is self-aware only in terms of being a disembeded entity encountered by the other. And in particular in cases of disturbed relatedness and co-experiencing or sharing a common perspective on the world, what the other encounters are only (some of) one's particular individual characteristics. One is acutely aware of oneself not merely as the disembedded bearer of certain characteristics but rather only as an incapable, failing self as described by 45 (36.89%) of the respondents to the DDQ UK (see also Crafton 2009, XIV; Danquah 1998, 40, 82, 140-141; Lewis 2002, 84; Malai Ali 2007, 11; Smith 1999, 11, 82, 185; Solomon 2001, 15, 19, 48; Styron 1989, 3, 17, and Thompson 1995, 36, 46, 126, 132 who describe similar experiences):[152]

> Second time – felt like a failure as could not complete university course, overwhelmed by all life's issues, not necessarily MY life's issues, everything! Didn't feel like I was getting anywhere in life. (R218UK, Q8B)

The self that is observed by the other becomes apparent solely in terms of its failures to lead and sustain living the life one used to prior to the onset of the illness. The sense of declining abilities and the severely disturbed performance of various routine and non-routine activities becomes apparent to one as presented to the observing other. What, for instance, others encounter is how one fails in various aspects of functioning as explicitly described here:

> Feel inferior, failure as a mother, employee. […]

[152] The two excerpts to follow were administered the code *Feeling useless, worthless, a failure*. Passages describing experiences of diminished self-worth are: R21UK, Q5B, Q7B, Q8B; R41UK, Q8B; R53UK, Q8B; R61UK, Q5B; R65UK, Q1B, Q7B; R66UK, Q1B, Q3B; R80UK, Q5B; R89UK, Q8B; R97UK, Q3B; R105UK, Q1B; R107UK, Q1B; R113UK, Q8B; R118UK, Q7B; R134UK, Q2B; R143UK, Q1B, Q5B; R145UK, Q8B; R150UK, Q1B; R154UK, Q1B, Q5B; R155UK, Q1B; R157UK, Q1B; R160UK, Q2B, Q8B; R161UK, Q3B; R166UK, Q2B; R192UK, Q8B; R199UK, Q8B; R218UK, Q2B, Q8B; R228UK, Q1B; R246UK, Q5B; R269UK, Q1B; R270UK, Q1B, Q7B; R271UK, Q5B; R285UK, Q1B; R288UK, Q1B; R291UK, Q1B; R292UK, Q8B; R316UK, Q1B, Q8B; R323UK, Q1B; R343UK, Q1B, Q8B; R347UK, Q1B, Q2B; R355UK, Q1B; R357UK, Q1B, Q8B; R360UK, Q7B; R366UK, Q1B, Q8B; R367UK, Q5B; R370UK, Q1B.

> [When I am not depressed I feel] Confident, enthusiastic. Like who I am and what I have achieved. (R285UK, Q1B)

Subsequently, this "deeply problematic self [is] doomed wholly unworthy of public presentation" (Karp 1996, 47) and is often concealed from others by isolating from and avoiding social encounters and interactions as reported by 3 (2.46%) of the respondents to the DDQ UK[153]:

> I feel hopeless and useless, and my self-confidence drops so low that sometimes I cannot even leave the house to buy food as I don't feel worthy to be taking up space or time. (R367UK, Q1B)

These instances of depressive shame, I propose, can be understood as a switch between tacit self-awareness based on a second-person perspective to an explicit awareness of oneself as perceived by the other. What first-person reports of self-awareness in depression highlight is, I suggest, the shift from a background awareness of oneself that is established by interpersonal interactions, to a self-awareness of a disintegrated bearer of specific characteristics, which is the object of foreign subjectivity.

Failing to establish an implicit and explicit second-person perspective based on the loss of fundamental intersubjectivity, the individual suffering with depression not only finds herself in a position of intersubjective isolation but also cannot properly resort to processes of intact self-reflection from an explicit first-person perspective. The experienced fundamental alienation from an intersubjectively shared world places her in a position of passive detached observation. Others, then, instead of being actively engaged with are also perceived as distant unrelated observers who in the absence of second-person interactions do not encounter one as a "bodily, animate being" (Fuchs 2013, 5) within a meaningful context. Rather, they encounter a disembedded entity, which is not part of a shared meaningful context and, thus, cannot be engaged with. So, instead of being encountered by the other as an embodied, active, meaningful, and co-experiencing presence, one is experienced from a detached third-person perspective. And a detached third-person perspective devoid of active engagement can perceive only the particular performance of various overt actions, which is severely compromised in depression. The tacit self-awareness

[153] The excerpt to follow was administered the code *Avoiding socialization because I am worthless*. Further responses describing avoiding social encounters and interactions explicitly in response to an experience of deficient and worthless self are: R160UK, Q5B; R367UK, Q1B; R370UK, Q1B. Smith (1999, 11-12) also describes tendencies towards avoiding interactions with others specifically with respect to acute feelings of diminished self-worth.

of second-person interactions is thereby replaced by a detached third-personal evaluation[154] of a disembedded self in terms of its various overt or observable characteristics[155]:

> When depressed, I feel hopeless, ugly, stupid, vulnerable, unlovable and worthless. […] My self-criticism reaches a high. (R228UK, Q1B)

Although these descriptions rarely if ever explicitly refer to being observed, watched, evaluated, or in any way approached by others, the inherent negative self-image they depict implicitly includes how one presents oneself to others. Indeed, it has often been argued that to experience shame, one should find oneself in the presence of others. In a detailed examination of the phenomenology of shame, Dan Zahavi (2013) argues that others are always implicitly present when one experiences shame in an explicit comparison with oneself or as observers of one. The different instances of shame he focuses on present us with cases of "other-mediated forms of self-experience" (Zahavi 2013, 305). One thereby becomes conscious of oneself in terms of how one is perceived by the other and the social and cultural standards and norms one is subjected to. Shame can thus be understood as a self-conscious emotion, in particular a peculiar self-conscious emotion whose object is the own self as experienced by the other. It "testifies to our exposure, vulnerability, and visibility, and is importantly linked to such issues as concealment and disclosure, sociality and alienation, separation and interdependence, difference and connectedness" (Zahavi 2013, 320). Shame, then, is the awareness of oneself as the object of intentional experience one cannot live through as argued by Christian Skirke (2015):

> [S]hameful self-recognition means living through the intentional experience of an intentional experience I cannot live through. […] being faced with experiences I cannot live through impinges on my subjectivity. What impinges on my subjectivity is the fact that I, who am a subject, experience myself directly as the intentional object of my own experience. This configuration arises on account of the presence of experiences I cannot live through, i.e., on account of my givennesss to another subject. If all subjectivity were my own, I could only ever appear to myself as the intentional object of higher-order reflections on my own intentional experiences. However, if I experience the presence of more subjectivity than my own, I can be given to myself like I am

[154] Although, according to some approaches passages of this kind describe mental states or cognitive convictions (e.g. cognitive models), they present us with instances of ways of finding oneself in the world, of background orientations, which possess a distinctive phenomenology and are manifested in affective experience, styles of thinking, and behaviour. Utterance of the kind "I am worthless and useless", "I feel worthless and useless", etc. thereby are expressive of a background orientation of shame, which encompasses radical changes in all aspects of one's being. Against this background, specific cognitive styles are more prominent, and one undergoes more frequently individual affective experiences and behavioural tendencies. But each of these instances are rarely if ever experienced in isolation from the others – when I am confined to the experience of an exposed deficient and flawed self, I am naturally also more likely to be convinced or to believe that I am not going to fare well at, for instance, my job and would attempt to avoid novel situations, which might require special expertise. Jennifer Radden (2014, 63-64), for instance, considers more cognitive affections such as the ones expressed by the utterance "I am worthless" as emotions. While they are not the protypical cases of emotions, they are more concrete and are directed at a particular object, here, the own self.
[155] The response to follow was administered the code *Feeling useless, worthless, a failure*.

> given to the other, namely directly as the intentional object of plain, first-order intentional experiences. (Skirke 2015, 191)

Thereby, I propose that we can understand depressive shame as a form of disturbed *intersubjective embeddedness*, in which the common tacit self-awareness of being the active participant in an intersubjectively shared world shifts to an experience of oneself as a disembedded bearer of certain characteristics and qualities.

From their position of detached observation, others can be experienced as representative of the standard of functioning one fails to reach and as the judges of one's failure and thereby be encountered mainly as disapproving, judgmental, or even aggressive and hostile as described by 41 (33.61%) of the respondents to the DDQ UK[156]:

> I have no motivation at all, I do not want to get out of bed, do any household chores, go out of the house or meet anyone. This produces an emotion akin to despair, that I am not the same as others, I cannot function properly and therefore I am not on the same level as *they are and they look down on me.* (R154UK, Q1B; emphasis added)

Thereby, others can appear primarily not only as detached observers of one's performance but also as espousing one's failures and negative characteristics. The negative third-personal self-awareness, thus, transforms the social world into one of threat and hostility where others can only be judgmental, mocking, and provocative as evidenced by responses to the DDQ UK:

> I assume my family dislikes me and that everyone is looking at me and thinking what a terrible person I am. I begin to feel as if my friends aren't real and secretly they see what I see in myself which is horrible. (R370UK, Q3B)

As one is painfully aware of the self as inherently negative, one is also frequently subjected to negative self-directed emotions such as self-hate and disgust in particular (Thompson (1995, 127) also reports of experiences of self-hate and disgust)[157] that 18 (14.75%) of the respondents to the DDQ UK refer to. Disgust in many cases is directed specifically at the body, which one finds "fat, ugly […] You look at your body and it looks disgusting, you hate

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[156] The two excerpts to follow were administered the code *Others do not like me*. Responses describing the experience of being subjected to the negative evaluation of others and avoided are: R16UK, Q3B; R20UK, Q2B; R21UK, Q2B, Q3B, Q7B; R22UK, Q2B, Q3B; R30UK, Q1B, Q2B; R37UK, Q3B; R53UK, Q3B; R85UK, Q3B; R105UK, Q3B; R107UK, Q2B; R109UK, Q3B; R115UK, Q2B; R118UK, Q8B; R143UK, Q7B; R145UK, Q2B; R154UK, Q1B; R160UK, Q3B; R166UK, Q2B, Q3B; R168UK, Q3B; R171UK, Q1B; R186UK, Q3B; R190UK, Q3B; R199UK, Q2B, Q3B, Q7B; R219UK, Q2B; R228UK, Q8B; R259UK, Q2B, Q3B; R285UK, Q3B; R288UK, Q1B, Q3B; R291UK, Q8B; R292UK, Q3B; R311UK, Q2B; R331UK, Q1B, Q3B; R334UK, Q1B; R350UK, Q8B; R355UK, Q2B, Q3B; R357UK, Q1B; R361UK, Q3B; R367UK, Q2B, Q3B; R370UK, Q3B; R371UK, Q3B. From the examined memoirs only Smith (1999, 11) describes similar experiences in his memoir, which might be due to the generally socially inappropriate nature of these experiences that make them a likely subject of omission of a published account.

[157] The three excerpts to follow were administered the code *Self-hate and disgust*. Responses describing feelings of disgust of one's body and self-loathing are: R8UK, Q1B; R21UK, Q1B; R49UK, Q4B; R61UK, Q1B; R107UK, Q4B; R112UK, Q4B; R160UK, Q4B; R166UK, Q1B, Q7B, Q8B; R190UK, Q4B; R192UK, Q4B; R200UK, Q4B; R218UK, Q1B; R224UK, Q4B; R269UK, Q4B; R271UK, Q4B; R307UK, Q1B; R316UK, Q4B; R371UK, Q1B.

it" (R112UK, Q4B), "grotesque" (R224UK, Q4B), "I hate my body. I look in the mirror and I can't stand what I see, it's disgusting" (R49UK, Q4B).

According to Fuchs' (2002) account of the phenomenology of shame[158], the corporealization of the lived body plays a central role in pathological experiences of shame. It transforms it into a heavy, resistant, corporealized body, which becomes a "body-for others" (*corps pour autrui*, Sartre, 1956 as in Fuchs 2002, 224). Failing to be the medium of experience and interactions, the corporealized body also attracts one's explicit attention to itself and turns into an object of contemplation, reflection, and manipulation, which stands in the way of sharing a common world with others (Fuchs 2002, 225). In depression, the experienced loss of ability goes along with feelings of bodily corporealization as discussed in Chapter 4 "Loss of Ability and the Experience of Agency", which foreground its materiality and present it as an obstruction to one's active engagements in the world. The awareness of oneself as a disembedded self perceived by the other focuses on bodily failure and the sense of corporealization and respectively, one becomes explicitly aware of the own body image (Gallagher 1986) as both a corporeal entity apparent in its heaviness and failure and as an object of perception for the other. Thereby, a negative body image fosters feelings of disgust in particular with respect to one's bodily appearance.

2.3.2. Being a Burden: The Deficient Self and Guilt

Feelings of guilt and tendencies towards self-blame are traditionally considered characteristic and symptomatic of depression (DSM IV; Bortolan 2016; Fuchs 2002; Ratcliffe 2010, 2015 Chapter 5). In experiences of depressive guilt, I am going to suggest, the third-personal self-awareness of being a deficient self is for some individuals accompanied by feelings of (potentially) harming others. Unlike non-pathological cases of guilt, in depression it is not related to tendencies towards redemption or attempts to repair a disturbed relation but rather to tendencies towards self-blame and even in some cases suicidal ideation. The orientation

[158] Fuchs (2002) examines the phenomenology of shame in particular in cases of body dysmorphic disorder. Unlike depression, body dysmorphic disorder is characterized by altered bodily experience according to the diagnostic criteria in DSM IV TR (DSM IV TR, 510):

A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive.

B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

Here, a very specific form of bodily experience, namely that of how it is presented and perceived by others is at the core of the disorder. In depression, as already discussed in previous chapters the general corporealization of the body is closely related to the loss of possibility and agency rather than to these aspects. So, the changes in bodily experience in depressive shame in particular can be conceived as bodily manifestations of intersubjective disembeddedness.

of depressive guilt described in its various manifestations by 37 (30.33%) of the respondents to the DDQ UK can be understood as a disturbed sense of responsibility for a deficient self, which significantly harms others[159].

The third-personal self-awareness of the deficient self in some cases presents it as directly inflicting harm or burdening those around. In particular with respect to specific relationships, one feels as a burden to specific others as exemplified by 17 (13.93%) responses to the DDQ UK (see also Danquah 1998, 62 and Wurtzel 1995, 134)[160]:

> think I am not a good mum, wife, friend, daughter and all would be better off without me (R37UK, Q8B)

Finding herself related to specific others in terms of these specific relationships, the respondent not only becomes self-aware in terms of her individual failures to perform but also as thereby harming her relational counterparts. Consequently, her relational counterparts, her children, her husband, friends, and parents, are a constant reminder of these failures. They are encountered here both as the sources of third-personal observation of her specific deficiencies and as the ones directly impacted by them. But depressive guilt is rarely limited to particular transgression against specific others. Rather, it has been recently suggested (Bortolan 2016; Ratcliffe 2010; 2015 Chapter 5), some individuals suffering from depression feel irrevocably guilty. Against this background of deep irrevocable guilt, they feel guilty of harming everyone in general. In line with Ratcliffe (2010; 2015a Chapter 5) and Bortolan (2016), I propose that depressive guilt can be understood as a general background orientation. As the analysis of depressive shame above suggests, I conceive of depressive guilt also in its deep or background variants as established by a disturbed self-awareness. Thereby, experiencing the own self as transgressional from the peculiar third-person perspective introduced above restricts the possible ways of relating to any other person, so that the only way one can relate and feel related to others is in the context of harming them in virtue of one's failures and deficiencies:

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[159] Here, I agree with Fuchs who considers shame and guilt, in particular in cases of pathologies, as closely related: "[…] shame already bears the germ of guilt. Shame becomes guilt when the social norms are internalized as one's own feelings of value and when self-condemnation anticipates public exposure" (Fuchs 2002, 230). Unlike his analysis, I do not attribute the transformation of shame to guilt to the internalization of social norms. Based on the reports provided by individuals suffering with depression, I propose that at the core of (depressive) guilt is the experience of the impact of the own deficient self on others. Shame, in contrast, is rather an instance of 'self-awareness' as presented to others, which lacks the active component of inflicting (significant) harm to others.

[160] The five excerpts to follow were administered the code *Feeling a burden*. Excerpts describing the experience of guilt in terms of burdening loved ones are: R16UK, Q1B; R20UK, Q1B, Q8B; R22UK, Q3B; R37UK, Q1B, Q2B, Q8B; R53UK, Q1B; R97UK, Q3B; R107UK, Q3B; R124UK, Q3B; R150UK, Q1B; R160UK, Q8B; R186UK, Q1B, Q3B; R219UK, Q3B; R270UK, Q3B; R271UK, Q2B, Q3B; R282UK, Q3B; R331UK, Q3B; R357UK, Q1B.

> I feel useless, worthless and feel everyone would be better off without me in their lives (R20UK, Q1B)

Here, rather than harming someone by failing to carry out something particular in a specific way, the potential impact of one's deficient self encompasses everyone and everything reflecting a background of unspecific irrevocable guilt, which ties one to the present predicament of permanent social isolation in terms of constant failure and harming others.

Some of the responses to the DDQ UK describing the experience of the own self as a burden on others frequently also refer to feeling threatened by others. Others are in particular experienced as concealing their true attitude or response to encountering one as a deficient self:

> I feel like I'm being a burden and that they [other people, including family and friends] only put up with me because they feel they have to. (R107UK, Q3B)

Others' hostility in these cases is experienced as a response to one's deficient self – they are burdened or in any way negatively impacted by it and wish to resolve this:

> I become paranoid. People don't like me, I'm a burden, they become patronising because they know I can't cope. When they care, it's because they have to – and their happiness always seems to be in spite of me, never because of me, and I know I get in their way. (R124UK, Q3B)

Against the background of irrevocable guilt, one also fails also to encounter others in terms of caring and loving relations. Thus, to some, despite of being repeatedly assured or engaged with in this way by others, one still feels estranged in terms of being only a burden to others' lives:

> [Others seem different] only in the sense that I cannot believe that they love me, and that I am letting them down. (R270UK, Q3B)

The deep and irrevocable conviction that one can only harm or burden others is in many cases persistent and encompassing – no matter how others engage with one or even in spite of the own cognitive realization that one has not harmed others, instances of depressive guilt dominate.

Finding oneself in the background orientation of depressive guilt, one also engages in tendencies towards blaming oneself excessively and even inappropriately as explicitly reported by 9 (7.38%) of the respondents to the DDQ UK. Being trapped in the detached position of a deficient agent, whose relations to others are marked by their burdensome and harmful character, one also naturally experiences a wide range of (sometimes even completely unrelated) occurrences as somehow within the realm of one's responsibility

(Crafton 2009, 58-59, 60; Danquah 1998, 61, 69, and Lewis 2002, 17 also report of tendencies towards blaming oneself for various (alleged) transgression):[161]

> If something goes wrong, I automatically assume it's my fault. (R200UK, Q2B)

Against the background of deep irrevocable guilt, the synthesis of past, present, and future in the experience of implicit time is also radically disturbed. The focus on the failures of the deficient self in particular those impacting others prompts a general dominance of the past over the present and subsequently one is more likely to revisit or fixate on episodes from one's past which revolve around real or alleged transgression as described by 11 (9.02%) of the respondents to the DDQ UK. The present, thereby, is dominated by reliving these episodes of past transgression, which creates a further rift between intersubjectively shared implicit time and individual explicit past. And this rift might further prevent one from re-connecting with others by amending for one's transgressions as described in this response to the DDQ UK:[162]

> My depression has a huge affect on the way I think, all my thoughts are negative, I question everything, especially decisions I have made in the past, I constantly feel that I have not achieved much in my life, but people tell me the opposite. (R360UK, Q7B)

Finding oneself locked in irrevocable depressive guilt, to some the only apt punishment might appear in the form of death in general or suicide in particular (Fuchs 2003). Being transformed into a deficient self that can only burden others can be both terminated and redeemed only in terms of ending this predicament, which is commonly experienced as permanent and ever lasting. Thus, to some death appears not as the only way to terminate and intolerable predicament (as in the case of a loss of possibilities discussed Chapter 3 "Loss of possibilities") but rather as the only way to compensate for one's overwhelming and encompassing moral transgressions as described by 8 (6.56%) of the respondents to the DDQ UK:[163]

> I am usually a creative, positive, very determined and logical person. When I am depressed the scope of my thinking becomes more and more narrow until my thoughts are only negative, self deprecating and often suicidal. (R271UK, Q7B)

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[161] The excerpt to follow was administered the code *Guilt and self-blame*. Further responses describing a general tendency to experience attribute oneself moral responsibility for various occurrences are: R16UK, Q2B; R21UK, Q1B; R200UK, Q2B; R212UK, Q1B; R246UK, Q7B; R316UK, Q3B; R323UK, Q8B; R355UK, Q1B; R361UK, Q2B, Q7B.

[162] The excerpt to follow was administered the code *Fixating on the past*. Further responses describing a tendency to focus on past (alleged) wrongdoings and transgressions are: R41UK, Q7B; R93UK, Q7B; R105UK, Q7B; R106UK, Q7B; R134UK, Q7B; R143UK, Q1B; R199UK, Q6B; R253UK, Q1B; R291UK, Q8B; R323UK, Q1B; R360UK, Q7B.

[163] The excerpt to follow was administered the code *I do not deserve living*. Responses describing the experience of being suicidal against the background of guilt and self-blame are: R20UK, Q1B; R97UK, Q1B, Q8B; R186UK, Q1B; R259UK, Q8B; R271UK, Q7B; R282UK, Q1B; R357UK, Q1B; R370UK, Q8B.

Depressive guilt establishes an even wider and deeper gap between one and the others. The deficient self that is deemed worthless and useless burdens and harms others. It has to be concealed not only due to its failure to function in the world but also as it potentially can induce harm both on specific others and everyone in general. This culminates in utter intersubjective disconnectedness[164], which likes depression to a form of solitary confinement.

2.4. Solitary Confinement and Loss of Intersubjectivity

The deprivation of social contact and direct interaction with others and its effects on one's (psychological) well-being and experience in general have recently moved into the focus of phenomenological research. For instance, Shaun Gallagher (2014) argues that solitary confinement directly disturbs primary and secondary intersubjectivity, which results in severe disruptions of the so-called relational self (Gallagher 2014, 3, 5). Being deprived of interactions with others disrupts the development of both primary and secondary intersubjectivity and culminates in so-called "induced autism" (Gallagher 2014, 3-4) characterized by difficulties sustaining reciprocal contact in social situations, symbolic communication, etc. that commonly develop from the engagement in enactive and embodied practices. Solitary confinement similarly disturbs primary and secondary intersubjectivity and culminates in states of derealisation and depersonalization that reflect a disruption of the experience of (shared) meaning and reality and of a stable and coherent self (Gallagher 2014, 5-6). Lisa Guenther (2013, 34) argues that individuals who survived solitary confinement describe a diminishment or a loss of a sense of personhood when deprived of the experience of other persons. She proposes that the absence of experience and active engagement with others impacts the most fundamental senses of the reality of the world and one's own personhood:

> It's not just that prisoners grow depressed or psychotic, although this could very well happen; it's that the intersubjective basis for their concrete personhood, and for their experience of the world as real and objective, as irreducible to their own personal impressions, is structurally undermined by the prolonged deprivation of a *concrete, everyday experience of other people*. […] the evidence overwhelmingly suggests that prolonged solitary confinement

[164] Thomas Fuchs also conceives of guilt in depression in particular as a form of social alienation: "In elementary guilt the person falls out of the common world; an abyss has opened between her and the others which cannot be bridged again. Every friendly word, every innocent gesture only increases the pain of being expelled. With that, and like shame, guilt causes a corporealization, though not so much by painfully felt gazes of the others but by the *separation* from them. It throws the guilty person back on herself and lets her corporeality come forth as a heavy load that drags her down" (Fuchs 2002, 231). Experiencing the own self as deficient in terms of one's declinig abilities and respectively the accompanying changes in bodily experience discussed were discussed in detail in the chapter "Loss of agency". In guilt, as in shame, the painfully felt corporealization of the own body, I suggest, establishes disconnectedness from others only circumstantially by directly impacting the experience of agency.

> undermines prisoners' capacity to make and sustain meaning. It not only dulls the senses and impairs the cognitive faculties […] but also attacks the structure of intentional consciousness by impoverishing the world to which consciousness is essentially and irrevocably correlated. In this sense, the practice of solitary confinement […] exploits the most fundamental capacities of their embodied existence, turning the constitutive relationality of their consciousness against themselves, using their most impressive power – the power of co-constituting a meaningful world – as a weapon against them. (Guenther 2013, 35-36; emphasis added)

The disruption of interactions with others in depression is also severe, but rarely reaches the extent of complete solitary confinement, like for instance that associated with the penitentiary system, which is in the focus of Gallagher's (2014) and Guenther's (2013) research. Although the individual suffering with depression might frequently find social interactions impossible or undesirable, these are not completely absent so that one still engages on specific limited occasions with others. Rather than losing an intersubjectively shared reality, in depression the loss of intersubjective interactions is manifested in experiences of a failure to *establish relatedness with others*. In this case, the world is still experienced as populated by other subjects, but one fails to relate to them.

Moreover, a further form of isolation more frequently occurs in depression. In addition to the various disturbances of fundamental relatedness and connectedness discussed so far, individuals suffering from depression are still often the subjects of avoidance, misunderstanding, and stigmatization in society. Depression, like many other (mental) illnesses, is unfortunately nowadays related to systematic and still widely spread social disapproval and those suffering with it are labelled unstable, over-sensitive, self-indulgent, overly emotionally invested, etc. Such misrepresentations of both the disorder and the experience that is associated with it place one in a position of social isolation by directly impacting one's sense of personhood, personal identity, and (moral) agency. Being confronted by a failure of recognition of their experience and emotional and physical suffering, individuals suffering from depression are oppressed in the expression and understanding of their identity and agentive potential, which precludes attempts towards re-connecting with others.

3. The Interpersonal World: Practices of Personhood

Commonly, we experience the world against the background of a tacit sense of our own personhood – we are not reflectively aware of being persons or being particular individuals but rather the way the world is disclosed to us is already a world for persons. Moreover, when encountering others, they appear to us as persons rather than as subjects. As argued in

the previous sections, a sense of sharing an intersubjective world is essential to interacting with others, but our immersion in a shared world is most frequently available to us in terms of encountering and interacting with persons. Here, one could argue that distinguishing between intersubjective and interpersonal experience is not necessary as, on the one hand, interpersonal interactions are made possible only against the background of fundamental intersubjectivity and, on the other, we find ourselves in a shared person-world. While this is generally so in the absence of radical changes in experience, first-person reports by individuals suffering from depression illustrate different patterns of disconnectedness and alienation: (a) in terms of a loss of intersubjective relatedness, which confines them to a detached perspective on the world, others, and the own self and (b) in terms of not being engaged in at least some person-specific practices, which culminates in interpersonal isolation or disconnectedness. These different emphases in descriptions of reflective experience illuminate individual aspects of sharing a world with others, which although not entirely independent establish, respectively, a pre-reflective sense of *intersubjective relatedness* and of *belonging to an interpersonal world*. Interpersonal relatedness, most importantly, encompasses feelings and conceptions of being a person in general and being a particular individual or having a specific personal identity, which I am going to suggest can be understood in terms of a practical conception of personhood and personal identity (e.g. Lindemann 2001, 2002, 2014; Schechtman 2014).

The subject can be broadly conceived as the "the constitutive source of every meaningful feature of the world" (Mertens 2011, 169). The person, in contrast, is determined by the structures of living in a natural, social, and cultural world[165] (Mertens 2011, 169). Finding oneself in a person-world is experiencing and interacting with others first and foremost as persons. And being a person, I propose, can be understood within the broad framework of social practices and interactions that characterize our everyday social life. Thereby, personhood, unlike subjectivity, can be conceived as the social, political, and cultural construct of being an agent, a subject, a self (Kockelman 2006, 15). Respectively, persons are both subjected to and apply specific concerns, obligations, and rights to their being. Subjects, on the other hand, are the directly experiencing, acting, thinking, etc. entities.

[165] Frequently, especially in phenomenology, it is commonly distinguished between a subject and a self. Here, I adopt the notion of a person and not that of the self as the latter can also be understood as a construct of reflection on one's experience, actions, etc. (Kockelman 2006, 13). In order to capture the relevant aspects of distinguishing between subjective and person-specific experience and interactions as highlighted by Mertens (2011, 169), I adopt the term 'person'. In the previous section, the detailed discussion of depressive shame and guilt presented the reflective, foregrounded experience of the *self* as the unit of experience and interaction in the social realm, which replaces the tacit background of immersion and embeddedness in an intersubjectively shared world. The notion of the self, thereby, is that of an entity, which can potentially be subjected to evaluation, engage in interactions, etc. rather than a subjective perspective on actively engaging with others.

Finding oneself in the world as a subject, thus, refers to finding oneself in a world of experiences, actions, and thoughts, which are not explicated in terms of social, cultural, and political concerns, obligations, and rights. Rather, it is the immediate or reflective experience of oneself as being subjected to specific experiences, as having a subjective perspective on the world without structuring these experiences within the framework of social and cultural values, norms, meanings, etc.

3.1. Social Practices and Personal Identity

Generally, from an early age, we are embedded in specific interpersonal social practices such as conversations, greetings, and further patterns of everyday social exchanges. Through continuous engagement in these practices, they become the tacit background of being in a person-world and are automatically engaged in at the appropriate occasion. Thereby, they constitute specific relations between persons. Accordingly, a change in how others engage with us, in what practices they involve us in, has a direct impact on how we experience them as persons and even oneself as (the same) person (for detailed discussions of the central role of social practices in (moral) agency and conceptions of personhood see Lindeman Nelson 2001, 2002 and Schechtman 2014).

Practices can be broadly understood as the routinized way of doing things (Reckwitz 2002, 249-250). A practice "consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, 'things' and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge" (Reckwitz 2002, 249). The most basic of social practices, it has been suggested, can be that of personhood (Nelson 2001, 2002, 2014). According to practical accounts of personhood and personal identity:

> [w]e are initiated into personhood through interactions with other persons, and we simultaneously develop and maintain personal identities through interactions with others who hold us in our identities. This holding can be done well or badly. Done well, it supports an individual in the creation and maintenance of a personal identity that allows her to flourish personally and in her interactions with others. Done badly, we hold people in invidious, destructive narratives. Some such narratives identify the social group to which someone belongs as socially and morally inferior, and in that way the stories uphold abusive power relations between "us" and "them". In other cases, we hold people too long in identities that no longer serve them, preventing them from moving on fully to identities that do. (Lindemann 2014, x)

Here, I would like to argue that the social alienation and isolation individuals suffering with depression report of are expression of a failure of recognizing and holding into a shared person-world. At least some experiences of being oppressed or marginalized, stigmatized,

avoided, not understood, and restricted in one's agency can be understood in terms of loss of *interpersonal* embeddedness. In many cases, this is the result of the dominance of oppressive master narratives, which make the communication of experience and (self-)understanding in depression even more challenging and difficult. Acting from such oppressive or misguided narratives, other persons might misrecognize or fail to recognize the depressed individuals' experience and self-understanding and subsequently deny them particular practices of personhood.

According to Lindemann (2014, ix), personhood consists of four elements: (1) sufficient mental activity to constitute a personality, (2) aspects of which are expressed bodily. These expressions are recognized by others as such (3) and (4) they respond to them accordingly. Respectively, failures in any of these elements constitute a danger to one's personhood, personal identity, and moral agency. Recognizing specific expressions of particular personalities or personal identities and responding to them accordingly is how others initiate and hold us into personhood. Individual personal identities, moreover, present us with specific ways in which we are treated, particular (social) practices we are engaged in rather than others, and specific actions that are expected from us (Lindemann 2014, 5-6). Thereby, personal identities provide us both with a range of practices that are to be anticipated from one and with specific ways to treat or engage with them. And feeling embedded in a person world, I propose, can be understood as (a) being appropriately recognized by others in line with one's self-experience and conception (within one's personal narrative). Others, in such cases, (b) do not attempt to impose disadvantageous or oppressive master narratives and (c) engage one in the full spectrum of interpersonal interactions and practices that go along with the respective identity. Frequently, how we engage with others and conceive of ourselves is based on the particular master narratives about specific groups, communities, people, etc. Mater narratives are "the stories found lying about in our culture that serve as summaries of socially shared understanding" (Nelson 2001, 6) and thereby provide us with a framework for the expression, recognition, and response when interacting with others. And in many cases, especially with respect to minority groups, they can be misguided and oppressive. At least some master narratives of depression misrepresent the condition by failing to capture the central role of the overwhelming emotional and physical suffering one undergoes and failing to acknowledge the status of depression as a (mental) illness. Misrepresenting or misguided master narratives of depression thereby fail to acknowledge central aspects of what being depressed feels like and in influencing how others engage and interact with one may culminate in situations of oppression and marginalization.

By influencing how others co-construct one's identity, master narratives play a major role in the processes of misrecognition and inappropriate response to individuals suffering with depression and subsequently impact their embeddedness in social life and self-identification. The master narratives that 52 (42.62%) of the respondents to the DDQ UK and authors of memoirs (e.g. Crafton 2009, XIV-XV, XVIII; Danquah 1998, 20, 21, 144; Malai Ali 2007, xi-x, 19; Solomon 2001, 53; Styron 1989, 37, and Wurtzel 1995, 63, 192, 253) identified in the recognition and response of others frequently fail to acknowledge the pathological character of the condition and its devastating effects on one. Depression is, for instance, considered as primarily a mood or affective state, which is a response to a particular life situation or an external stressor and can be controlled by the one undergoing it as described in these passages:[166]

> The fact that it is not drowning in self pity. It is real and it is an illness and it is as physically debilitating as a broken leg or a terminal illness. It can kill and it is not something that you can just snap out of. I'm not sure why people don't understand this. It's hard for me to understand that people don't understand this because I have been depressed since I was aged 12 (although I didn't seek help from the doctors until many years later) and so I have lived with it for over half my life. (R14UK, Q10B)
>
> nobody understands it they all think I'm just moody and need to cheer up or snap out of it. No one understands how disabling it can be either because the general public just like to judge (R30UK, Q10B)

Here, the failure to recognize the expressions of depressive experience as such (3), misrepresents it as an exaggerated response to events in the world. Thereby, one fails to recognize that the experience is qualitatively different from non-pathological states of grief, intense sadness, loss of hope, or despair that one might experience in particular circumstances (Ratcliffe 2015, 15) and locates it in a 'normalizing' context – everyone has experienced these intense affects specifically in response to certain circumstances and these can either be regulated by one or simply pass. This 'normalizing' master narrative, which pictures the condition as an affective response to external stressors that, most importantly can be regulated attempts to hold one in a particular identity encompassing the practice of

[166] The two excerpts to follow were administered the code *Master narratives of depression.* Responses describing being confronted with inappropriate or misrepresentational master narratives of depression in interpersonal interactions are: R14UK, Q10B; R17UK, Q10B; R20UK, Q10B; R21UK, Q10B; R22UK, Q10B; R28UK, Q10B; R30UK, Q10B; R38UK, Q10B; R41UK, Q10B; R51UK, Q10B; R53UK, Q10B; R66UK, Q10B; R84UK, Q10B; R89UK, Q10B; R107UK, Q10B; R115UK, Q10B; R118UK, Q10B; R129UK, Q10B; R130UK, Q10B; R134UK, Q10B; R137UK, Q3B, Q10B; R145UK, Q10B; R150UK, Q10B; R154UK, Q3B; R157UK, Q10B; R160UK, Q10B; R162UK, Q10B; R166UK, Q10B; R168UK, Q10B; R180UK, Q10B; R186UK, Q10B; R189UK, Q10B; R190UK, Q10B; R192UK, Q10B; R199UK, Q10B; R200UK, Q10B; R228UK, Q10B; R237UK, Q10B; R259UK, Q10B; R269UK, Q3B; R271UK, Q10B; R292UK, Q10B; R308UK, Q10B; R313UK, Q10B; R316UK, Q10B; R323UK, Q3B, Q10B; R334UK, Q10B; R343UK, Q10B; R350UK Q10B; R357UK, Q10B; R367UK, Q10B; R371UK, Q10B.

being in control of one's affective response and, thus, responsible at least to some respect for it. While it might be commonly true that we can regulate at least some negative emotions, in particular in cases of widely varied and encompassing alterations of all aspects of experience, thought, and action, this is not the case. And attributing one responsibility for coming to terms with this type of changes in the general existential background can potentially gravely impact one's sense of personhood. Being continuously confronted with a misrepresentation of one's realm of responsibility can eventually culminate in feelings of 'second-order' shame and guilt for having depression and failing to deal with it.

3.2. Disconnectedness from an Interpersonally Shared World: Failure of Recognition and Response

It can be argued that the failures of recognition and response of depressive experience in particular are the result of the failure of appropriate expression of the radical changes in one's experience. Indeed, many of those who suffer with depression in particular and mental illness in general often face the problem of making their experience comprehensible to others. Most generally, this can be related to the radical changes in all aspects of finding oneself in the world. As depicted in first-person reports, their authors frequently cannot make others, especially those who have not suffered with depression, understand their utter lack hope, despair, sense of not being able to deal with everyday life, and urges to harm themselves or even end their lives. The failure to communicate the experience of depression can be, for some, the result of lacking the appropriate conceptual and linguistic means to talk about one's affective experience, thoughts, and behaviour especially when aspects of these that we commonly do not reflect upon change radically as discussed in Chapter 2 "Studying the Experience of Depression". It has been suggested that this can be the result of the lack of the appropriate conceptual apparatus to comprehend the illness and the experience associated with it (Karp 1996, 38-40). According to David A. Karp, in particular during an initial period of "inchoate feelings" (Karp 1996, 38), one lacks the appropriate vocabulary to describe the experience. During this period, "[d]epression is still only a code word that cannot bridge the chasm of feelings separating their world from that of friends and family whom they believe, in contrast to themselves, are "normal"" (Karp 1996, 40). While this is the case for initial depressive episodes, the general indescribability of depressive experience exceeds it by far. What is at the core of the failure to communicate depressive experience is a complex blend of undergoing radical changes in most if not all aspects of affective experience, thinking, and behaviour, lack of appropriate vocabulary to refer to changes in the background structures of experience that we take for granted (such as the experience of

possibility, for instance), and the influence of different master narratives that impact how one and others conceive of depression and its symptoms.

The alienation and isolation from a shared *person-world* that individuals suffering from depression report of is not exhausted by the difficulty or even impossibility of communicating one's emotional and physical distress. Additionally, based on (3) the failure of recognition resulting from oppressive master narratives, others also (4) respond inappropriately to individuals suffering from depression. In these so-called misshapen responses, the oppressive master narratives "commonly make it impossible for the people bearing those identities to express themselves adequately, and then, of course, what they say won't get the right kind of response. It's not that people in the stigmatized group can't utter the words or perform the actions that reveal their mental states, but their oppressors refuse to acknowledge their right to have those states" (Lindemann 2014, 115). Thus, communicating one's experiences of, for instance, loss of the disposition to have any hopes, one might be confronted with attitudes, which attribute this to one's general outlook that can be modified in particular in the case of 'normalizing' master narratives. And accordingly, when communicating their distress, individuals suffering with depression face not only lack of empathy and understanding but also a misguided attribution of responsibility for the particular experience they are having. So, responses in the form of 'Pull yourself together', 'Snap out of these moods', etc. seem to allocate agentive potential where they mostly lack it[167]:

> The fact that if I could 'pull myself together', I would!
>
> My depression is not a voluntary feeling of being just a bit fed-up. It is all consuming and debilitating. (R228UK, Q10B)

One might, then, in response feel ashamed or guilty for having the condition and retreat further from social interactions as explicitly identified in 3 (2.46%) of the responses to the DDQ UK (Danquah 1998, 18; Malai Ali 2007, 18; Lewis 2002, xi, and Styron 1989, 37 describe tendencies towards avoiding interpersonal interactions in particular in view of others' stigmatized perception of depression): [168]

> A few years ago I felt ashamed of sharing my mental health issues with others. It's a general fear of others reactions, of being rejected laughed at or ridiculed.
>
> I don't tend to tell people about suicidal thoughts as I do feel I should embrace life rather that taking the coward's way out. And others DO see it as that!

[167] The excerpt to follow was administered the code *Master narratives of depression.*

[168] The excerpt to follow was administered the code *Withdrawal due to stigma.* Further responses describing tendencies towards social isolation and the avoidance of social interactions due to the stigmatized perception of depression are: R54UK, Q3B; R150UK, Q3B; R269UK, Q10B.

> Now days I do share my condition as I feel people need to be educated, after all few are immune to becoming mentally ill. (R269UK, Q10B)

And under the influence of master narratives and in particular as a result of the inappropriate recognition and response, some might actively avoid the depressed individual. Here, I do not wish to suggest that this is always deliberately and intentionally done. Rather, encountering someone suffering from depression and interacting with her under the influence of a misguided master narrative places others in uncertainty and social discomfort as well. Failing to empathise with the depressed individual at a fundamental level might already be unsettling and this can be further fostered by a failure of responding appropriately based on master narratives. So, ultimately, one might feel uncomfortable as they fail to adequately respond to someone suffering from depression and in some cases even avoid them:

The impacts of responding inappropriately to individuals suffering from depression cannot by far be exhausted by this discussion as they are also highly specific and depend on the particular relationship one has to the one failing to respond appropriately and the general social and cultural context surrounding mental illness in general and depression in particular. Further more specific studies have to be conducted so as to identify individual instances of the restriction of both (moral) agency and personhood in particular with respect to essential everyday practices. Based on the 12 (9.84%) responses to the DDQ UK and memoirs (e.g. Crafton 2009, XVIII and Danquah 1998, 186), which described others as patronizing or overly involved in their everyday lives, as "over-bearing [and] pussy-footing" (R118UK, Q3B), "too nagging" (R246UK, Q3B)[169], I propose, that a detailed examination of the impact of misguided master narratives on specific everyday practices of living can impact one of the most fundamental person-specific practice of autonomously leading a life.

Being confronted with misrecognition and inappropriate response to their experience, many choose to deliberately hide or not communicate their suffering. They either do not express and communicate their experience or attempt to continue performing their everyday activities in spite of severe difficulties. Pretence behaviour in both forms is frequently related to the social unacceptability and stigmatization of the condition. In the former case, the combination of lacking the vocabulary to describe their experience, the belief that others fail to understand or empathise with them, and the general social stigma surrounding mental illness motivate individuals suffering with depression to keep their

[169] The three excerpts were administered the code *Others are patronizing*. Further responses describing others as engaging in patronizing practices are: R24UK, Q3B; R110UK, Q3B; R112UK, Q3B; R115UK, Q3B; R118UK, Q3B; R150UK, Q10B; R157UK, Q3B; R169UK, Q3B; R180UK, Q10B; R228UK, Q3B; R240UK, Q3B; R246UK, Q3B.

feelings private (Karp 1996, 38) as described by 21 (17.21%) of the respondents to the DDQ UK and authors of autobiographical accounts (e.g. Danquah 1998, 77):[170]

> Family and Friends very rarely know when I am depressed, because I am extremely good at slipping on a mask and acting normally/hiding my true feelings, so no they do not seem different when I am depressed. (R23UK, Q3B)
>
> I feel that I have to try and put a brave face on it most of the time otherwise everyone will think I'm malingering (R186UK, Q1B)

In the latter case, commonly the continued identification with a specific practical identity and the stigmatization of depression move one to continued performance of at least some tasks:

> This varies for me between episodes, I have become an expert at hiding how I feel and sometimes I can continue with work, meeting people and then feel a huge sense of relief when I am not with others so I can finally be myself without having to put on a front, which is incredibly exhausting. (R189UK, Q5B)

In both cases, the repression of the expression of one's experience is associated not only with great effort but also eventually with self-alienation (Karp 1996, 43). This can culminate in a sense of loss of authenticity and incoherence of self-identity and its outward expression.

The isolation ensuing from processes of misrecognition and misidentification discussed above induces feelings of loneliness, social disconnectedness, guilt, and shame, which closely resemble the orientation of lost fundamental intersubjectivity and as I am going to suggest in the next chapter emphasize or highlight particular changes in the existential bavkground. Thus, processes of social misrecognition and inappropriate response to those suffering with depression can additionally both contribute to the general disturbance in intersubjectivity and even induce experiences similar to the symptomatic orientations of fundamental intersubjective alienation. The brief exploratory discussion of the impact of misguided narratives of depression illustrates the profound impact they have not only on secondary aspects of the experience of the disorder but also on their potential compounding effects on primary or symptomatic experiences. Moreover, crucial aspects of one's self-understanding as a person such as autonomy, responsibility, and authenticity can be gravely impacted. This highlights the importance and pressing need for the careful examination of such processes and how they impact the course of depression, the experience of the illness, and one's self-understanding. I suggest that further research on the phenomenology of social

[170] The three excerpts to follow were administered the code *Pretence*. Further passages describing tendencies towards pretence behaviour by either not communicating and expressing one's (affective) experience or continued engagement with everyday life are: R21UK, Q5B; R23UK, Q3B, Q5B; R38UK, Q1B; R41UK, Q10B; R42UK, Q3B; R47UK, Q1B, Q5B, Q10B; R49UK, Q5B; R84UK, Q10B; R130UK, Q1B; R147UK, Q10B; R161UK, Q1B; R162UK, Q10B; R168UK, Q1B; R186UK, Q1B; R189UK, Q5B; R218UK, Q1B, Q10B; R240UK, Q5B; R246UK, Q10B; R269UK, Q2B; R282UK, Q5B; R316UK, Q3B.

isolation and withdrawal in particular due to stigmatization of mental illness can highlight its potential damaging effects with respect to experiences of disconnectedness and disturbances of agency. These, being some of the characteristic experiences of depression in particular and most mental illnesses in general can be intensified or even induced in the absence of the appropriate social framework for the communication and interpretation of the experience of mental illness. What can alleviate and potentially prevent these effects is an integrated multifaceted study of the conceptualization, institutionalization, and practical engagement with mental illness in general, and depression in particular, focusing on (1) first-person reports, (2) medical practices, and (3) social and cultural values and norms. In particular, the role of narratives and narrative (self-)understanding in illness experience can be deployed as a powerful tool for both illuminating and studying these effects and developing models for the prevention of stigmatization and its impacts. Misguided master narratives of the sort described above frequently reflect the general lack of integration of various aspects of mental illness experience, treatment, institutionalisation, folk understanding, etc. I propose that a careful analysis and integration of three groups of narratives, namely such authored by those afflicted with mental illness (1), medical professionals (2), and socially and culturally shared master narratives about mental illness (3) can contribute to the alleviation of social stigmatization by a systematic investigation and integration of the following aspects:

1. the life-world of the depressed individual with an emphasis on the meaning of the illness and its symptoms, everyday life, and self-understanding as being depressed;
2. medical understanding of the illness with an emphasis on a neutral and non-stigmatized concept of (mental) illness, symptoms, and treatment in particular based on medical practices that professionals, depressives, and non-depressives might encounter; and
3. social and cultural meaning and practices of mental illness, which illuminate potentially misguided and oppressive models of mental illness and depression.

By identifying potentially harmful discrepancies across these, a unitary framework for expression, response, and recognition of the experience of depression can be devised that might provide those suffering from the illness with the appropriate vocabulary to communicate and conceptualize it, identify and express symptoms or characteristic experiences without either resorting to means that fail to capture the essential aspects of the first-person experience of depression or be forced into reclusion and pretence. This might also inform medical and institutional practices that can be respectively informed by first-personal insights. And the ultimate integration of the insights gathered from a systematic analysis of the three groups of narratives can revise existing oppressive or misguided master

narratives particularly in combination with various campaigning and awareness raising methods.

4. Conclusion

Testimonies produced by individuals suffering from depression consistently describe the condition as one of profound and utter isolation from others. In this chapter, I suggested that we can understand this in terms of the breakdown of a two-fold embeddedness and relatedness to others – in terms of sharing a world with other subjects and with other persons. Moreover, these also encompass modes of self-experience and self-understanding that are disturbed in depression. The individual suffering from depression fails first and foremost to relate and feel related to others based on a disturbance in our common second-person perspective, which enables meaningful interaction and intersubjective engagement. Others are encountered as the bearers of a radically different perspective, which is not reconcilable with one's own and makes it impossible to relate to them. Being confined to a position of being observed by others and observing instead of relating to them disturbs implicit and explicit self-awareness, which are replaced by a peculiar mode of third-personal awareness of the own self. Particularly when coupled with disturbances in agency, more specifically the experience of ability and the performance of various activities, one becomes self-aware only in terms of one's own deficiencies and failures as these are present to the detached third-personal observation of others. This establishes background orientations of depressive shame and guilt that contribute further to the encompassing alienation and intersubjective disembeddedness.

At the level of interpersonal experience and interaction, the social isolation one is subjected to can be seen as the result of stigmatization, which is embodied in oppressive narratives that restrict the range of interpersonal practices available to the individual suffering from depression. These, moreover, as I am going to suggest in the next chapter, not only alienate one from an interpersonally shared world but also emphasizes or highlights manifestations of background orientations in individual cases.

6. Social and Cultural Influences on the Experience of Depression Described in First-person Testimonies

The preceding chapters focused on the study of the experience in depression in particular in terms of the changes in different background structures that come to the fore of experience as various affective, cognitive, bodily, and behavioural phenomena. As these were derived on the basis of the study of first-person testimonies of depressive experience produced mainly by UK and US-residents (the memoirs are almost exclusively authored by residents of the United Kingdom and North America), they also present us with foregrounded manifestations of depression-specific changes in background structures that are embedded in particular cultural context. Recently, it has become widely accepted that mental illnesses in general do not have universal manifestations across cultures. For instance, in the case of depression, numerous studies have noted significant differences in reflective manifestations across various cultures spanning the increased incidence of somatic complaints, of experiences of guilt and shame, and suicidal ideation (see Tseng 2007, 102-105). Specifically, socially shared cultural beliefs, assumptions and conceptions of mental illness, identity, autonomy, etc. have been demonstrated to exert an impact on the manifestation and descriptions of experience of mental illness. Thus, specific understandings of what depression is and how it is related to oneself that are shared within cultural groups can variously shape how it is experienced and described in first-person testimonies.

Culture is a notoriously vague and ambiguous term that encompasses both patterns of specific values and beliefs and situated practices such as customs and rituals, for instance. For my purposes here, the relevant sense of culture can be understood as:

> shared and learned behaviour and meanings that are socially transmitted for purposes of adjustment and adaptation. Culture is represented externally in artificats (e.g., food, clothing, music), roles (e.g., the social formation), and institutions (e.g., family government). It is represented internally (i. e., cognitively, emotionally) by values, attitudes, beliefs, epistemologies, cosmologies, consciousness patterns, and notions of personhood. Culture is coded in verbally, imaginistically, proprioceptively, viscerally, and emotionally resulting in different experiential structures and processes (Marsella and Yamada 2010, 105).

By constituting a complex network of socially transmitted ways of perceiving, understanding, experiencing, and responding to mental illness, culture determines the local norms for mental functioning, the acceptable ways for expressing distress and suffering, appropriate ways of being ill, and the like that are all inextricable components of experiencing and living with a

mental illness. Accordingly, being depressed and attempting to describe what this feels like is subjected to various culture-specific factors that determine what counts as depression-specific experience, how and what aspects of it can be communicated to others, and how the condition is related to oneself. My aim here is to attempt to identify possible ways in which the conceptions of depression reported by members of different cultural groups impact and shape even subtle differences in the experience and description of depression. For this purpose, I am going to engage in an examination of the anonymous first-person testimonies provided in response to the original version of the DDQ that gathered responses mainly from residents of the United Kingdom (which was discussed so far) and its Bulgarian version that was similarly administered online and collected testimonies from participants residing mainly in Bulgaria. An initial comparison of these revealed differences in the experience of depression and how it is communicated in particular with respect to processes of social stigmatization of mentally ill individuals. At a more general scale, I am going to propose that the socially and culturally shared conceptions of depression as a (pathological) psychological reaction and a mental illness resulting from a complex combination of various social and biological factors, which were reported in both versions of the survey, can shape the experience of depression by highlighting or emphasizing different background orientations that undergo radical changes during depressive episodes. These conceptions as described in the responses to the DDQ UK and the DDQ BG also present us with subtle differences specifically with respect to the relationship between the condition and one's individual psychological organization, self, or personality and reflect different degrees of social stigmatization. For instance, socially stigmatizing conceptions of depression, which view the condition as an individualized reaction to adverse events rather than an illness, associate it more strongly with evaluative judgments of the own psychological organization, self, or personality. Consequently, suffering from depression is itself experienced as a sign of psychological deficiency, which emphasizes experiences of shame and guilt that might be otherwise present as well. In particular in these cases, one tends also to self-attribute personal responsibility for the condition and engage in tendencies towards social isolation and self-denigration for suffering from depression. In contrast, in the cases of understanding depression as rooted solely or mainly in biological changes that are not within the realm of one's voluntary and volitional control, assumptions of personal responsibility for the condition are not pertinent and respectively orientations of shame and guilt are not emphasized in the descriptions of the experience of depression or during depressive episodes. Here, the focus might shift to the incapacitating and disabling effects of depression emphasized by viewing it as a disabling condition of the type of harmful purely somatic

diseases that impact one's functioning and well-being. Before proceeding to the detailed presentation and discussion of the different conceptions of depression reported in the responses to the two versions of the DDQ, I am going to engage in a review of the relevant aspects of cross-cultural studies of mental illness. Moreover, the testimonies also indicate that particular patterns of individual significance associated with depression (e.g. commonly based on specific causal factors such as the nature and character of adverse events associated with the development and onset of the condition) impact experience and how it is described as well. For this purpose, I am going to examine the responses provided to the DDQ UK and the DDQ BG in view of both the differences and similarities in the experience they depict and its communication and propose that we can understand at least some of these as resulting from particular socially and culturally shared conceptions of depression. I am also going to suggest that further aspects of the reported views of depression impact experience and its description in general by highlighting or emphasizing particular background orientations that resonate well with the respective understanding.

1. Culture and Mental Illness: Conceptions of Mental Illness Across Cultures

Mental illnesses are embedded in complex networks of specific socio-culturally constituted and transmitted beliefs, assumptions, and meanings, which, as it has been demonstrated, have a strong impact on both the experience of particular mental illnesses and how it is being communicated. Recently, cross- and transcultural psychiatry have begun to establish both theoretical and methodological foundations of a comprehensive research program that studies the cross-cultural differences in their various relevance to psychopathology. Culture, here, is examined both in its impact on the aetiology and development of different disorders and on illness-specific experience and on how it is (linguistically) communicated. The anonymous first-person testimonies from two different cultures I am going to examine in detail here demonstrate some specific influences that respective conceptions of mental illness in general and depression in particular exert on particular changes in the experiential background and how these are communicated. Unfortunately, many of the socially and culturally shared conceptions of depression reported by the respondents from both cultures still display tendencies towards social disvaluation, failure of acceptance, and rejection of those who suffer from depression. As discussed in the previous chapter, they are communicated through (oppressive) master narratives that can in many cases lead to a failure of recognition of distress or suffering and exclusion from membership in social communities, for instance. Here, I am going to examine the conceptions of depression as reported by

Bulgarian and British responders to the DDQ with a two-fold aim: on the one hand, the two groups display some subtle differences in how one understands depression that, accordingly, are reflected in nuanced aspects of the experience of the illness and how it is expressed; on the other hand, at least some of the different conceptions of depression promote its stigmatization along various lines, most notably, by attributing responsibility for the condition to the one afflicted with it. I am going to suggest that this not only highlights specific background orientations and makes their reflective manifestations more pronounced, and thus more frequently referred to in first-person testimonies, but also further negatively impacts the individual's well-being by means of heightened negative self-evaluation, experiences of diminished self-worth, lack of prospects, and isolation that are integral to the experience of depression. Thereby, I want to draw attention to the devastating effects of a stigmatized understanding of depression and more specifically to those that place the condition within the realm of voluntary and volitional control of those afflicted by it.

In view of this focus on social stigmatization, I propose that culturally and socially shared beliefs, assumptions, and normative evaluations of illness, mental illness in general, and depression in particular determine the scope or range of what counts as illness experience and at least to some extend intensify, promote, and emphasize some specific experiences (e.g. guilt and shame, tendencies towards avoidance of interactions with others, etc.) and how these are described in first-person testimonies. The particular socially and culturally shared conceptions of depression described in anonymous first-person testimonies, I am going to suggest, are characterized by different degrees of stigmatization (1). Moreover, they also encompass beliefs, assumptions, and judgements that do or fail to recognize depression as a valid illness category (2) and attribute (personal) responsibility to those afflicted with the condition in a different manner (3). Additionally, depression, like any (potentially chronic or recurrent) harmful and incapacitating condition associated with suffering, disability, etc. is loaded with specific personal significance (4) that varies with respect to the impact it has on one's life, capacities and abilities, etc. (see Kleinman 1988, Chapter 2 for a detailed discussion of the personal and social meaning of illness and symptoms).[171] These characteristics of the conceptions of depression (1-4) impact how it is experienced (a) and described (b), help-

[171] The focus on the discussion of the impact of social, cultural, and personal significance in Chapter 2 "Studying the Experience of Depression Described in First-person Testimonies" fell on the demonstration of the impact of these on experience and how it is described in view of more general aim – to demonstrate that the experience of depression is not an isolated phenomenon that occurs independently of a larger social and cultural and narrower more specific personal context. Here, as already mentioned, I am going to expand this both in terms of investigating cross-cultural differences in the social and cultural meaning of depression and of how these, together with the individual meaning of illness and symptoms impact concrete experiences with a focus on the effect of stigmatization in particular.

seeking and treatment (c), and the individual's integration and successful participation in society (d).

The socially and culturally shared conceptions of mental illness, depression, identity, and autonomy are in a constant dynamic interaction with the personal meaning of the individual condition one is afflicted with and the experience associated with it. The complex interplay of these factors has pathoplastic and pathoreactive (Tseng 2007) effects on the experience of illness. Pathoplastic effects are the "ways in which culture contributes to the modeling or 'plastering' of the manifestations of psychopathology. Culture shapes symptom manifestations at the level of the content presented" (Tseng 2007, 99) and pathoreactive effects "influence people's beliefs and understanding of the disorders and mould their 'reactions' towards them. Culture influences how people perceive pathologies and label disorders, and how they react to them emotionally, and then guides them in expressing their suffering. Consequently, the clinical picture of the mental disorder is coloured by the cultural reaction – at a secondary level – to the extent that the total process of the illness varies" (Tseng 2007, 99-100).

The social and cultural beliefs, assumptions, and normative evaluations of illness, mental illness, and depression in particular determine what individual changes in experience or experiential phenomena count as symptoms, complaints, and signs of an illness rather than simply unpleasant changes in experience related to non-pathological factors. Thereby, clusters of "valid" complaints, presentations, or signs of illness (and a specific illness) are formed. For instance, in societies and cultures where mental illness is highly socially stigmatized, mental complaints might have less validity as illness symptoms or signs that require medical attention and treatment but rather support from spiritual leaders and loved ones resulting in an increased incidence of and more pronounced somatic complaints in the presentation of the disorder in particular within medical settings. These shared social and cultural models of illness and illness experience are based on and also communicated thorugh large-scale common master narratives of illness, suffering, institutionalisation of health care, etc. For instance, as observed by Kleinman (1988a), cases of major depression in China are diagnosed and interpreted as instances of neurasthenia, whereby depressive symptoms (e.g. changes in affective experience and cognition) are considered the result of neurasthenia rather than signs or manifestations of a pathological condition. Neurasthenia, being widely popular in China and an official diagnosis is "a syndrome of exhaustion, weakness, and diffuse bodily complaints believed to be caused by inadequate physical energy in the central nervous system" (Kleinman 1988a, 7). Given this cultural conception of particular forms of suffering and distress, the somatic complaints associated with depression are highlighted and

more frequently reported rather than the alterations in affective experience, which become only secondary as they are the direct results rather than symptoms in their own right.

Central to any description of the experience of depression is the notion of suffering, feeling bad, and emotional distress. Most if not all of the experiential phenomena associated with depression (discussed in detail in the previous chapters) go along with an intrinsic negative evaluation that is commonly attributable to a positive focus and emphasis on feeling good, well-being, and social comparison and acceptance. Thus, feeling bad or experiencing emotional or mental distress is first and foremost circumscribed by this focus on disvalued instances of the experience of suffering and (emotional) distress and might subsequently not be reported or communicated or described only briefly. Moreover, the stigmatization of emotional distress related to or resulting from disturbances in mental functioning is unfortunately still highly socially disvalued and might in some societies and social groups not be seen as a valid medical complaint. Accordingly, strong social stigmatization of emotional distress related to mental illness (and frequently such that is symptomatic of mental illness) might be 'downplayed' or experienced more strongly in terms of bodily complaints, even in the presence of elaborate vocabulary for expressing emotional distress.

The communication of (emotional) distress and suffering in particular is subjected to normative social evaluations, which also determine how and what aspects of distress and suffering within illness are publicly expressed and shared with others (Bebbington and Cooper 2007). Different cultures have emotional vocabulary for the communication of distress of varying complexity and richness so that distress can be described in terms representing different categories in different languages (Bebbington and Cooper 2007, 226). Lacking words for expressing psychological distress, thus, can be associated with descriptions of experience in terms of somatic complaints. It has been observed that class differences as well impact the manifestations and descriptions of distress in predominantly somatic terms (Bebbington and Cooper 2007, 227).

In a detailed critical review of cross-cultural research of mental illness, King (1978, 422) observes that three conceptions of mental illness have been identified: (1) mental illness is biologically determined, which is often accompanied by the conception that it cannot be cured; (2) that it is a psychological problem that the individual might be responsible for and that one can improve with help and maturation, and (3) that it is a supernatural condition that could be cured by the appeasement of higher spiritual powers such as spirits or gods. Each respective conception goes along with a particular scope of complaints that can be considered manifestations, symptoms, or signs of the illness and also shapes their content. Moreover, these conceptions are also related to particular affective responses to suffering

from a mental illness that in many cases compound the illness-specific manifestations. For instance, conceiving of depression as an individual style of psychological functioning can, for some, further exacerbate feelings of guilt and tendencies towards self-blame as one understands oneself and is responded to by the general public with an attitude that attributes the responsibility for one's suffering to oneself. Thereby, additional strain is posed on one – I am not only suffering but also the one who brought it on myself that further magnifies the intensity of the common experiences of guilt in depression. Similarly, the presence of oppressive master narratives of depression discussed in Chapter 5 "Loss of Intersubjectivity and Social Isolation: Loneliness, Shame, and Guilt", presents the emotional distress of depression as a common problem of living, which everyone faces or has faced and as potentially subjectable to voluntary control by introducing ways of dealing with it in terms of 'snapping out of the blues', 'picking oneself up', etc. Facing this absence of social validation of distress not only increases the experienced isolation, lack of understanding, and the desire to avoid contact with others, but also transforms the low, oppressive, crushing sense of loss of prospects and possibilities into a 'personal' problem of dealing with everyday life that is not a valid medical complaint, a symptom, or a sign of an illness. Moreover, mental illness in particular, it has been suggested, "[…] is reckoned to lie within the general biomedical domain, but also to be an allowable alternative to physical conditions and to the expression of physical distress. In other cultures, this separation is often not made, and approved expressions of distress are limited to the physical alone" (Bebbington and Cooper 2007, 228). Subsequently, manifestations of mental illness can be expressed predominantly in physical complaints in particular after becoming aware that the suffering and distress one is experiencing is related to a pathological condition.

It can also be suggested that by failing to understand depression as an illness but rather as a highly individualized psychological reaction to various external factors and events, those suffering with it are not able or permitted to access the so-called sick-role (Parsons as in Varul 2010). The sick role replaces the multiplicity of everyday roles and respectively the obligations that go along with them and thereby "bridges periods of incapability by establishing a single role that enables conformity within the deviance of illness. […] the individual's everyday obligations – and also their everyday rights – are suspended and replaced by a set of sick-role specific rights and obligations. The exemption from normal role expectations itself obviously is the most fundamental right. Other rights are the assumption of innocence and access to professional help. These rights are matched by complementary obligations" (Varul 2010, 76-77). The incapacitating effects of depression, thus, when seen as resulting from a personal failing deprive one of access to this role and

one is still seen and also sees oneself in light of the own further roles. Despite severe incapacitation, one might feel obligated to continue to perform these roles and actively follow their normative prescriptions (for a detailed discussion of identifications with various (practical) roles, see Chapter 4 "Inability and Loss of Agency"). Consequenlty, both different complaints and experiences might be highlighted or emphasized such as the incapacitating and disabling effects of depression, for instance, on one's everyday performance as these are still part of the roles one is associated with. Also, as a direct consequence of to fulfil these, tendencies towards self-denigration, self-blame, and experiences of guilt can be emphasized.

Thus, socially shared cultural conceptions of mental illness can impact the experience of the condition and how it is described in first-person testimonies by providing one with a complex network of patterns of meaning that frame the various phenomena one is subjected to. I propose that the responses to the DDQ UK and the DDQ BG differ first and foremost in terms of the degree of social stigmatization of mental illness in general and depression in particular. The high social stigmatization of depression in general, I propose, encompasses assumptions of underlying personal deficiency or weakness (1), a failure to recognize the pathological status of depression (2), and (3) beliefs about personal responsibility for the condition. In the case of (1), depression is presented as an indication of personal deficiency or weakness and social undesirability, so that the experience of depression is presented in a framework of social disvaluation, lack of support, potential social rejection, which are associated with experiences of shame that can be secondary, i.e. resulting from the stigmatization such as feeling ashamed of being depressed or emphases of manifestations of depression specific disturbances of intersubjectivity (as discussed in the previous chapter). The failure to recognize depression as a 'valid' pathological condition (2) might shift the focus of descriptions of experience to phenomena that appear to be the result of a prototypical illness. If we consider purely somatic conditions as prototypes of pathologies, then, the somatic complaints associated with depression can be strongly emphasized for some while emotional distress is framed as only secondary to these and evades the emphasis of description. Stigmatized conceptions of depression can in some cases associate personal responsibility with the condition (3) more than other understandings of its nature (e.g. a biological pathology manifested in psychological impairments). Presenting depression as the result of a faulty psychological organization that is potentially under the volitional and voluntary control of the individual, they can strongly emphasize feelings of shame and guilt, tendencies towards social withdrawal and isolation, and unwillingness to communicate emotional distress. The individual significance depression has for those suffering from it (4) is derived from the specific situatedness of the condition in and its impacts on the trajectory

of one's life, its coherence and continuity. It, naturally, varies greatly at an individual level and emphasises highly specific experiences based on their general embededness in one's life.

2. Stigmatization of Mental Illness

Stigma in general is "a sign of disgrace or discredit, which sets a person apart from others" (Byrne 2000, 65). Stigma, thereby, devaluates one's intrinsic worth by basing social acceptability, judgements, and evaluations on individual socially undesirable attributes or characteristics that are used as the sole basis of evaluation and membership is social groups, communities, or even society in general. The stigmatization of persons can revolve around stereotypes of specific groups bearing particular attributes that present them as different from other (socially acceptable groups) and absolve individual difference within these groups (Bryne 2000). In the case of mental illness, the stereotypical figure of the mentally ill patient is portrayed as the bearer of an irrational and dysfunctional mind, which results in deviant, unpredictable, and uncontrollable behaviour, thinking, and affect. In spite of the general increase in medical knowledge, awareness campaigns, etc. mental illnesses are unfortunately still highly stigmatized and the ones suffering from them are subsequently frequently the victims of oppression, discrimination, blame, and lack of empathy and understanding. As discussed at the end of the previous chapter, many common master narratives of depression encompass misguided and misleading presentations of the condition that moreover directly impact the embeddedness of those affected by it in social interaction by the failure to recognize their experience and suffering and by the subsequent restriction of the range of practices available to them. These master narratives incorporate broadly stigmatized understanding of mental illness and depression and present us it the prototypical figures of the mentally ill patient who is potentially dangerous, unpredictable, responsible for the own condition, and not a full member of society. The mentally ill individual encounters these narratives not exclusively from others – experiencing immense mental distress, she is already aware of the prototypical culturally specific and socially shared understanding of illness, illness behaviour and experience, and mental ailments. Her experience is instantly presented against the background of such master narratives and carries the respective significance. Thus, even in cases where overt discrimination is absent or one is not confronted by others in terms of oppressive stigmatized narratives, one might still experience the stigmatized nature of the condition in a form of self-stigmatization, which is embedded in the context of master narratives of depression. So, by incorporating stigmatized conceptions of mental illness master narratives are the first and foremost tool of social stigmatization.

Mental illnesses in general and depression in particular are commonly understood as conditions that assault and radically alter one's self. Rather than attributing them to a dysfunctional diseased organ (system) in the biological body, they are understood as originating from a dysfunctional mind and thereby constituting a faulty self. Specifically in contrast to purely somatic conditions, depression can, thus be understood as residing within the individual and assaulting all aspects of their psyche. Stigmatized conceptions of depression in particular entail judgements of the sufferers themselves rather than of "some temporary, disembodied concept afflicting the body but of the sufferer themselves" (Walker 2008, 31). The stigma of mental illness, moreover, it has been demonstrated (Corrigan et al. 2000) operates along two main attribution constructs – stability and controllability. Controllability attributions associate mental disorders with personal responsibility, restrict or eradicate empathy for the mentally ill, and present them as potentially dangerous and thus to be avoided. Stability attributions address concerns about recovery and treatment (Corrigan et al. 2000) and tend to assign responsibility and blame for the condition and are associated with experiences of shame, guilt, and tendencies towards social isolation for those afflicted with a mental illness. Attributions of stability present particular conditions as recurrent, chronic, or treatment resistant, which is related to subsequent anticipation of repeated episodes, attitudes towards treatment and recovery, etc.

Stigmatized conceptions of depression present those afflicted with the condition as dysfunctional and deficient. Accordingly, they fail to cope with the vicissitudes of everyday existence and are the one responsible for being depressed. Although they might not be subjected to direct overt discrimination, their suffering thereby is both nor recognized as a valid expression of distress and as potentially within the bounds of their voluntary and volitional control. So, even in the absence of discrimination, being afflicted with depression, the experience one is undergoing is framed by a network of assumptions and beliefs that present it as indicative of personal deficiency, potentially controllable by the sufferer, and recurrent or chronic. As a direct consequence, then, those suffering from depression are more likely to experience not only lack of understanding and empathy from others, but also be more prone to a diminished self-evaluation specifically in terms of interpersonal comparison (others can cope successfully, but I have failed), feelings of shame and embarrassment for being depressed and in terms of the incapacitating effects of depression that can culminate in a failure to successfully participate in social life and achieve standards of membership in society (for instance when incapacitated by an affective disorder like depression and failing to perform as commonly specified by shared social norms, one might

be subjected to attitudes that diminish the effects of the impairments as these result from an affective disorder rather than from one that might carry the status of a legitimate disability).

3. Conceptions of Depression in the DDQ BG

Being characterized by changes mainly in psychological states, depression is frequently understood as a psychological reaction to adverse events in life. Most commonly, these include traumatic experiences and neglect in (early) childhood but also most recent psychological trauma and unfortunate developments in (personal) life that might often lie outside the scope of one's control such as economic and social hardship, for instance. Although depression is commonly recognized as a pathological condition, an illness, understanding it as a psychological reaction, places it at a problematic juncture between an individualized pattern of responding to the world and events in it and a medical condition. Thereby, on the one hand, it is seen as rooted in one's individual 'subjective' and historically situated psychological organization, and on the other, as a pathological change in functioning that is not within the bounds of one's voluntary control. Consequently, these aspects of the conception of depression impact and shape experience, how the illness is manifested, and what is considered a valid (illness) complaint. Focusing on the former aspect, the painful experiences associated with depression might often be experienced as individual, private, and subjective reaction to the world, as a failure to deal or cope with it like everyone else does rather than symptoms of a medical condition. These, moreover, can be seen as closely related to one's self-concept or personality regardless of what their causal underpinnings are. So, although a deficient or less resilient psychological organization, which encompasses a reactive attitude that makes one prone to depression, can be causally related to adverse and traumatic events, it is still associated with a negative evaluation of the individual. Subsequently, conceiving of depression as mainly the result of an individualized psychological reaction expressive of a deficient self is strongly associated with feelings of shame and guilt, tendencies towards isolation and avoidance of at least some social interactions. In its extreme form, the understanding of depression as resulting from an individualized reactive attitude can even completely stripe away its pathological status. Then, in spite of its harmful and dysfunctional nature, the condition is exclusively viewed as self-inflicted, potentially controllable, and, unlike illnesses that can affect anyone for various reasons, a direct result of a, for instance, particular way of perceiving, experiencing, and evaluating the world that is essential to one's self.

It is nowadays widely accepted, though, that depression is an illness. And indeed, many understand the disorder as a *pathological individualized reactive attitude*, which places it one step closer to the realm of medical pathology. Rather than being only a highly subjective individualized manner of responding to the world, it is a particular harmful and dysfunctional condition that warrants medical attention. Thus, in particular with respect to the understanding of depression as (the result of) an individualized psychological reaction to adverse events and the vicissitudes of everyday life, we can find two further distinctions: (a) an extreme form according to which depression is an individualized reactive attitude that is aberrant and harmful and within the bounds of one's volitional and voluntary control; and (b) an understanding of depression as a pathological psychological reaction that can be due to various factors such as adverse and traumatic events that make one susceptible to a failure in successfully coping with the stresses of everyday life culminating in depression. In the former case, there are stronger associations with attribution of responsibility for both the individualized patterns of response and the specific states, processes, and tendencies resulting from it, which one is subjected to during a depressive. In the latter case, although depression is clearly a pathological condition, which is, here, characterized by changes in psychological functioning, it is still at least only to some extent associated with one's individual psychological make-up, resilience, and coping potential. Unlike the former case, it is a condition that results from adverse events and psychological trauma, which impinge on one's psychological organization and establish a proneness to or even a firm pathological 'depressive' reactive attitude. Here, it is important to note, the associations with personal responsibility for the condition are not so strong as the main causal factors appears to be the traumatic and adverse events rather than the own deficient self or personality.

On a second understanding of depression, it is an illness rooted in biological changes such as brain function or chemical imbalance. It, thereby, is not within the bounds of voluntary and volitional control and similarly to all somatic afflictions assaults and overcomes the individual in this case specifically by impacting psychological functioning. This conception is also not so strongly socially stigmatized and commonly not seen as expressive or indicative of a deficient or inferior self. In spite the current, commonly widely transmitted, advances in the understanding of the neurobiological correlates of depression and its respective acknowledgment as an 'illness or dysfunction of the brain', the responses to the DDQ BG indicate of this understanding in only two cases. In the remainder of this chapter, I am going to engage in a detailed examination of the different conceptions of depression as described in the respective testimonies and attempt to study their impact on the experience

and descriptions they present us with (see Fig. 2a for an overview of the conceptions of depression reported in the DDQ BG).

3.1. Depression is a Psychological Reaction: Pathology and an Individualized Reactive Attitude

Eleven (84.62%) of the respondents to the DDQ BG described a general understanding of depression as resulting from a dysfunctional reactive attitude, whereby we can distinguish among three more specific notions of depression: one that focuses on its somatic manifestation, another, which emphasizes the failure of volitional control over one's reactive attitude, and a third that explicitly refers to the causal role of adverse and traumatic events. The experience of depression, although qualitatively distinct from non-pathological (affective) responses, is traditionally seen as displaying a continuity with non-pathological, appropriate, and justified affective states that we all are familiar with from everyday life such as intense grief, despair, sadness, hopelessness, anxiety. This continuity, though, as I hope to have demonstrated in the detailed examination of depressive experience in the previous chapters, is rather misleading. During depressive episodes, the overwhelming and encompassing loss of the sense of possibility, agency, and intersubjective embeddedness constitute a radically different way of being in the world that is unimaginable and incomprehensible to those who have been spared by the illness. The presence of this superficial similarity, though, is still prevalent among the wider public and can in many cases present depressive states and the wide-ranging varied impacts of the condition as resulting from an extreme sensitivity, failure to deal with or regulate the negative experiences we all undergo at some point, and low psychological resilience or stability. As we all face the challenges of everyday life, the fact that some react to these by 'being miserable', 'being sad, despaired, and hopeless', and above all 'failing to live life to the fullest and follow their duties' are taken as the result of a failed or inappropriate coping strategy. Thereby, it seems that we attribute the same levels of resilience and coping potential to everyone, which make us expect also the same 'outcome' when facing adverse events. Thus, those who fail to do that and become depressed or experience intense emotional distress that interferes with their everyday functioning are labelled weak, incapable, lazy, self-indulgent, etc. Depression, subsequently, becomes a highly individualized, inappropriate, dysfunctional psychological reaction to the adversities of everyday life rather than an illness that one suffers from, that befalls one and renders one incapacitated, disabled, and isolated in spite of its (subjectively) harmful impact. Those who become depressed have failed to deal with life, give up in the face of challenges, cannot overcome loss, rather than being seen as people suffering from a 'legitimate' illness.

On this understanding they are also frequently confronted with practical advice, suggestions, and even demands to lift their spirits, see the world in a different way, pull their socks up and confront the world and its challenges as discussed in the previous chapter. Those suffering from depression, when entertaining and constantly or predominantly encountering this understanding of the illness, find themselves inhabiting a world that does not validate their suffering and attributes the burden of additional responsibility for it to themselves. I am going to suggest, that in extreme forms this impacts the experience of depression and how it is described in first-person testimonies by highlighting or emphasizing some of the common background changes on undergoes in particular. Subtle variations in individual understanding, more specifically with respect to the particular causal factors associated with the development of a self or a personality that has a 'depressive' reactive attitude, moreover, exert impact on the experience of depression in this manner as well.

In its probably most extreme form, the conception of depression as a psychological reaction resulting from an individualized reactive attitude places the condition outside of the realm of medical pathology. Emotional distress, considered the primary manifestation of depression, is not within the realm of medicine, which treats disturbances of the body not of the mind. Even psychiatry, in some societies and social groups, is not concerned with disorders of affect as it deals with the grave disturbances of mental functioning and its patients are the prototypical mad men who talk to themselves, see and hear things that are not there. Studies indicate that at least to some extent there is lack of awareness of the nature, scope, and treatment that psychiatry offers among the wider public in Bulgaria (Kozhuharov, Taskov, and Boncheva 2015). Thus, depression in particular and conditions characterized by emotional distress are not within its realm as well. According to this extreme form of the view of depression as resulting from an individualized reactive attitude, what warrants medical attention is purely somatic complaints, such as changes in heart rate, pains, aches, itches, dizziness, etc. So, to some who suffer from depression, it can become apparent or most pronounced that one is afflicted by a pathological condition, and thus warrants medical attention, in terms of various differentiated somatic complaints. Depression, as already discussed in the preceding chapters, is indeed associated with a variety of changes in bodily experience that can range from tiredness, exhaustion, and sensations of heaviness, to headache, back pain, nausea, etc. But for some, bodily symptoms can be the first and main indications that one might be suffering from a pathological condition. For instance, one of the respondents to the DDQ BG, describes a host of bodily experiences and dysfunctions as the first signs that alerted her of something being wrong rather than changes in affective

experience, which are the hallmark symptoms of depression (also according to diagnostic manuals):[172]

> In 2012, I felt very ill, high blood pressure with close borders, pains, gastritis, only later, after a lot of tests and consultations I found out that that my condition was due to an anxious depressive disorder. (R84BG, Q9A)

Depression, moreover, is even after a medical diagnosis most salient in its misleading bodily manifestation:

> In my case, it caused physical symptoms, expressed very strongly so that I was first mistaken and saw a cardiologist, made any kind of tests, my body reacted very strongly. (R84BG, Q11B)

Thereby, it seems to be both a mysterious condition without any particular causal underpinnings and a pathology of the physical body. Moreover, given this particular presentation, the appropriate treatment seeking, in this case contacting a mental health professional "was very hard […], I went all alone and fought this terrible illness, I do not have any relatives, but my desire to live was very strong. I WANTED TO LIVE AND FOUGHT" (R84BG, Q12B). Rather than being treated (with medication), depression is a condition, which has to be fought. Unlike somatic illnesses, which are treated and, in many cases, cured with medication, depression here requires an active deployment of personal resources to be battled. Thereby, its ambiguous position between a psychological reaction and a medical pathology is further strained by the opposition between mainly physical presentation and changes in mental functioning that might appear rather arbitrary.

Rather than noticing the lack of interest, loss of motivation, feelings of hopelessness, despair, etc., this respondent experienced a host of changes in her physical body, which alerted that there might be something wrong. And when asked more specifically about her affective experience during depressive episodes, she again focuses on these as described for instance in this passage:

> Well, there was a period, it happened once, and during it I felt terrible, this was the worst thing that has ever happened to me, I did not believe I was going to survive it, I thought that I was dying, and I had a lot of physical symptoms, heart palliations, insomnia, I could barely sleep, I felt without a soul. (R84BG, Q1B)

Here, it appears that the fear and anxiety are more closely related to the dominant changes in bodily function and experience. Upon experiencing uncontrollable and unexplainable intense physical complaints, the respondent reacts with terror and anxious anticipation rather experiencing these as the primary indications that something is wrong.

[172] The excerpt to follow was administered the code *Somatically manifested depression*.

When responding to the more specific questions about changes in the world and others, though, she is able to identify depression-related differences in these. The condition is compared to the eternal damnation of hell, a terrifying nightmare one longs to wake up from:

> Yes, it [the world] looks very different, horrifying, hopeless, you have the feeling that this hell will never end, that it is going to last forever and that you will never leave the nightmare. You have the feeling that you are having your biggest and scariest nightmare, that if you pinch yourself you are going to wake up/ I have even done this, I myself did not believe I was in Hell. (R84BG, Q2B)

Others, similarly, have become uncaring, unconcerned and one also fails to be moved by them or the world:

> Yes, people are different, too and this is true, you do not care about anything, and it appears to you that they do not care about you. You do not feel anything, absolutely anything, only despair and enormous pain and you are agonising every second. (R84BG, Q3B)

Thus, although depression clearly involves changes in affect what was interpreted as a pathological condition were solely the somatic complaints, the world of terror, insecurity, and loneliness, the absence of affect, it seems are still not described as signs of an illness, albeit one of the mental.

Given the prevalence of somatic complaints, interestingly the respondent focuses on rather general changes in bodily experience when explicitly prompted to describe these as for instance here:

> I had an anxious depressive disorder and my body was constantly tense, constantly moving, I wanted to move all the time, I could not stand still at one spot, my heart palliations were also disturbing me, and the insomnia as well, which lasted for months. (R84BG, Q4B)

For her, it seems, that these are depression-specific experiences, now that her condition was diagnosed as a mental illness. So, the tension between suffering from a somatic illness and a mental condition, manifested mainly in misleading yet differentiated somatic complaints points towards the interpretation of rather general changes in bodily experience, namely agitation and restless, as related to depression.

Another extreme form of the understanding of depression as the result of an individualized reactive attitude, places it within the bounds of one's voluntary and volitional control (a), which is reported by three (23.08%) of the respondents to the DDQ BG:[173]

> It would be so nice if I knew what caused it… I can list a lot of reasons that brought me to this condition but not other people. My thoughts cause

[173] The response to follow was administered the code *A reactive attitude that can be controlled.* Responses that report this understanding of depression are: R53BG, Q11B; R56BG, Q11B; R81BG, Q11B.

> depression. My attitude towards what is happening causes depression… I do not know… (R81BG, Q11B)

Depression, for this respondent, is the direct result of her specific attitude towards events in the world. Moreover, by explicitly referring to a host of reasons that have causal relations to being in this condition, namely to adopt exactly this particular attitude, which have not obtained the same for others, she also suggests that the main causal factor for being depressed is a *highly individualized reactive attitude*. Without appealing to the specific reasons (e.g. traumatic and adverse events, lack of supportive environment, etc.) for this, she suggests that their nature is not important rather how they have operated on one so as to establish a specific (inappropriate, dysfunctional, and harmful) reactive attitude is the main causal factor here. Subsequently, the affective experience characteristic of depression is experienced as potentially within the bounds of one's volitional and even voluntary control – if only I could come to view the world in a different way, I would also feel better. But in spite of the realization of the inappropriateness of the own affective responses, these resist regulation as described here:

> The inability to deal with your emotions although you realize how ridiculous or exaggerated they are. You cannot explain this to anyone who has not been down the same road. It is hard to describe that the word will loses its meaning. This means that there is no such thing as to strain your powers, your will and to keep on doing things like you did earlier. I think it is the same with people who have an addiction. (R81BG, Q10B)

Having lost one's will, one is, thus, left at the mercy of uncontrollable (affective) responses that themselves originate from a highly individualized reactive attitude, which during depressive episodes cannot be intervened on. The underlying assumption about the nature of affective experience comes very close to a 'cognitivist' understanding of emotions, which views them as resulting from appraisals or judgements of the world. Moreover, the individualized reactive attitude one has is strongly associated with volitional capacities and the responses suggest that these are considered within the bounds of one's control. Thereby, the experience of depression can be understood as an indication of loss of will, of not having a strong will that can be used to regulate these responses. Depression, thus, is placed within the realm of personal responsibility and is the manifestation of a failure to cope with the daily vicissitudes. This particular conception emphasizes experiences of general incapacitation and diminished self-worth for not being able to deal with life, to successfully cope, and enjoy life as described in this response:

> When I am depressed, I think that I cannot deal with life and the challenges of life that we all face. I think that I do not want to live this life, if it is like that (when I am depressed). Otherwise I am a person who values life terribly much … even a poor one, one in misery, one of difficulty … I think that life is good

> and we have to live it, to fight, to be happy with it, to bring ourselves joys and so on. So, there apparently is a strong contrast… (R81BG, Q8B)

Depression, according to this understanding, is undoubtedly a condition of harmful dysfunction, but still appears to lack a full illness status. Its experience, as described above is a manifestation of lack of will, the failure to regulate aberrant affective responses that themselves result from a faulty or negative individualized reactive attitude. Illnesses, in contrast, are also conditions of harmful dysfunction but commonly of specific organs or organ system and here, one might come close to the assumption that a failure of volition might not be closely associated with the realm of medicine and thus not a legitimate illness. Illness complaints, accordingly, are specific harmful manifestations of the underlying dysfunction rather than the result of a weak will or personality. This understanding might, then, emphasize the experience of valid illness complaints indicative of a (bodily) failure such as clearly differentiated and individuated somatic complaints:

> I do not have the energy for basic things. As if I have been run over by an excavator. I feel smashed. Very often I suddenly feel as if I am going to faint, get heart palliations, elevated blood pressure and I have even fainted. (R81, Q4B)

By being physical manifestations of a possible underlying condition, moreover, the additional burden of responsibility, in particular for their impact on everyday functioning is stripped away. Rather than being the result of being weak-willed, the failure to perform in everyday life is then experienced as more closely associated with the overwhelming exhaustion and general lack of bodily well-being as explicitly described in this passage:

> I experience apathy, lack of energy, as if one is down with the flu. It is hard (purely physically) to carry out different tasks, as for example, to do the dishes at home. I feel down, useless, I feel that I myself am a burden to my close ones, maybe to the world… (R81BG, Q1B)

These incapacitations are nonetheless associated with feelings of diminished self-worth and guilt as one fails to still function in everyday life. This can be the result of failing to access the sick role that replaces other practical or social roles. By failing to understand depression as a legitimate or valid illness but rather a condition resulting from one's individualized reactive attitude, one still closely identifies with the respective roles that require one to still be able to do the dishes. Thus, even in cases of physical incapacitation as this, it is still a personal failure to not follow one's duties or obligations.

A strongly pronounced negative self-image closely related to understanding depression as a manifestation of a failure to gain control over a dysfunctional reactive attitude places the emphasis of the sense of lack of hope and prospects for change on the own failure to intervene on these. The oppressive and hopeless current existential situation cannot be

remedied by a deficient self, which appears the sole bearer of responsibility for being in this condition as the following passage suggests:

> I feel that there is no exit, that I am unable to change my life. These differ from periods when I am not depressed exactly with respect to the listed above, when I am not depressed I am more optimistic, I trust my abilities more, I have the will to fight. I believe that my existence has purpose and meaning. I believe that I can have a normal life. (R81BG, Q1B)

Still others might entertain a more specific understanding of the nature of the individualized attitude that results in depression. The condition for them is characterized mainly by an orientation of diminished self-worth that is based on alleged or real failures to deal with as, for instance, described by this respondent:[174]

> Depression is a temporary disappointment with myself because I was not able to deal with something. (R53BG, Q10B)

The characteristic experiences of helplessness and hopelessness are particularly pronounced with respect to one's failure to fulfil the demands of self-imposed overload of responsibilities:

> I take more responsibilities that I can handle. A feeling of helplessness and hopelessness. (R53BG, Q1B)

The depressive condition, rather than changing one's pattern of thinking, is considered as the result of respectively, "being anxious and worrying" (R53BG, Q8B) as the own thoughts are seen as the cause of a depressive episode: "[…] my thoughts send me into depression" (R53BG, Q7B). Similarly, the world and others have not changed, rather how one is affected by them constitutes the experiential profile of depression:

> No, the world is alright. But I cannot understand why I bother myself. (R53BG, Q2B)

Thus, the condition is the direct result of one's way of thinking rather than the response to changes in subjective reality. Here, as well, the respondent does not refer to any events or occurrences that might have had a causal role on her having this particular style, which even more so frames it in terms of an individual reactive attitude that one might be responsible for. Accordingly, an important aspect of depression that this respondent considers not addressed by the questionnaire (Q13B) is the experience of self-hate that is brought into a sharper forcus by the framing understanding of the condition as both the result of deficient or dysfunctional way of thinking and a general dissatisfaction with oneself.

Another respondent similarly thinks that "[…] the attitude of people causes […]" depression (R56BG, Q11B)[175]. The resulting condition, similarly to the instances discussed above, in spite its disturbing and harmful nature is noticeable mainly in terms of its

[174] The response to follow was administered the code *A reactive attitude that can be controlled.*
[175] This response was administered the code *A reactive attitude that can be controlled.*

incapacitating effects with respect to everyday or professional performance. Illnesses are generally associated with particular symptoms, signs, and manifestations that are usually clearly defined and circumscribed in specific diagnostic manuals. For instance, the chicken pox is manifested with a particular rash, fever, the production of antibodies, etc. Depression, being the result of a way of thinking, is not an illness and, thus, its onset might not be associated with specific symptoms and signs but rather only in its general effects on everyday performance as this respondent describes it here:

> I did not know that I had depression, I just could not work. (R56BG, Q10B)

Similarly, one fails, on the basis of current experience to identify depressive episodes based on changes in affective states in particular and seems to attempt to do this with respect to 'objective' criteria such as the use of medication:

> I do not know if I am currently depressed because I am taking 150mg of Tritiko (R56BG, Q1B)

The incapacitating effects of depression are here as well seen as resulting from a failure of volitional capacities rather than physical incapacitation, for instance:

> The tasks that I have to do are standing in front of me and I do not have the will to do them. (R56, Q5B)

One fails to move oneself to perform various tasks rather than being rendered incapable to function. The experience of lack of drive or motivation here is presented as a failure of the will, the active component than we can deploy to successfully function in everyday life and deal with its challenges. And rather than being an illness, volitional incapacity is a failure of an inferior, deficient self. This, rather than a valid incapacitation by a pathological condition, is a personal failure of coping and functioning, which in this particular case is also closely related to the oppressive narrative that reduces depression to a condition resulting from personal problems of living the respondent has been confronted with:

> No one, the doctor just told me to find a boyfriend but it gets worse when I go on dating sites because everyone is lying to me (R56BG, Q12)

The suffering one is undergoing is, thereby, not seen as indicative of a pathological condition bur rather an existential problem of everyday life, which, moreover, can be solved by the patient herself. This exclusion of the realm of the medical by those who are experts in it culminates in a stance towards the own suffering as if brought on by oneself as described here:

> Right now I am feeling very bad but I do not want to be hospitalized again and this time it is not my fault (R56BG, Q13B)

The responses to the DDQ BG discussed above describe a conception of depression as the result of an individualized reactive attitude and thereby alienate it from the view of depression as a pathological condition or an illness that is manifested in specific symptoms

and signs. The prototypical pathological conditions such as somatic illnesses are commonly not considered within the bounds of one's volitional and voluntary control and moreover are not considered (with a few notable exceptions such as HIV and sexually transmitted diseases) indicative of any sort of personal failure. In contrast, conceiving of depression in the manner discussed above awards it a status of a condition that in spite of its harmful and dysfunctional nature is not a prototypical illness but rather the result of personal idiosyncrasy. The understanding of mental illness as resulting from a particular reactive attitude that is within the bounds of one's voluntary and volitional control is closely related to its social stigmatization and it has been shown to be common in Bulgarian society. In a study examining the stigmatization of mental illnesses in Bulgaria, Kozhuharov et al. (2015, 74) found out that 11% of the individuals afflicted with mental illness who participated in their study did not want to identify as mentally ill. The strong social stigmatization of mental illness, its conception as a personality flaw or shortcoming, for which the mentally ill might even be responsible can be seen as the basis for this unwillingness to identify as mentally ill. Despite being diagnosed by a medical professional and treated as a patient, these participants indicated that they have not been in a personal contact with people suffering from a mental illness. It can be suggested that they choose to interpret their condition either not as an *illness* or not as a *mental* illness. In the case of the former, this could be at least partly due to the conception of mental illness as a psychological reaction or a personality trait, which places it outside of the realm of medical conditions. In the case of the latter, the prevailing conception of mental illnesses as interfering and impacting the rational capacities of the mind (e.g. in cases of psychoses) might make them view their respective conditions as belonging to the realm of madness and strongly impaired rationality.

The stigmatization of mental illness is also reflected in the attitudes of the participants in the survey who have not suffered from a mental illness (Kozhuharov et al. 2015). More than half (65%) of them report of having no experiences with mentally ill individuals. 37% of this participant group conceive of the mentally ill as the bearer of negative personality traits and 73% think that the mentally ill are responsible for their condition (Kozhuharov et al. 2015, 74). Similarly to the findings discussed above, mental illness is, thus, frequently considered as within the realm of responsibility of the patient rather than society at large, for instance. This added burden of responsibility for the own condition might impact help and treatment seeking, the communication of the diagnosis of mental illness, or even psychological distress and suffering, etc. Moreover, the findings indicate that often mental illnesses are not clearly differentiated and lumped together in the prototypical image of the mentally ill who suffers from a grave and severe condition that can be treated

only with medication. The ambivalence in the medical status of mental illness – as both a serious condition that has to treated with medication and a psychological trait or psychological reaction to adverse events – also suggests that there is little awareness of the various psychiatric categories and disorders such as schizophrenia, personality disorders, mood disorders, etc. This culminates in the clustering of all conditions regardless of the scope and nature of the symptoms and impairments they are associated with, which oscillates between these two poles. Thereby, for some, their condition, being not 'serious' enough, becomes a personality trait, a failure of resilience or coping resulting in an inappropriate and harmful psychological reaction. Being faced with the prospect of being misunderstood or misclassified as 'insane', 'lost their minds', 'crazy', etc. these patients might also more readily frame and experience their symptoms in the context of individualized response to adverse events as well.

The conception of depression as a psychological reaction to adverse events or life's vicissitudes is, according to the literature wide spread (see Kokanovic, Bendelow, and Philip, 2013). Emotional distress in general is rarely seen as a medical complaint and respectively it is also often considered that one should mobilize personal strength to deal with various adverse events. This automatically places those suffering from depression outside of the realm of valid or legitimate medical conditions that warrant treatment and institutional support. The associated trend of the attribution of responsibility for one's condition, thus, places suffering from depression at an ambiguous position of a warranted, appropriate, and justified reaction to particular occurrences and a personal shortcoming or failure mainly in terms of having an individualized highly subjective reactive attitude, which might be seen by some as causally related to depression.

Some of those who understand depression as the result of an individualized reactive attitude in contrast place it closer to the realm of (medical) pathology. Although the condition is still understood as the result of an individualized reactive attitude, here, this attitude viewed as causally related to various underlying factors that have negatively affected, for instance, capacities for coping and resilience and culminated in a dysfunctional and harmful pathology (b). Commonly pathological conditions of mental functioning display a widely accepted association with different causal factors such as adverse and traumatic events in early childhood, and a proneness to react in a specific way to various triggering events. Thereby, the additional burden of responsibility for suffering from depression is more closely related to various events and upbringing rather than to individual character and resilience. Depression, thus, is understood as the result of a *warranted, justified, or appropriate reactive attitude* that makes one prone to become depressed in some situations (e.g. times of economical,

financial, personal, or social hardship, etc.), experience long-term change in affect, thinking, and behaviour that can be (medically) intervened on, or become chronic and be considered by some as part of their identity. In the former cases, usually the changes in experience, thinking, and action are often described as related to a 'depressed' self that replaces a so-called 'core self' one commonly identifies with. In the latter case, depression is an integral part of the self, so that there is no clear distinction between a 'core', 'non-depressed' or 'depressed' self. The respective causal and triggering factors that the respondents identified as related to suffering from depression and individual depressive episodes can also emphasize emphasise specific experiences such as loss of control and helplessness, anxiety and loss of security, diminished self-worth, etc. that resonate with the putative causal and triggering factors.

For instance, understanding depression as being triggered by the misfortunes of life or adverse events and traumatic experiences, that was reported by eight (61.54%) of the respondents ot the DDQ BG, can be associated with feelings of helplessness and hopelessness in particular with respect to one's life as described by this respondent:[176]

> With me, depression appears in periods of misfortune that I cannot control. (R23BG, Q11B)

> Strong anxiety accompanied by insomnia. A feeling that everything is falling apart, that I cannot control my life. (R23BG, Q1B)

The feelings of loss of control also make one feel that they have lost their grip on their life and the world in general. The world is experienced as distant, the lack of grip is manifested in feelings of not being engaged with it and one feels as not being part of it. Moreover, the own life is experienced and conceived as outside of one's control, the performance of even simple routine activities is gravely impacted, and one feels as if one cannot successfully deal with it especially during depressive episodes as described in this response:

> A feeling of not being able to cope that does not exist when I am well. (R23BG, Q8B)

Understanding depression as a psychological reaction to the overwhelming stresses of everyday life brings into sharper focus feelings of helplessness and incapability specifically in view of the problems of everyday living as described in these passages:[177]

> Depression is exhaustion. It was caused by stress and very adverse factors that did not depend on me. (R55BG, Q11B)

[176] The response to follow was administered the code *Depression is caused by adverse events and traumatic experiences*. The responses reporting of this understanding of depression are: R23BG, Q11B; R43BG, Q11B; R46BG, Q11B; R55BG, Q11B; R74BG, Q11B; R77BG, Q11B; R83BG, Q11B.

[177] The response to follow was administered the code *Depression is caused by adverse events and traumatic experiences*.

The demanding nature of everyday life and in particular adverse events that one fails to control or intervene on seem to have depleted one's coping potential or resilience. Subsequently, the accumulation of the challenges of everyday living robs the future of prospects for change both in terms of what one is able to do and what possibilities it offers. Moreover, the notion of depression as resulting from a depleting of coping potential emphasizes experiences of diminished self-worth as one has failed to overcome or deal with the vicissitudes of everyday life:

> Depression made me think that there is no way out. I panicked. I felt weak, focused on the problems without a realistic estimate of the abilities and the possibilities I have. When I am not depressed, I am in a better mood, I am more confident, calmer, I do not worry about everything so much, I am more relaxed in my relationships with people. (R55BG, Q1B)

The focus on diminished capacities (memory) and somatic complaints ("elevated heart beat and sweating of the palms" (R55BG, Q7B)) accompanying panic attacks can be seen as related to the failure of the wider public and even medical professionals to view depression and a pathological condition described in these passages:

> I do not know about different, but they [other people] do not have the right strategy – they simply talk about how everything is going to be okay or that you do not have so serious problems instead of just hearing you out and helping you cheer up. (R55BG, Q3B)

> The doctors always try to convince the patient that there is nothing wrong with her because she is not in a state of severe psychosis, i.e. there is no big problem. But this does not seem adequate to the patient because she herself does not have any experience in solving such problems and her condition is severe. It is not clear what the options for controlling the symptoms are, the bodily sensations are unfamiliar and the professionals neglect this effect! In general, I think that I did not find anyone who was adequately prepared who could explain to me how to fight the problem. I managed thanks to the sedative, my boyfriend, some fortunate events at my new workplace, which stabilized my situation. And also my desire to fight and rise above my problems. It still happens from time to time, but I know that this is normal and I do not demand too much from myself in this respect. Gradually, I am regaining my lost confidence. (R55BG, Q13B)

Depression, according to most here, is a failure in coping resulting in specific a 'mild' or 'moderately severe' dysfunctional psychological reaction that might even not deserve medical attention, be short-lived, or disappear when external circumstances change. This view also demonstrates that the concept of mental illness in particular is based on severe conditions such as those involving psychosis, thus, mental illness is a grave disturbance of rationality, intellect, cognition, coherence of the self rather than of affect. Therefore, depression might be considered as a 'valid' psychiatric complaint mainly in view of the individual capacities that it impacts and how these affect everyday living and coping.

The incapacitating effects of depression that render one unable to participate in everyday life were emphasized by another respondent to the DDQ BG as well who in contrast does not appear to associate a strong self-evaluation with them. The condition, here, is understood as resulting from "[d]ifficult situations and such that do not offer any way out" (R74BG, Q11B)[178] but appears to not be related or resulting from a personal failure. Rather, it causes difficulties with everyday living and one is "[…] barely able to do anything" (R74BG, Q5B).

Understanding depression as "[a]n illness that depends on many factors, on adverse events in childhood as well as on the environment at the moment, on the support that one receives or does not receive" (R46BG, Q11B)[179] weakens its association with diminished self-worth and feelings of responsibility. Rather, it presents it as an illness that is causally related to a combination of many different psychological factors that are external to one. The multiplicity of causal factors this respondent associates with her depression, namely adverse events in the past, hostile, or unstable and unsupportive environment in the present are aspects that define one's existential situation and cannot be (easily) changed or intervened on. This emphasizes the orientations of loss of hope and point and purpose to life in general, which are manifested at the foreground of experience in overwhelming feelings of lack of prospects and meaning (of existence) as described in this passage:

> Low-spirited, sadness, hopelessness, thoughts that life does not make sense, that everything is pointless, suicidal ideation. (R46BG, Q1B)

Long-term psychological trauma and a general dissatisfaction with one's life and current existential situation are also understood as causes of a depressive psychological reaction[180]:

> It is caused by tiredness – after many years of repeated psychological trauma of various character, the feeling that this is not the life I wanted. And the realization that nothing can be changed. (R77BG, Q11B)

Long-term psychological trauma has depleted one's coping resources, which transforms the world in to one lacking prospects for change. Subsequently, these changes in the world occasion feelings of "[h]opelessness, powerlessness, anxious thoughts, lack of desire for any activity, a desire to run away from everything and everyone, unwilling to talk (R77BG, Q1B)". This emphasis on changes in the world that are not within the realm of one's control, moreover, resonates with the putative causes of a depressive reactive attitude – traumatic events and a general dissatisfaction with one's life bring the experiences of lack control and prospects, and anxious anticipation in a sharp focus in the foreground of experience. By viewing antecedent adverse events or psychological trauma as causally relevant for

[178] This passage was administered the code *Depression is caused by adverse events and traumatic experiences.*
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[180] The response to follow was administered the code *Depression is caused by adverse events and traumatic experiences.*

developing a depressive reactive attitude, the respondent also distances the condition from the realm of her personal responsibility – rather than viewing it as related only to a highly individualized pattern of responding to the world, here it is rooted in a depleting of coping resources pursuant of psychological trauma and this depletion, similarly to immense tiredness or exhaustion transforms every aspects of one's existence. Within this framework of depletion of resources, routine tasks and everyday activities become most pronounced in their taxing, demanding, and challenging nature. Having exhausted all of one's resources for dealing with adverse and traumatic events, everything takes more effort, "[…] even things that concerned only me – to take a shower, to eat" (R77BG, Q5B).

The lack of control that is associated with precipitating traumatic events is also mirrored in the experience and description of the changes in one's style of thinking during depressive episodes. The oscillation between a stream of anxious thoughts that cannot be controlled, through inability to focus on individual thoughts, to obsessions and fixations cannot be intervened on and leaves one at the mercy of random cognitive processing, which can exacerbate the experiences of powerlessness and helplessness:

> From anxious thoughts, that I do not have the power to stop, to lack of any thought/or only a single obsessive one, to blackouts for a few seconds/ but you are never sure how long they lasted. (R77BG, Q7B)

An explicit identification of depression with "a state of the mind, in which it becomes fixated on something it does not want to accept (in the past) or something it strongly desires (in the future) and does not have in the present" (R83BG, Q11B)[181], similarly emphasizes a tendency towards an obsessive preoccupation with specific thoughts and desires. Although, according to this respondent, depression is a mental state, it is expressive or a reactive attitude, which is the direct result of adverse and traumatic events as described here:

> In my case, the cause of my depression was that I met a boy and his family who considered themselves very spiritually sophisticated people an I had accepted that I am not like that and that I need spiritual growth and development but following their criteria. This made me question my own worth and it was expressed in a desire to change myself – to lose weight physically and to be more moral. But I did not go through any form of self discovery so that I could learn who I am and thereby change, but started keeping not normally strict diets and to ponder on specific thoughts that I had heard in their circle. As a result, I started viewing myself as a bad person who has to change. This ideal was some unattainable, abstract image that I could never reach. This was the cause, and the reason is that deeply I have not had faith in myself, I was not brought up with virtues such as self-knowledge, peace, and understanding the world. […] (R83BG, Q11B)

[181] This response was administered the code *Depression is caused by adverse events and traumatic experiences.*

These traumatic events are specifically understood in terms of their formative impact on one's self-worth, which impinges on general psychological resilience so that adverse events and lack of support in life or a precarious and unstable existential situation trigger a depressive reaction. Depressive symptoms, subsequently, are explicitly viewed as a reaction to particular situations such as the ones described here:

> I am a single parent with a small child and it is difficult for me to carry all the responsibility of parenthood and also that life form me is changing. Of course, there are other factors involved here – moving to live at another place, choosing a smaller apartment, i.e. the conditions which I am used to live in. Moreover, my mother passed away two years ago. (R83BG, Q11B)

Similarly to the previous respondent, here, the lack of control over the causal factors underlying depression is mirrored in an emphasis on the uncontrollable nature of obsessive thinking that can be experienced as rendering one unable to think or experience anything positive:

> The depression sticks me in a past moment, when something that I cannot accept happened. Keeping this thing in my mind it is hard to let other, stronger thoughts in it. (R83BG, Q7B)

Being a state of mind, depression transforms how the world is experienced – what has changed is one's appraisal rather than the world itself. Although, this change is not seen as within the bounds of one's volitional and voluntary control similarly to obsessive thinking, it is the result of a depressive reactive attitude, which occasions radically different responses to one and the same situation as observed here:

> I do not have a calm environment, but one that puts a load on me and I feel bad. During times when I am not depressed, I see how the same environment does not appear that hostile. (R83BG, Q1B)

> At the moment, I am not depressed and I see happiness and hope in most situations, I feel gratitude and meaning in my life, everyday tasks bring me satisfaction and pleasure, although they make me physically tired. When I was depressed, these feelings were absent. I felt mostly grief and I was waiting for a wonder that would change the past, so that I do not have to accept it. But at that moment I did not understand that it was like that. Because of this everything appeared so difficult and burdensome. And happy people – as if they were from a different world. (R83BG, Q8B)

The alternation between a depressed self, which entertains a depressive attitude and a core, non-depressed one that can enjoy life and anticipate future prospects. Rather than completely identifying with the depressive reactive attitude, thus, it is seen as constitutive of a transient, illness-related self that is the direct result of the causal factors mentioned above but does not exclusively dominate one's existence. Analogously, the only emphasis on experiences of diminished self-worth and guilt is with respect to the role of causal factors rather than with respect to being depressed or during depressive episodes. The experience of depression here

is embedded in a framework that presents it a transient reactive attitude originating from adverse and traumatic events that replaces one's common reactive attitude in times of hardship and misfortune.

For others, though, a depressive reactive attitude can be more closely associated with a core self:[182]

> I think that I have adopted this stance since I was little, it has become my second nature. In contrast, I also think that it is very closely related to the biochemistry of the brain because of the way that medication impacts it. (R43BG, Q11B)

This respondent entertains a mixed conception of depression as a resulting from an individualized reactive stance that can be intervened on with the help of medication, which reflects the general public's ambivalent understanding of the condition – it is rooted in one's personality or self that can be modified by the use of specific medication. But in this particular case, although this reaction appears to be the subject of the modification of medication and, thus, has a neurochemical underpinning, it attributes the condition to the particular individualized way in which one reacts to events and states of affairs in the world. Thus, one also appears to associate depression or at least its occurrence with a faulty or somewhat 'weak' or dysfunctional style of thinking, experiencing, and reacting to the world. Thereby, the condition is also additionally very strongly associated with feelings of guilt and tendencies towards self-blame. Respectively, in particular during depressive episodes, the loss of prospects, hope, meaning, and purpose are experienced as closely related to one's failure to cope or deal with the world as described here:

> Because of the lack of an aim and faith that I can cope with challenges, I experience a lack of perspective, it looks as if life does not make any sense, but is just a torture. When not depressed, I think about things that I want to achieve, I believe in them, and get inspired from the idea that I can achieve them, life looks like fun. (R43BG, Q8B)

Moreover, this attribution of responsibility for the own condition and how one feels and performs during depressive episodes is also closely related to the general stigmatization of depression that is based on oppressive master narratives (discussed in detail the previous chapter) that place the burden of being in control of one's affective states and thoughts on the individual as described here:

> When people tell you "Come on, pull yourself together, there is nothing to be depressed about", it is very difficult to explain that it is not possible for you to not be depressed. In this moment, you simply do not know what good mood is. As if it has never existed and you cannot imagine what it is like. It is not possible to have fun. (R43BG, Q10B)

[182] The response to follow was administered the code *Depression is caused by adverse events and traumatic experiences.*

Within the framework of a general lack of recognition of the validity of one's, others appear "as if they were not caring or ill-willing, critical, menacing" (R43BG, Q3B).

The strong framing association of depression with a specific personality or self that is understood as more or less long-lasting or permanent, alienates the condition from the realm of medical pathology. Although, it can be intervened on with medication, it is still mostly an expression of a deficient and weak self. These assumptions present its manifestations not as symptoms but rather as the result of a specific psychological organization, which is deeply ingrained in the core self here. Specifically with respect to the lack of acknowledgement of suffering from others, experiences of depression do not appear as valid symptoms. But the harmful and dysfunctional nature of depression is apparent to the sufferer and to make it more clearly obvious to others in terms of its pathological character, the emphasis on changes in bodily experience falls on very specific and clearly individuated physical symptoms that resemble those of somatic illnesses as described in this passage:

> An experience of being very tired and sleepy. I often had a sour stomach, in the worst periods – vomiting and feeling sick. The body is heavy and energy is low. (R43BG, Q4B)

The feeling of tiredness and diffuse bodily heaviness in this case is combined with specific somatic complaints of gastro-intestinal discomfort and vomiting, which are commonly valid symptoms of different somatic illnesses rather than merely a reaction or response. Here, the lack of an illness-status of depression, might shape the experience of somatic symptoms and make these more pronounced in particular.

Among the conceptions of depression as a psychological reaction to adverse and traumatic life events we can observe more subtly differentiated understandings of the condition. In its extreme forms, in spite of its dysfunctional and harmful character, it might lack the status of a medical pathology. This, for some can frame the changes in experience one is subjected to during depressive episodes as not indicative of an associated illness and respectively introduce an emphasis on clearly individuated and differentiated medical complaints. For others, depression is the direct result of one's individualized reactive attitude, which, moreover, is potentially within the bounds of one's volitional and voluntary control. The depressive condition, thus, is indicative of a personal failure to alter this attitude and particularly in the cases where there is no explicit identification of underlying causal factors places a strong emphasis on feelings of guilt and self-blame both for suffering from depression and during depressive episodes. Acknowledging the pathological status of depression in combination with the view presenting it as the result of a specific reactive attitude alleviates this burden to at least some extend. Here, I propose that the assumption

of underlying causal factors such as adverse and traumatic events presents the depressive reactive attitude as resulting from the impact of events beyond one's control that have negatively affected one's resilience, coping potential, and appraisal in general. These assumptions and beliefs construct a framework of lack of control, anxious anticipation, and helplessness above all in the face of life's vicissitudes, which is also mirrored in the emphasis on experiential changes described in first-person testimonies. Moreover, the personal meanings of depression, frequently resonating with the alleged underlying causal factors, also shift the focus to specific experiential phenomena such as lack of security, for instance.

3.2. Depression is an Illness

Only two (15.38%) respondents to the DDQ BG understood depression as an illness that is rooted solely in biological changes. On eof them identifies it explicitly as "[a] chemical imbalance in the brain" (R36BG, Q11B)[183]. He also emphasized the incapacitating effects of the disorder throughout his responses by identifying them with a handicap and explicitly referring to its impact on individual capacities that interferes with the performance of everyday routine activities:

> It affects it very much! My thoughts are very disorganised, I cannot concentrate on anything and my memory is most strongly affected. (R36BG, Q7B)

In this case, though, the incapacitating effects of the illness are not accompanied by altered experience and normative evaluations of the own self and there are no descriptions of feelings of guilt, diminished self-worth, and shame although the change in how others are experienced is attributed to one's own altered state.

In a similar manner, another respondent identifies depression as an incapacitating condition that is seemingly not related to external events or the own personality[184]:

> Unfortunately, in my case, I do not think it results from my thoughts or feelings, it just appears and feel powerless against it. (R59BG, Q11B)

The overwhelmingly incapacitating effects of the condition one is powerless against have devastating effects on the experience of the coherence and continuity of the own self as one feels that during depressive episodes "this is not me" (R59, Q10B). Rather than conceiving and experiencing the condition as part of one's self or personality, here, there is a clear sense of its effects on the a 'core self' manifested in mainly in terms of its grave impact on one's functioning and everyday performance emphasized in several responses:

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[183] This response was administered the code *Depression is an illness caused by faulty biology*. This understanding of depression was reported only by one further respondent: R59BG, Q11B.
[184] The response to follow was administered the code *Depression is an illness caused by faulty biology*.

> I do not have the energy to get out of bed, and the motivation for it, as well. I am constantly sleepy. I do not want to talk to people, I neglect my appearance, it is hard to deal even with basic everyday tasks. (R59BG, Q1B)
>
> When I am very bad, I do not do anything, I do not get out of bed, I smoke a lot. (R59BG, Q5B)
>
> I have the feeling that my head, more specifically my brain, is wrapped by a ring/band that makes it hard to think, I feel stupid and I am afraid I will go insane. (R59BG, Q7B)

These culminate in the sense of loss of the ability to cope in everyday life, which, though is the result of an incapacitating and disabling illness rather than a personal shortcoming:

> Hopelessness, I fear that I cannot deal with life, work, child, family. (R59BG, Q8B)

The status of depression as a mental illness has become increasingly more accepted by the 'lay public' since the late 1990s. A large-scale study by Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) inquiring about the wider public's conceptions of different mental illnesses and their causes has demonstrated that vignettes depicting descriptions of depressive experience are recognized as mental illness by 69% of the respondents. When asked about the causal factors for developing the condition, almost all participants agreed on the major role of adverse events or stressful circumstances (94.8%), followed by an understanding of a chemical imbalance in the brain as the cause of depression (72.8%). Additional causal factors for depression that were included were genetics or an inherited condition (52.9%), how the person afflicted with depression was raised (47.6%), the person's own bad or deficient character (38.2%), and God's will (15.4%). In a more recent survey of the conceptions of mental illness in general and depression and schizophrenia in particular Pescosolido et al. (2010) observed that larger portions of the wider public embrace the understanding of both conditions as causally related to changes in neurobiology. In line with this trend, "social or moral conceptions of mental illness decreased across most indicators, and a significant decrease in labeling the condition as "ups and downs" was observed for depression" (Pescosolido et al. 2010, 1323). Unfortunately, no significant decrease in the levels of social stigmatization of the conditions was observed and these still remained high in spite in the changing attribution of causal factors to underlying neurobiological changes. As evidenced by the preceding discussion, the majority of the respondents to the DDQ BG understood depression mainly as a psychological reaction to different adverse events and upbringing and a failure of coping with these. The otherwise widely recognized causal role of neurobiological and neurochemical factors was reported by only one respondent, in contrast, which might reflect the general trend of considering depression as an individualized psychological reaction and also the absence of dialogue with the psychiatric discipline in

general, the lack of psychiatric knowledge in the wide public and the major influence of media on one's understanding of depression and its causes (cf. Kozhuharov et al. 2015). Although all respondents to the DDQ BG report of having consulted a medical professional and most of them have received treatment in the form of medication, the still prevailing conception of depression as a psychological reaction rather than as an illness (caused by aberrant neurochemistry or other underlying neurobiological changes) still appears to be present among the wider public. The levels of stigmatization of depression in Bulgaria still remain very high as identified by the mentally ill participants in their study and the healthy population's responses to questions about the social acceptability of mentally ill individuals. In a study of the stigmatization of mental illness in five European nations (Bulgaria, Hungary, Spain, Germany, and Iceland), Pescosolido, Olafsdottir, Martin, and Long (2008) observe variations of social acceptability across three different venues (community, workplace, and family) for individuals suffering from schizophrenia and depression among these countries. The highest levels of rejection across all venues are reported in the two Eastern European countries, whereby in Bulgaria in particular, it is the highest with respect to acceptability in the community for both schizophrenia and depression. The still prevailing social stigmatization of mental illness, the authors suggest, is a complex cultural and historical phenomenon that is also closely related to multiple economic factors (Pescosolido et al. 2008) and in need of further examination in order to determine the intricate patterns of various influences on it. Along similar lines, Kozhuharov et al. (2015) report that in particular among those who have not suffered from a mental illness, the prevailing view of the mentally ill patient is negative – 65% indicate that thinking about mentally ill patients is associated with negative or unpleasant feeling, 75% are have a sceptical attitude towards those who have been treated by a psychiatrist, 72% indicate that society has a negative view of the mentally ill and psychiatry, and 62% think that mentally ill patients have to be treated only in psychiatric facilities and not in neurological or somatic ones (Kozhuharov et el. 2015, 74). The authors propose that the general stigmatization of mental illness in Bulgaria is mainly based on the lack of contact and proper awareness and information about mental illness, the individuals suffering from it, and psychiatry as a discipline in general.

4. Conceptions of Depression in the DDQ UK

A broadly similar pattern of conceptions of depression can be observed in the responses to the DDQ UK. Unlike the responses to the DDQ BG, though, here a larger portion of the respondents understand the condition as a pathological state of the organism or an illness

rather than as a pathological psychological reaction (see Fig 2b for an overview of the conceptions of depression reported in the DDQ UK). Moreover, the conceptions of depression reported in the testimonies show a wider variation in terms of the conception of underlying and contributing factors, more detailed and complex understanding of the illness and its (causal) mechanisms, and a less stigmatized view of depression in general. While this might be due to the much larger number of responses submitted to the survey, which thereby also reflect many more different conceptions and experiences associated with depression, it is also embedded in complex social, cultural, and institutional context surrounding mental illness in Britain. Here, I am as well going to highlight the specific differences in the ways the respondents understand their condition, in particular its causal underpinnings and nature. As the experience described in the testimonies produced in response to the DDQ UK was discussed in detail in the previous chapters, I am going to focus only a small number of reports of experience and engage in more detail in an examination of the particular conceptions of depression reported, specifically in view of the difference between them and those described by the respondents to the DDQ BG.

4.1. Depression as a Pathological Psychological Reaction

Depression is, according to 34 (27.87%) of the respondents to the DDQ UK, a (pathological) condition that results from an individualized psychological reaction, whereby here we can distinguish among several more detailed and finely nuanced understandings with respect to causal and triggering factors. Commonly, the respondents explicitly distinguish between the different roles adverse events and psychological trauma play in depression – some traumatic and adverse events (frequently such in early childhood) have a causal role in particular in view of the formation or development of a proneness or a disposition to specific psychological reactions, while other adverse events (frequently the stresses of everyday life, loss of a loved one, romantic, financial, and social misfortunes, etc.) are explicitly identified as triggers of individual episodes. The latter ones, thus, are experienced, appraised, and dealt with, according to some of the respondents, unsuccessfully or inappropriately so that they become overwhelming, more stressful and demanding based on the respective psychological organization that itself is the result of earlier traumatic events. This *explicit* differentiation is present in many of the responses to the DDQ UK but absent in those to the DDQ BG where those who mention adverse events do not explicitly distinguish between causal and triggering factors. Thereby, adverse and traumatic events are not differentially associated with depression in particular with respect to their role in developing a particular reactive attitude. Rather, as described in the responses to the DDQ BG, these are mainly seen as triggers while

the individual psychological organization that makes one prone to experience triggers of depression is by many not explicitly related to any underlying causal factors. Thus, rather than viewing depression as the result of an individualized reactive attitude, which itself is causally linked to psychological trauma, it is still framed in terms of personal deficiency or failure. The responses to the DDQ UK, in contrast, seem to explicitly associate the individualized reactive attitude with various underlying causal factors and thereby distance the harmful, dysfunctional, and undesirable condition from the realm of the self and personal responsibility resulting in less pronounced emphasis on experiences of diminished self-worth and guilt in particular with respect to being depressed.

For instance, two (1.64%) of the respondents to the DDQ UK specifically relate the condition to the lack of attachment in early childhood as described here:[185]

> I think it is my situation. I am not close to anybody and never have been. The idea of being loved by your parents or loving them seems bizarre to me. (R84UK, Q11B)

Depression, here, is the result of a specific situation external to one – the lack of early attachment has had a causal impact on the specific way one relates to others, rather than this being within the realm of one's control.

Accordingly, the descriptions of how the world and others appear during depressive episodes emphasize the experiences of disconnectedness and alienation:

> [The world appears] distant irrelevant (R84UK, Q2B)
>
> I hardly see anybody at the best of times (R84UK, Q3B)

Feelings of diminished self-worth and guilt in particular with respect to being depressed are accordingly not emphasized in the responses as well.

Twelve (9.84%) of the respondents to the DDQ UK locate the causal impact of adverse life events explicitly in their role impacting one's self-image, self-worth, self-esteem, etc. Self-confidence and appreciation of one's own self-worth is commonly seen as related to susceptibility to depression in particular in view of the lack of confidence that impacts both how one relates to others and the world and how appraises and evaluates adverse life events. This wide-spread conception influenced by various models and therapeutic approaches in both psychiatry and clinical psychology has enjoyed a long tradition and is by

[185] The passage to follow was administered the code *Depression is caused by lack of attachment*. Responses describing an understanding of depression as causally related to a lack of attachment (in early childhood) can be found in R84UK, R153UK. The lack of attachment in particular as a causal factor for depression was also mentioned in descriptions of conception that identify it as an illness caused by a complex and intricate interplay of biological factors, genetic predisposition, adverse life events, and genetics. This conception will be discussed later in the current section as it views the condition explicitly as an illness resulting from the combination of various different factors.

a large extent present in works of popular culture. Depression, on such conceptions, can be understood in the following way:[186]

> I have no idea what depression is apart from that it is a state of mind which in my view once you have it never will fully go away. If you tackle depression you are tackling low self esteem (in my opinion).
>
> My depression comes from my childhood. I had parents who were up-standing citizens with a nice house and garden and job etc but didn't know how to parent a child. Constantly reminded of my place and not to outshine my brother academically. Other family 'stuff' which I won't go into. (R161UK, Q11B)

Understanding depression explicitly as a 'mind set' that determines how one responds to various events in the world and is mainly characterized by a diminished self-worth and a negative attitude to the own self. And this respondent's answers emphasize experiences of diminished self-worth, guilt, and lack of prospects for a significant future, or to get better as in these passages:

> Not to any extreme. Other people do appear to have perfect lives which I know isn't true. They just seem to be able to cope better and enjoy themselves more and not have the struggle that I have. I describe it as 'they are wired up correctly' (R161UK, Q3B)

A larger portion of those who understand depression as a pathological psychological reaction (20 (16.39% of the respondents to the DDQ UK)) refer to adverse events and psychological trauma in general as impacting one's psychological organization and resilience without explicitly identifying their causal role with respect to self-worth and self-confidence. Moreover, when referring to the vicissitudes of everyday life that trigger depressive episodes, these are also frequently not associated with a personal failure or weakness of character. For instance, for some of them violence, bullying, and abuse in particular as a causal factor for their specific psychological organization that makes them prone to depression as, for instance described in these responses:[187]

> I'm not sure what depression is. I just know it controls almost every aspect of my life. In my view, my depression clearly started at school. I was bullied for being overweight from the day I set foot in secondary school. Anorexia and bulimia followed, as well as damaging relationships and being bullied at work as well as numerous other problems throughout my life. My life has been a

[186] The excerpt to follow was administered the code *Adverse events impacting self-worth*. Responses describing a conception of depression as caused by diminished self-worth, which is itself the result of adverse life events are: R21UK, Q11B; R41UK, Q11B; R97UK, Q11B; R106UK, Q11B; R161UK, Q11B; R228UK, Q11B; R269UK, Q11B; R285UK, Q11B; R288UK, Q11B; R292UK, Q11B; R307UK, Q11B; R370UK, Q11B.

[187] The three excerpts to follow were administered the code *Adverse life events make one susceptible to depression*. Responses reporting this conception of depression are: R14UK, Q11B; R60UK, Q11B; R65UK, Q11B; R66UK, Q11B; R85UK, Q11B; R105UK, Q11B; R115UK, Q11B; R143UK, Q11B; R145UK, Q11B; R199UK, Q11B; R200UK, Q11B; R212UK, Q11B; R218UK, Q11B; R240UK, Q11B; R259UK, Q11B; R291UK, Q11B; R352UK, Q11B; R355UK, Q11B; R366UK, Q11B.

> category of disasters which I think has caused and contributed to my depression. (R14UK, Q11B)
>
> Growing up and spending my formative years in an environment that was fraught with domestic violence. Then sexual abuse at the hands of my father. Also several episodes of sexual assault by family members (R66UK, Q11B)

Abuse in particular, has been widely accepted as a causal factor in the development of depressive disorders in particular. Here, as well, in line with this particular understanding of depression, the descriptions of depressive experience emphasize experiences of anxiety, fear, and a general loss of habitual trust. Others and the world, in particular, appear hostile, ill-meaning, and threatening as described here:

> Yes. It seems to be full of more hatred, evil and fear. When I am depressed, the world is a truly awful place to be. (R14UK, Q2B)

Depression is, for others, a normal psychological reaction to a cruel, hostile, violent, and menacing world that makes existence pointless as, for instance, this respondent writes:

> Honestly, I don't know and I don't know. I'm not sure depression is one thing. The depression you feel because your mum has just died is different to lifelong bipolar disorder. Surely, being depressed because your mum has died is not a mental illness?? Surely it's just a normal reaction to a situation. Likewise, maybe some long term depression is a normal reaction to modern day lifestyles, society or a difficult past. Is it normal to be depressed when people all over the world are killing each other, starving, and inflicting terrible cruelties? When in England dogs are being hung off bridges and pensioners are too scared to leave their homes and lie dead for 2 weeks before anyone notices? When half of all marriages end in divorce and many people my age will never be able to buy their own home or retire? Maybe it isn't, maybe our survival instinct prevents 'normal' people from thinking about depressing things, I don't know. One thing I would like to know is, is there any correlation between depression and intelligence? There certainly seems to be one between creativity and depression. (R212UK, Q11B)

Here, the objective reality one faces is characterized by particular qualities that warrant responding with experiences of pointlessness, anxiety, and lack of prospects, for instance. Depression, thus, is a realistic and appropriate psychological reaction to the cruelty and meaninglessness of the reality one lives in. This sort of depressive realism in its extreme form as described above places the condition in an ambiguous position between being appropriate and warranted by reality, and thus not dysfunctional, and in spite of this still signifying pathology as suggested by the explicit reference to normalcy in the passage above. Moreover, in line with the understanding of depression as a warranted and appropriate reaction to a meaningless and cruel world, the respondent emphasizes the difficulty to compare the experience of the world, others, and the changes in affect during depressive and non-depressive episodes. As the phenomena characteristic of depressive episodes are direct responses to this particular objective reality, they seem to also have been constantly present

in the long term as reality itself has not changed drastically. Moreover, the main identifiable difference between depressive and non-depressive episodes seems to be in the intensity of negative experiences as described in these passages:

> Again, I find it hard to say. Also struggling with the word 'world'. A beautiful view is always a beautiful view to me, but on a bad day I may be less likely to go and look at it. I find life and people more difficult on a really bad day, but I think the difference is more one of scale than outlook or viewpoint. (R212UK, Q2B)

Only two respondents (1.64%) to the DDQ UK report of understanding depression as a psychological reaction to a demanding and overwhelming environment. Unlike the formerly discussed instances, they focus rather on the accumulation of stressful or demanding events in everyday life and not on adverse events and psychological trauma and early adverse events that shape how they later respond to the vicissitudes of everyday life. Although they also share the belief that depression is a pathological condition, commonly triggered by a specific event, they appear to associate the specific stressful and demanding events also with their failure to deal with them without relating this to upbringing, psychological organization, etc. Interestingly, they also retrospectively identify with suffering from depressive episodes of various severity in the long-term, which awards the condition a status similar to that of an integral or constitutive personality trait. For instance, one of the two respondents who demonstrated this understanding of depression describes it in the following manner[188]:

> For me it is just an inability to cope, I feel as if I am teetering on the edge. I have a stressful job, and lost my father. My GP said my father's death was the catalyst that brought my depression/anxiety to a head, but not the cause. Now with a better understanding, I think I have suffered from depression most of my adult life. I just used to think I was a horrible person, weepy and prone to mood swings. (R366UK, Q11B)

In line with this understanding, the respondent emphasizes experiences of diminished self-worth and loss of prospects for a significant of better future as this deficient personality trait might appear a permanent personal characteristic that cannot be intervened on:

> […] Normally, I am very placid and organised, but when I am depressed I can't see the wood for the trees, everything feels insurmountable. (R366, Q1B)

The differentiated understanding of depression as the result of a psychological reaction to adverse events described in the DDQ UK encompasses the assumption of various causal and triggering factors that shape the experience of depression and how it is described. As discussed above, the condition can be viewed as rooted in a particular psychological organization, which has developed in response to various traumatic and adverse events and

[188] The excerpt to follow was administered the code *A failure to cope with demands of life*. One further respondent reports of a similar conception of depression: R355UK, Q11B.

attachment styles (1) in some cases. In others, depression is a psychological reaction to a hostile and meaningless world, in spite of its pathological nature is warranted (2). And in a third group of instances, it is the result of a failure to cope or deal with the increasing and overwhelming demands of everyday life (3). Although on all of these, depression is ambiguously associated with the status of an individualized reactive attitude, the seemingly subtle differences in the underlying causal factors and the assumptions about the processes they operate in have differential impact on the experience of depression and how it is described. While (1) and (3) include judgements and evaluations of one's self-worth, for instance, by deploying different notions of underlying causal factors and their impact they have somewhat distinct emphases on experiences of diminished self-worth. The attribution of responsibility and subsequent negative self-evaluation with respect to being depressed is more pronounced in the case of (3), while in the case of (1) the causal factors for suffering from depression are attributed rather to events that are external and not within one's control in spite of their formative influence on one's psychological organization. Although both (1) and (3) can be associated with general social stigmatization in particular in terms of the ambiguous status of depression as a pathological psychological reaction that can be indicative of a deficient or weak personality, the individual meaning associated with the condition (here, specifically in view of the underlying causal factors), in the case of (1) has ameliorating effects – the dysfunctional psychological organization is the direct result of psychological trauma, childrearing practices, etc. rather than the in terms of a personal failure of coping with a demanding environment as in the case of (3). Respectively, they do not display a strong emphasis of experiences of diminished self-worth and guilt in particular. And in contrast to these, in the case of (2), depression is rather the appropriate psychological reaction to the hostilities and meaninglessness of objective reality.

Only three (2.46%) of respondents to the DDQ UK described a conception of depression that focuses solely on its experiential character. Characterizing the condition as anger (R224UK), self-hate (R285UK), and a general restriction of the range of affective experience (R61UK), they view it exclusively in terms of changes in affect or rationality, which establish a new way of finding oneself in the world. The absence of explicit elaboration on putative causal and triggering events reflects a failure to recognize the validity of its illness status. Similarly to the affective responses that characterize it, depression is a highly subjective an individualized way of responding to the world rather than a pathological process or state. For instance, understanding depression as "anger gone cold and hard" (R224UK, Q11B), one respondent places it firmly in the realm of changes in affect, which in this case appear to be unrelated to any underlying causal factors in particular:

> Having absolutely no idea what is wrong with me. Not even wanting to discuss it because the weight is too big and too solid for any human or treatment to reach. It's hopeless. (R224UK, Q10B)

The incomprehensible and incommunicable suffering of depression is, moreover, not recognized by others, who seem "self-centred and shaming, either ignore comments which don't fit with their picture of how things should be going or […] decide that shaming you into 'pulling yourself together' will sort it out" (R224UK, Q3B). The lack of recognition of the depressive condition by others combined with the absence of a realization as to what causes and actually is depression, emphasises experiences of loss of hope and purpose, which present life as pointless, meaningless, and futile.

4.2. Depression is an Illness

The majority of respondents to the DDQ UK understand depression as an illness, a pathological state. In line with advances in medical understanding and treatment and the increasing public awareness of neurochemical or neurobiological underpinnings of mental disorders in general, depression here is commonly seen as a pathological state of the brain that impacts all aspects of functioning and experience and is expressed in radical changes in affect, thinking, and behaviour. A neurobiologically oriented understanding of the condition of this kind is not straightforward, though. On the one hand, not only among the wider public, but also within medicine and neuropsychiatry, there appears to be no widely accepted consensus as to how exactly various causal factors interact – for instance, do genetic predispositions make us more susceptible to undergo radical changes in brain chemistry that in turn are characteristic of depressive disorders, do inherited predispositions lead to developing depression only in combination with specific traumatic events, are changes in neurochemistry or the functioning of the brain in general the direct result of (repeated) psychological trauma and adverse events, etc.? The 64 (52.46%) responses to the DDQ UK that refer to a conception of depression as an illness reflect this ambiguity as well and can be clustered in three main groups regarding the assumptions or beliefs about underlying causal factors and how these (allegedly) interact: (1) a combination of a malfunction of the brain and adverse events or psychological trauma; (2) a combination of genetic predispositions, adverse events, and specific psychological organization; (3) an illness caused by aberrant brain chemistry only without an explicit identification of additional causal factors. In what follows, I am going to examine these conceptions and the way they impact and shape the experience of depression and how it is described in anonymous testimonies.

Twenty (16.39%) of the respondents to the DDQ UK understand depression as a change in how the brain functions or operates that is itself caused by psychological trauma or adverse life events (1). The condition is explicitly understood as the manifestation of a change in biological structures or processes that underlie particular aspects of processing and functioning. Thereby, it can be argued, the psychological identification with the condition or rather with the factors that cause it or that it is manifested in is weakened – rather than directly associating depression with the self, it is first and foremost identified with the underlying impaired biological functioning, which itself is realized in the psychological organization of the self. So, while one could directly identify with aberrant psychological organization at the level of the self or the person, it is more difficult to carry this identification over to the underlying neurobiological changes. What is the root of the problem that makes one depressed is not a depressive self but rather a dysfunctional brain that makes the self depressed or prone to suffering from depression. While one can entertain the reductionistic assumption that the self is determined or even identical to its underlying brain processes, this does not imply responsibility for a diseased brain that can to some extend alleviate the burden of social stigmatization. For instance, this understanding of depression can be exemplified in the following way:[189]

> To me depression is a mental illness, and can be due to chemical imbalances in the brain. It can affect anyone and is the mental equivalent of having a physical illness like chickenpox. It just takes a lot longer to recover from. It's very ongoing.
>
> I think a large number of factors contributed to my depression. I really struggled growing up with identifying with those around me such as peers and family. I felt completely different to everyone else so I had quite a low self image from a young age. I felt frustrated that I couldn't communicate my feelings very well so I got angry a lot of the time. I grew up with a brother and sister who were naturally very smart and I felt like the complete opposite. They seemed to do well at school quite easily whereas I really struggled even though I tried hard. I felt like an outsider, I felt stupid, I felt ugly, and I didn't want to be the person I was.
>
> It gradually started going downhill. I had to go through a lot of changes and I didn't cope well with change. I got really fed up and low and couldn't see a way out of the situations that I came across. My life just seemed completely pointless to me. (R22UK, Q11B)

Depression, here, is explicitly identified as a mental illness originating from a biological change. Analogously to purely somatic conditions, it is manifested in particular signs and

[189] The excerpt to follow was administered the code *Depression is a combination of brain malfunction and adverse events*. The responses describing this conception of depression are: R8UK, Q11B; R22UK, Q11B; R23UK, Q11B; R24UK, Q11B; R28UK, Q11B; R38UK, Q11B; R54UK, Q11B; R80UK, Q11B; R107UK, Q11B; R128UK, Q11B; R168UK, Q11B; R190UK, Q11B; R231UK, Q11B; R237UK, Q11B; R239UK, Q11B; R270UK, Q11B; R312UK, Q11B; R343UK, Q11B; R350UK, Q11B; R371UK, Q11B.

symptoms that in this case span the realm of mental functioning. Combined with adverse life events and a negative self-image, this chemical imbalance makes one susceptible to becoming depressed specifically in stressful and demanding situations. Rather than viewing one's self as deficient, here, the failure to cope with commonly challenging events is more closely linked to both one's lack of self-confidence and changes in brain chemistry. Being susceptible to specific changes in bodily function is not something one can exercise control over. Moreover, the incapacitating effects of depression here are experienced mainly in their disruptive effects on the continuity of the trajectory of one's life. The illness makes it impossible to sustain meaningful existence as it interrupts one's characteristic strivings and practical endeavours:

> I didn't want to do anything. Everything I ever used to be interested in just stopped, such as cooking or swimming. I didn't want to see anyone, I just wanted to stay in bed all day. First thing in the morning I would wake up and burst into tears and feel like getting out of bed was the hardest thing ever. […]
>
> I'm a very sociable person – I love people and I love doing things like cooking, especially cooking for other people, so when I don't want to do those things for a very long time I tend to know that there's something wrong. (R22UK, Q1B)

Understanding depression as an illness, in particular one involving specific bodily underpinnings, places it closer to the realm of medicine and psychiatry. Being a medical condition characterized by changes in a bodily organ, the individuals suffering from it are likely to not associate it with their selves directly. Rather than being characterized by a particular psychological organization, it is a change induced by aberrant functioning of the body that itself can in at least some cases be caused by psychological trauma and adverse life events. Depression, thereby, is a biological reaction to psychological stresses and is manifested in alterations of pre-existing core self. This conception places less emphasis on a normative evaluation of the self and highlights experiences of loss of prospects, incapacitation, and loss of control during depressive episodes as described in the responses to the DDQ.

A further conception of depression as an illness associated with changes in the underlying biological substrate and adverse life events also deploys the notion of the role of a genetic predisposition (2). 35 (28.69%) of the respondents to the DDQ UK reported of understanding the condition as one that involves a complex and intricate interplay between genetic factors, adverse life events, and changes in the functioning or chemical balance of the brain. Thereby, depression is, as well, more closely associated with somatic illnesses that develop in specific environments on the basis of a genetically inherited tendency. By encompassing a variety of biological and psychological factors, this understanding of the

disorder distances it from the realm of individualized subjective reactive attitude and places an emphasis on pre-determined biological and psycho-social factors rather than on individual character or personality traits, psychological resilience, etc. in particular in view of the stresses of everyday life. The respondents to the DDQ UK who understand depression in this way commonly present us with the following conceptions[190]:

> Depression is a mental health issue. It is a disability, in the same sense that cancer might be as it can be invisible, it can be misunderstood and it can be in remission for a long time before it comes back – it can even be cured in that sense but it is something that affects you in a debilitating way. It is not easy to express this to the wider world, they can't see that you have it, but they probably know someone that has had it!
>
> There are a number of causes to depression, I believe that some of it is genetic in the sense that there are other people in the family that have it, or express symptoms of it (not just the general issues but also severe depression or mental health issues) but also causality. My depression is made worse due to the fact that I had an abusive childhood and was bullied, which added to feelings of worthlessness and low self-esteem. It is also worsened by stress. (R118UK, Q11B)
>
> I suspect a genetic element as depression as an extra dimension always felt part of me. Also my son has suffered from depression for many years.
>
> However, on my case, I suspect environmental factors plays a part in depression manifesting itself so severely at times.
>
> In the 1950's and 1960's my desire for education and a career were very much at odds with the beliefs of my family. And to some extent, society at that time. It was a huge struggle for me to follow my own pathway. There was much loneliness, lack of money and lack of self belief. Being, I feel, inherently, rather frail emotionally, the toll has been at times a heavy one. (R137UK, Q11B)

Depressive episodes are, as explicitly pointed out by some of the respondents to the DDQ UK triggered by adverse life events and are characterized by changes in affective experience, thinking, and behaviour. Depression, thus, is a biologically determined illness that makes one prone to react in particular ways to specific triggers. In some situations, it overcomes one and one is powerless against it. It is a "fog that sits over your brain and changes all the rules, it makes everything hard to understand and turns the world into a frustration, physically it makes your body old and everything is working against you" (R134 UK, Q11B). The disorder envelops one's mind, and it feels "as though a black blanket smothers me and takes away all pleasure, interest or enthusiasm for anything" (R282UK, Q1B). It transforms the world into

[190] The three excerpts to follow were administered the code *Depression is caused by a combination of brain malfunction, genetic factors, and adverse life events*. Responses reporting of this understanding of depression are: R37UK, Q11B; R47UK, Q11B; R53UK, Q11B; R93UK, Q11B; R117UK, Q11B; R118UK, Q11B; R129UK, Q11B; R133UK, Q11B; R134UK, Q11B; R137UK, Q11B; R147UK, Q11B; R150UK, Q11B; R155UK, Q11B; R157UK, Q11B; R160UK, Q11B; R162UK, Q11B; R166UK, Q11B; R169UK, Q11B; R171UK, Q11B; R186UK, Q11B; R189UK, Q11B; R192UK, Q11B; R219UK, Q11B; R246UK, Q11B; R253UK, Q11B; R271UK, Q11B; R282UK, Q11B; R303UK, Q11B; R313UK, Q11B; R316UK, Q11B; R323UK, Q11B; R334UK, Q11B; R347UK, Q11B; R349UK, Q11B; R367UK; Q11B.

a place of doom and gloom, a colourless, dull, and bland realm of existence. The notion of depression as an illness radically altering one's subjective reality, in particular as described in some of these responses, suggests that it is a particular entity or a process that is not integral to the self but rather affects it in a markedly negative manner. Thereby, it radically changes not how one responds to the world that has not changed, but rather *the quality of one's subjective reality*.

Thus, it is not the result of a specific individualized reactive attitude but a radically different mode of being, which is the direct result of a complex interaction of genetic predispositions, adverse events and psychological trauma, and changes in underlying neural substrate. And this new way of being brings with it a new way of thinking, experiencing, feeling, and acting in contrast to understandings of depression as causally related to how one conceives of the world, the own style of thinking, etc. that were mentioned by some of the respondents to the DDQ BG. The illness, thus, for many changes all aspects of their existence by introducing them to a new reality that prompts various responses and does not offer prospects for change. Consequently, these respondents emphasize mainly changes that are attributable to the world and depression rather than such in their reactive attitude to it. In doing this, they also often focus on metaphoric descriptions of the changes in the qualities of the world that are associated with the illness as described in these passages:

> I'm not sure I can describe how the world looks different except it's wrong, gloomy; even when it's sunny. sometimes this can make me feel worse. (R93UK, Q2B)
>
> Everything is grey, flat and joyless. However there are many shades of grey…leading into the blackness.
>
> It feels like there is nothing left to give. There is no 'self' to give.
>
> I feel like I'm a 'No-thing'
>
> I find the feelings roll up insidiously, then I realise I feel flat and grey. Then everything around me is viewed through this perception and therefore everything around me is also (in my mind at that time) flat and grey. (R117UK, Q2B)

In these cases, one can also detect tendencies towards viewing the condition in terms of its disruptive effects on the continuity and coherence of one's life in general. Conceiving of depression as a severe disabling illness resulting from the complex interaction of two different factors – biological and psychological – is embedded in a background of assumptions and beliefs about severe, possibly long-term or chronic illness and its transformative impacts on one's life. Thus, I suggest that this particular understanding of depression highlights how the illness disrupts the coherence of one's life in particular as opposed to understanding it as an integral part of one's self or personality. In this case, for

some, depression is bad fate, a state of misery one is condemned to for no particular reasons. Its disruptive effects on the coherence and continuity of one's meaningful existence are especially apparent in the lack of meaningful patterns of experience during depressive episodes – rather than integrated, albeit brief descriptions, these are presented in lists of individual phenomena that appear seemingly unrelated and devoid of any coherence. These culminate in an intolerable, unjust predicament of suffering that not only lacks any point and purpose but also appears entirely random and arbitrary.

Still some of those understanding depression as caused by a combination of psychological and biological factors can consider it to at least some respect an integral part of one's self. Consequently, their descriptions of the experience of depression focus more on individual impairmenst in everyday life rather than on feelings of discontinuity and lack of personal coherence.

Only a handful of respondents to the DDQ UK (eight respondents (6.56%)), similarly to the Bulgarian version, understood depression only as characterized by changes in brain chemistry without the influences of adverse life event or psychological trauma (3). This understanding carries the highest similarity with the conceptions of somatic illnesses as changes in bodily structures of the functions of various organs or systems. It also locates at the highest proximity to the prototypical value-free pathological conditions, purely somatic illnesses that are expressed in various symptoms, signs, and manifestations. This naturalistic understanding of depression, moreover, is a rather value-free view of mental illness – it is condition of mostly psychological symptoms that is caused by bodily changes, which are not the (direct) result of processes at the level of the self or the person. Consequently, it is also not accompanied by attribution of responsibility for the condition and less negative self-evaluations. On this view, commonly depression is:[191]

> Depression is a chemical imbalance within your brain, that manifests itself with emotional symptoms. It is much like any other physical illness, but lacks understanding by other people because you cannot see it, and it expresses itself in uncomfortable ways.
>
> I don't know what caused my depression, I may simply have a genetic predisposition to it; there is family history of mental illness. I have been experiencing the symptoms in one form or another since I was about 8 or 9 years old. (R17, Q11B)

The disturbed chemical balance of one's brain is essentially a problem of biology rather than one of the self, although it is manifested in disruptions of affect, cognition, and behaviour. In this manner, depression is first and foremost a somatic dysfunction, which underlies

[191] The excerpt to follow were administered the code *Depression is a chemical imbalance*. The responses describing this understanding of depression are: R17UK, Q11B; R30UK, Q11B; R51UK, Q11B; R89UK, Q11B; R130UK, Q11B; R154UK, Q11B; R180UK, Q11B; R357UK, Q11B.

psychological functioning. In most of the responses that reported of this understanding, there are descriptions of experiences of shame and guilt in particular only with respect to problems in everyday functioning resulting from the incapacitating effects of depression as for instance described in this passage:

> I have no motivation at all, I do not want to get out of bed, do any household chores, go out of the house or meet anyone. This produces an emotion akin to despair, that I am not the same as others, I cannot function properly and therefore I am not on the same level as they are and they look down on me. (R154UK, Q1B)

In general, the understanding of depression as a mental illness caused by a combination of biological, psychological, and situational factors places the condition more closely to the realm of dysfunctions and pathologies. Thereby, it at least to some extend reduces the social stigmatization of the condition and alleviates the additional burden of shame and responsibility for being ill. Importantly, this conception for some of the respondents to the DDQ UK highlights or emphasizes particular aspects of the experience of illness and impacts how these are described. Commonly, similarly to other illnesses, symptomatic complaints of incapacitation and the disruptive effects the condition has on the continuity and coherence of one's life are in a sharper focus. Moreover, the experience of lack of prospects can also be highlighted as the complex factors lie outside the realm of one's control and the illness is commonly understood as a chronic or recurrent condition. Unlike the respondents to the DDQ BG, many of those who participated in the British survey reported this understanding of depression. The more wide-spread awareness of mental illnesses, psychiatry, and depression in particular and the longer tradition of mental health awareness campaigning among the wide public (such as those regularly organized by SANE, the Mental Health Foundation) can be seen as the basis for this. Although the responses to the DDQ BG were far less numerous that those to the original British version, they appear to be representative of a large-scale lack of awareness about mental illness, treatment, etc. (Kozhuharov et al. 2015). Furthermore, the small number of respondents to the Bulgarian version can also be indicative of the more socially stigmatized conception of mental illnesses in general and depression in particular, which results, among other things, in a decreased readiness or willingness to participate even anonymous research of the experience of mental illness as suffering from it is itself conceived not as a valid medical condition but rather one that is the direct result of a deficient or weak personality that fails to overcome and cope with the vicissitudes of everyday life and various adverse events. While most of the respondents to the DDQ BG viewed depression as the result of an individualized reactive attitude that, in spite of medical diagnosis, was not a 'real' or 'valid' illness condition, only very few

respondents to the British version understood depression in this manner. For instance, only one respondent to the DDQ UK described the condition as an illness caused by herself:

> I know depression is an illness but at the same time I feel like I caused it.
>
> The doctor explained that it could be because of genetic reasons because my biological dad had bipolar and his mum did too. Also my psychologist believes that because I feel like I am to blame for the violence caused by my biological towards me and my mum, which started when she was pregnant with me so I have always felt to blame because of that. (R16UK, Q11B)

Here, depression is understood as a pathological reaction to adverse events in early childhood, which are at least to some extend causally related to oneself. This apparent paradox of being responsible at least to some extent for the adverse events that are the basis for suffering from depression and the causal role of genetic predispositions that are similarly to the one's own causal role is mirrored in the emphasis of lack of prospects that are experienced as directly related to oneself. And several of the responses provided by this participant describe in detail a general orientation of loss of hope, feelings of entrapment, which themselves are causally related, like the disorder itself, to oneself:

> […] Some days I don't want to get up because I fear that I will do everything wrong and I don't want to let people down. I hate everything about myself and wish I could change but I know that I never would be able to. (R16UK, Q1B)

The lack of prospects for the future is not an integral part of the world, but rather the direct result of who one is. The strong causal attribution of the causal factors for depression in the paradoxical conception described above is mirrored in this kind of self-induced lack of prospects. Although this is a rather idiosyncratic and highly individualized understanding of depression, it illustrates also the complexity and ambiguity of the individual meaning of the illness and its symptoms.

5. Conclusion

Embedded in a complex network of socially shared cultural conception and assumptions about identity, mental illness, and the relationships between the two, the experience of depression can vary greatly across different social and cultural groups. The underlying changes in the experiential background that were in the focus of the discussions in preceding chapter, I proposed here, are shaped by both socially and culturally specific conceptions of depression and patterns of meaning situated at the level of the individual. How one conceives of depression, in particular, for instance can emphasize different changes in the existential background described in first-person testimonies. Conceptions of depression, as I have attempted to demonstrate here, exhibit various differences. Although the condition has

occupied the forefront of discussion of mental health and is at least to some extend present the wider public discourse, it is still in many cases strongly associated with social stigmatization. It status is characterized by vagueness and ambiguity as it alternates between that of the result of an individual reactive attitude that can in some cases even be considered within the bounds of one's voluntary and volitional control and in others the result of traumatic and adverse events; and that of being an illness caused by biological and genetic factors and manifested in impairments in mental functioning. Each of these, moreover, can include individual instances of different degree fine-grainedness and differentiation, which can be considered to reflect the general institutionalization of mental illness, awareness of their nature, of the realm and scope of psychiatry, etc. The testimonies studies here, for instance, showed a higher variance and more complex understanding of depression in the UK as compared to Bulgaria. Respectively, the descriptions of the experience of depression showed subtle differences with respect to the emphasis on some of the changes in the experiential background and their foregrounded manifestations. This, moreover, was compounded at the level of individual responses by the influence of assumption of specific putative causal factors such as adverse events and traumatic experiences that can also in some cases shift the focus of experience and descriptions to specific phenomena.

The analysis presented here, is not intended as a comprehensive list of factors that impact the experience of mental illness in general and depression in particular. Specifically with respect to the patterns of individual meaning associated with the condition, many various such can be identified with the help of interviews and narratives directly targeted at these aspects. Moreover, mental illnesses, as nearly all pathological condition in the realm of medical knowledge and intervention, are embedded in a complex network of institutional, social, political, and cultural processes and structures such as the respective status and availability of psychiatric treatment and consultation, the social and communal availability of mental health care, traditions in medical care in general, etc. Thus, more detailed examinations of these can be used to help identify the multiplicity and complexity of locally shared culture-specific assumptions, conceptions, and beliefs that influence the experience of mental illness and how it is described in first-person testimonies of various formats.

Fig 2a: Conceptions of depression described in the responses to the DDQ BG (the respective codes developed for the analysis of the testimonies are presented in italics)

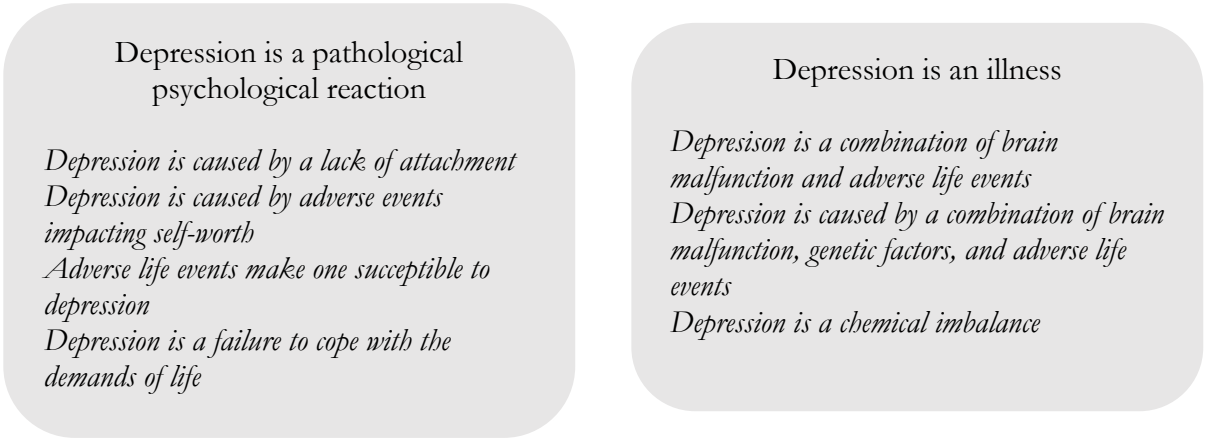

Fig 2b: Conceptions of depression described in the DDQ UK (the respectivel codes developed for the analysis of the testimonies are presented in italics)

Concluding Remarks

Depression is a devastating disorder, it radically disrupts the lives of those it afflicts along numerous dimensions and confines them to a solitary and potentially meaningless predicament of immense suffering, pain, and emotional torment. It transforms them into disengaged observers of the world and life, incapacitates them drastically, and alienates them from other people. As I have emphasized in the preceding chapters, experiencing and living with depression is a radically different mode of being that encompasses a host of various experiential phenomena, which moreover are embedded in the complex context of society and culture. Thus, the experience of depression as lived by those suffering from it is shaped and coloured also by how those afflicted with it and the people surrounding them understand it.

In order to gain an insight into experiencing and living with depression we can study the first-person narratives or testimonies produced by numerous "experts by experience" in different formats. In Chapter 1, I engaged in a detailed presentation and discussion of the main source of testimonies that were examined, those produced in response to an online questionnaire, the DDQ. Although, the sudy of these goes along with specific requirements and limitations, I argued that they present us with rich and reliable sources to study the experience of depression. Based on my aim to arrive at a phenomenological framework of what it is like to experience and live with depression, only certain testimonies were eligible for further analysis. Subsequently, I designed a set of criteria to sample the testimonies to be studied so that that these can present us with descriptions of depression-specific changes in experience. Moreover, as I aspire to propose a phenomenologically inspired account of depressive experience that is derived from first-person testimonies, I chose a combination of methodological principles of grounded theory and phenomenological analysis for identifying various experiential phenomena described in these. These were then clustered in categories in line with the general theoretical background, so that they can be understood as reflective manifestations of different background orientations (Ratcliffe 2005; 2008), which are established by changes in the experience of possibility, agency, and intersubjectivity that figure as the main themes in first-person testimonies of depression. Background orientations are variously manifested in reflective phenomena such as moods and emotions, bodily feelings, actions and behaviors, and cognitive styles, processes, and states, which are shaped and coloured by the complex context of social, cultural, and personal meaning surrounding mental illness in general and depression in particular.

In Chapter 2, I argue for the central role and importance of narratives in different formats for both coping and living with mental illness and studying its experience. Narratives are essential for the organization, understanding, and expression of radically altered experience, particularly such experience that disrupts the continuity, meaningfulness, and coherence of one's life. Mental illnesses in general and depression in particular introduce a rift of being of this sort. And this rift can be understood and bridged by narratives in different forms and formats – whole life stories, short anonymous testimonies, implicit (merely thought through) accounts of experience, and book-length autobiographies. Based on central considerations about the role of narratives in establishing the meaningful coherence of one's existence, self-experience, and -understanding (e.g. Taylor 1985, Schechtman 1996, 2011; Goldie 2011, 2012, 2012a), I have proposed that these are powerful sources for the study of the experience of depression.

The experience of possibility is one of the main structures of our experience. In Chapter 3, I examined in detail what it amounts to, how it is altered in depression, and also the specific orientations that it establishes. Experiencing what engagements with the world are possible, I suggested, provides us with one of the aspects of our common tacit sense of embeddedness and interaction with the world. This experience encompasses a sense of what actions are afforded in different situations and how these are significant for one's ongoing practical endeavors and projects. I suggested that in depression, while one can still encounter possibilities, these are mainly there for others. Things might appear generally possible but not possible for the depressed individual specifically in terms that she fails to feel moved or enticed by them. Thereby, possibilities become merely present for others, which also radically disturbs how she actively engages with the world. Subsequently, in the absence of one's common or habitual way of engaging with the world, one's existence lacks prospective orientation, so that the present condition is experienced as permanent, meaningless, and intolerable. The loss of individualized possibilities in depression, thereby, I suggest highlights the central role of an anticipatory structure grounded in common or habitual engagements that endows existence with a sense of meaningfulness, stability, security, and hope.

Testimonies of depression are also replete with descriptions of how their authors feel and are unable to act, to actively engage with the world. By dramatically impacting the experience of one's abilities, depression deprives one of the sense and exercise of agency and establishes a mode of inability and loss of agency. In Chapter 4, I suggested that we can understand the loss of agency in depression in terms of disturbance to the (experience of) two broad kinds of abilities – skills and capacities. Skills (1) commonly automatically deployed for the performance of numerous everyday activities, are lost in depression and

this loss originates from radical disturbances of embodiment. The corporealization of the lived body (Fuchs 2005) transforms it from the medium of all experience and action into an obstacle to these and thereby disturbs effortless skilled engagement and transforms everyday life into an insurmountable challenge. One can feel unable to perform particular activities also in terms of a general incapacitation (2), whereby the disturbance or loss of various capacities such as memory, attention, etc., impacts both how one encounters the respective activities and how one performs these. In these cases, individuals suffering from depression report of a experiences and failures of sustaining performance or functioning at the level of evaluative standards. These disturbances of (the experience of) abilities, moreover, illustrate the normative and evaluative aspects of agency and agentive performance, which merit further study in a broader philosophical context.

The final major theme resurfacing in testimonies of depression is that of a profound isolation from other people, which was the subject of Chapter 5. There, I suggested that we can distinguish between two levels of isolation from others. At a fundamental level, one fails to relate to other subjects by means of a disturbance of a shared second-person perspective. Others, while still encountered as subjects, present one with a radically different perspective that is irreconcilable with one's own and subsequently one fails to sustain even basic relatedness in terms of sharing at least to some extent a common world of meaning and significance. This confines one to a position of detached and distant observation and also radically disturbs one's self-awareness that now is framed from the perspective of the observing other. The own self is experienced as disembedded presence, which in particular in combination with the loss of agency discussed in the previous chapter, establishes background orientations of depressive shame and guilt. At a higher level of interpersonal exchanges, one is unfortunately still frequently confronted with stigmatized conceptions of mental illness in general and depression in particular, which are embodied by oppressive master narratives (Lindeman Nelson 2001, 2002, 2014). These stand in the way of appropriate recognition and response to the individuals suffering from depression and directly impinge on their sense of personhood, personal identity, and moral agency.

Being embedded in a social and cultural context, the experience of depression can exhibit at least some significant variations among different social and cultural groups. In view of the different degrees of social stigmatization of mental illnesses in general and depression in particular, the conceptions thereof can vary greatly. A comparative study of testimonies provided in response to the DDQ UK and its Bulgarian version revealed interesting differences in what people think depression is and the stance they assume towards it. While in both cultural groups there were two main understandings of depression, which also

differed in their degree of social stigmatization, the close examination of the individual understanding of the illness revealed some intriguing and relevant differences. In Chapter 6, I focused on examining these and attempted to demonstrate how the degree of stigmatization and the personal meaning of illness and symptoms highlights or emphasizes various reflective manifestations of the experience of depression.

Understanding the experience of depression, in particular as it is lived and described in first-person accounts has also diverse practical implications pertaining to how individuals suffering from depression come to terms with the illness in society. Viewing it as a radically different way of existence or being which shape affective experience, actions, and thinking, rather than a conglomerate of discrete and distinct affective and cognitive states or processes and action patterns, emphasizes its encompassing and pervasive nature. Most notably, the failure to recognize that what changes for the individuals suffering from depression is not a specific set of attitudes or range of affective experiences, for instance, but all aspects of being is central in instances of social stigmatization and oppression. The recognition of this failure, though, can aid in the prevention of misrecognition and subsequent inappropriate response to depressive suffering by recognizing the encompassing and overwhelming nature of changes associated with depression. By focusing on background changes in experience, which alter each and every aspect of human existence in this manner we not only *more* accurately capture what it feels like to be depressed, but also draw attention to the fact that depressive moods, emotions, cognitive styles or particular thoughts, cannot be merely shaken off at will. To the individual suffering from depression, these are the only possible states to experience as how she encounters everything has shifted radically. Moreover, examining the underlying changes in fundamental structures of experience can aid the identification of structural and qualitative similarities among psychiatric conditions, which otherwise belong to distinct diagnostic categories. These insights can motivate a revision of how we view, classify, and intervene on mental illnesses, understand and treat comorbidities of psychiatric conditions. Focusing on changes in experiential background can, notably, also be beneficial to those suffering from the illness who are dissatisfied with a medical understanding of depression and its experience and feel silenced by modern medicine. Their quest for meaning, explanation, and understanding of the devastation caused by depression can be supplemented by a phenomenological framework that focuses on the lived experience of depression specifically in the context of cultural, social, and personal meanings that are inseparable from it.

Appendix 1: Overview of the Durham Depression Questionnaire (DDQ UK)

Questionnaire – Section A Background Information

Q1A: Age

Q2A: Gender

Q3A: Country of Residence

Q4A: Have you ever received a medical diagnosis of depression?

Q5A: If you answered yes to the previous question, please tell us in which year you were first diagnosed.

Q6A: If possible, please provide further information about the specific diagnosis/diagnoses (e.g. major depression, dysthymia, bipolar, etc.)

Q7A: What forms of treatment have you received for depression, if any, and when?

Q8A: Have you been diagnosed with any other psychiatric condition?

Q9A: If you answered yes to the previous question, please provide brief details of what was diagnosed and when.

Q10A: Are you currently depressed?

Questionnaire – Section B Your Experience of Depression

Q1B: Describe your emotions and moods during those periods when you are depressed. In what ways are they different from when you are not depressed?

Q2B: Does the world look different when you're depressed? If so, how?

Q3B: Do other people, including family and friends, seem different when you're depressed? If so, how?

Q4B: How does your body feel when you're depressed?

Q5B: How does depression affect your ability to perform routine tasks and other everyday activities?

Q6B: When you are depressed, does time seem different to you? If so, how?

Q7B: How, if at all, does depression affect your ability to think?

Q8B: In what ways, if any, does depression make you think differently about life compared to when you are not depressed?

Q9B: If you have taken medication for depression, what effect did it have?

Q10B: Are there aspects of depression that you find particularly difficult to convey to others? If so, could you try as best you can to indicate what they are and why they are so hard to express.

Q11B: What do you think depression is and what, in your view, caused your depression?

Q12B: Who and/or what have you consulted in order to try to understand your depression? (E.g., medical practitioners, friends, books, internet sources, etc.).

Q13B: If there are important aspects of your experience of depression not covered by this questionnaire please describe them here

Appendix 2: Background Information DDQ UK

R	Age	Gender	Diagnosis of depression/Currently depressed	Additional psychiatric diagnosis
8	55	Confused	Moderate depression/Yes	Gender dysphoria; AADD
14	28	Female	Major depression/Yes	Anxiety
15	34	Female	Severe depression/Yes	Borderline personality disorder
16	16	Female	Severe depression with hyper-manic traits/Yes	No
17	25	Female	Major depression/No	No
20	35	Female	Depression/No	Bipolar II disorder
21	24	Female	Depression/No	Not answered
22	23	Female	Major depression/No	No
23	24	Female	Major depression/Yes	Bulimia nervosa
24	19	Female	Major depression/Yes	No
26	43	Female	Bipolar disorder/Yes	Borderline personality disorder
28	37	Male	Clinical depression/Yes	No
30	17	Male	Clinical depression/Yes	Severe anxiety disorder; attachment disorder
34	39	Female	Severe depressive illness/No	Anxiety disorder; borderline personality disorder
37	40	Female	Post-natal depression/No	No
38	35	Female	Standard (not major) depression/No	No
40	17	Female	Clinical depression/Yes	No
41	36	Female	Major depression/Yes	No
42	46	Female	Depression/Yes	Anxiety
45	20	Female	Depression/Yes	OCD; BPD; eating disorder
47	27	Female	Endogenous depression/Yes	No
49	22	Female	Mild depression/No	Anxiety
51	18	Female	Depression/Yes	Attention deficit disorder; post-traumatic stress disorder

53	17	Female	Mild depression/No	Generalised anxiety disorder
54	38	Female	Major depression/Yes	Complex PTSD with related psychosis
60	35	Male	Depression/Yes	No
61	35	Female	Clinical depression/No	No
65	33	Female	Depression and possibly bipolar 2 or cyclothymia/Yes	No
66	50	Female	Reactive depression and anxiety/Yes	No
69	19	Female	Severe depression/Yes	Post-traumatic stress disorder; anxiety disorder; anorexia
75	26	Female	Major depression/No	Eating disorder
78	46	Male	Major depression, long term/Yes	CSP; anxiety
80	38	Female	Postnatal depression; reactive depression/No	No
84	58	Female	Depression/Yes	No
85	31	Female	Severe depression/Yes	No
89	28	Female	Depression/Yes	No
93	52	Female	Major depression/Yes	No
97	30	Female	Major depression and anxiety/Yes	No
98	44	Female	All sorts from different consultants/Yes	Bipolar; borderline personality disorder; chronic lack of self esteem; narcissism
105	17	Female	Chronic depression/Yes	No
106	45	Female	Severe depression/Yes	No
107	21	Female	Depression/Yes	No
109	40	Female	Depression as part of bipolar/No	Bipolar
110	48	Female	Depression/No	Panic attacks/anxiety disorder
112	32	Female	Severe depression/Yes	No
113	46	Female	Severe medical depression/nervous breakdown/Yes	Bipolar
115	46	Female	Depression/Yes	Not answered

117	49	Female	Endogenous dysthimic depression/No	No
118	30	Female	General/clinical depression/Yes	No
124	20	Female	Depression and anxiety disorder; bipolar I/Yes	Anorexia; bulimia; social phobia
128	55	Male	Major depression/No	No
129	37	Male	No details provided/Yes	Drug-induced psychosis
130	21	Female	Depression NOS-cyclic dysthymia with MDD/Yes	No
133	21	Female	No diagnosis of depression/Yes	No
134	37	Female	Depression/Yes	Agoraphobia; sociophobia; GAD
137	65	Female	Major depression/No	No
138	18	Female	Depression/138 Yes	Emotional dysregulation; borderline personality disorder; anxiety; body dysmorphic disorder
143	54	Male	Depression/Yes	Affect disorder
145	38	Male	Clinical depression/Yes	No
147	22	Female	Depression – non specific/Yes	No
150	37	Female	Clinical depression/Yes	Brief period of psychosis with first major breakdown
153	63	Female	Unspecified depression/No	Compulsive hoarding
154	50	Not answered	Bipolar disorder with prominent depressive episodes/No	No
155	50s	Male	Chronic depression/Yes	Anxiety
157	40	Male	Major depression/Yes	No
158	20	Female	Clinical depression/Yes	Borderline personality disorder
159	20	Female	No diagnosis of depression/No	No
160	52	Female	Postnatal depression; moderate depression with occasional hypomania/No	No
161	30	Female	No diagnosis of depression/Yes	No
162	34	Female	Post-natal depression/Yes	No
166	28	Female	Depression/Yes	No

168	40	Female	Depression/Yes	No
169	22	Female	Major depression with occasional psychotic episodes/Yes	Anorexia nervosa; obsessive compulsive disorder; post traumatic stress disorder
170	24	Genderqueer	No diagnosis of depression/No	No
171	33	Female	Depression; dysthymia/Yes	ADD; anxiety
179	40	Female	A nervous breakdown, cause of which was subsequently diagnosed by mental health professionals as Post Traumatic Stress Disorder and Disassociative Disorder/No	Anorexia nervosa
180	30	Male	Depression/Yes	No
183	55	Male	Clinical depression/No	Psychotic episodes
186	54	Female	Post-natal depression; severe anxiety and depression; entrenched moderate to severe depression/Yes	No
189	24	Female	Major depression/Yes	No
190	31	Female	Major seasonal affective disorder/Yes	Anxiety/stress
192	140	Female	Bipolar/No	No
195	50	Female	Clinical depression/major depression/Yes	No
199	34	Female	Depression/Yes	Obsessions; PTSD
200	35	Female	Major depression, stress and suicidal thoughts/Yes	No
212	29	Female	Depression/bipolar disorder/Yes	No
218	26	Female	Mild depression/No	No
219	63	Female	Bipolar/Yes	Acute psychotic episode; depressive Psychosis; acute psychotic episode; depression with psychotic symptoms; post-natal depression
224	30	Female	Anxiety and depression/No	Acute transient psychotic episode
225	31	Female	Dysthymia/Yes	Prolonged duress stress disorder and anxiety
228	33	Female	Depression and anxiety/Yes	No
231	49	Male	Clinical depression and dysthymia/Yes	No

Appendix 2: Background Information DDQ UK

232	21	Female	Depression/Yes	Borderline personality disorder; psychosis
234	23	Female	Major/severe depression/Yes	Borderline personality disorder; anxiety
235	20	Female	No diagnosis of depression/Yes	Anxiety NOS; Asperger's Syndrome
237	28	Female	Generalised clinical/ situational depression/No	Non-epileptic attack disorder
239	52	Female	Mood disorder/Yes	Schizophrenia
240	21	Female	Depression with psychotic features/Not answered	Anxiety; social phobia
242	22	Male	No diagnosis of depression/Yes	No details provided
246	33	Female	Chronic depression/Yes	No
250	20	Female	No diagnosis of depression/No	No
253	55	Female	Clinical depression/No	No
259	42	Male	Depression and anxiety/Yes	No
261	51	Female	Recurrent depressive disorder/Yes	No details provided
266	41	Female	Severe clinical treatment resistant depression/Yes	Personality disorder
269	53	Female	Severe clinical depression; bipolar disorder and post-traumatic stress disorder/No	No
270	50	Male	Severe depression, self-harm (cutting)/No	No
271	26	Female	Bipolar disorder/Yes	PTSD/generalized anxiety disorder
277	25	Female	Major depressive disorder/No	Generalised anxiety disorder; borderline personality disorder
280	23	Female	Recurrent depressive disorder/Yes	Anxious/avoidant personality disorder; OCD
282	42	Male	Major depression/Yes	No
285	57	Female	Depression/Yes	No
288	24	Female	Depression/Yes	No
291	52	Female	Bipolar disorder/No	Incorrectly diagnosed as schizophernic
292	19	Female	Major depression (intermittent)/Yes	No
301	50	Female	Major depression/	PTSD; borderline personality disorder

303	2	Female	Severe endogenous clinical depression/Yes	No
307	26	Male	Major depression/Yes	Social phobia
308	40	Female	Acute clinical depression/Yes	No
311	26	Female	Depression and anxiety/Yes	No
312	31	Female	No diagnosis of depression/Yes	No
313	34	Female	No details provided/Yes	Bulimia
316	59	Female	Reactive depression/Yes	No
322	53	Male	No diagnosis of depression/Yes	No
323	24	Male	Major depressive disorder/Yes	PTSD; recovering addict
324	17	Female	No diagnosis of depression/Yes	No
325	23	Female	Major depression, anxiety and panic attacks/Yes	No
326	34	Female	No diagnosis of depression/Not answered	No
331	19	Female	Major depression/No	No
334	44	Female	Cyclothymia/No	No
337	23	Male	Schizoaffective disorder; depressive type/No	No details provided
341	23	Female	Social anxiety, minor depression/Yes	No
343	34	Female	Major depression/Yes	No
347	47	Male	Bipolar disorder/Yes	No
349	76	Female	Post-natal depression/No	Cyclothymia
350	35	Female	Major depression/Yes	No
352	55	Male	Depression/Yes	No
353	21	Female	No diagnosis of depression/Yes	No
355	24	Male	Depression and anxiety/Yes	No
357	43	Male	Anxiety, social-phobia and endogenous depression/Yes	No
360	51	Female	Severe depression/Yes	No

361	40	Female	Moderate to severe clinical depression/No	No
362	24	Female	Depression and anxiety/Yes	No
366	48	Female	Depression and anxiety/Yes	No
367	20	Female	Depression/No	No
369	19	Female	No diagnosis of depression/Yes	Borderline personality disorder; anorexia nervosa
370	17	Female	Panic attacks; major depressive episode/Yes	Anorexia nervosa
371	17	Female	Major depression/Yes	Anorexia nervosa

Table 1A: An overview of the background information provided by the respondents to the DDQ UK.

Appendix 3: Overview of Sampling Criteria DDQ UK

Criterion for sampling of testimonies (SC)	Responses not included in the sample of testimonies to be studied
SC1 – no medical diagnosis of depression (excluded from the study of Q1B-Q13B)	R133UK; R159UK; R161UK; R170UK; R235UK; R242UK; R250UK; R322UK; R324UK; R326UK; R353UK; R369UK; R312UK
SC2 – additional psychiatric diagnoses	
SC2.1 – personality disorder (excluded from analysis of Q1B-Q13B)	R15UK; R26UK; R34UK; R45UK; R98UK; R138UK; R158UK; R226UK; R232UK; R234UK; R277UK; R301UK
SC2.2 – confounding symptoms and experiences related to additional psychiatric diagnoses	
SC2.2.1 – schizophrenia	R253UK, Q5B - explicit emphasis on the difficulty of distinguishing between the effects of schizophrenia and depression
SC2.2.2 – psychosis	R129UK, Q1B, Q3B – experiences of paranoia R183UK, Q3B – effects of psychosis and depression are not clearl separable R219UK, Q1B, Q2B – experiences of paranoia
SC2.2.3 – eating disorders	R23UK, Q4B; R69UK, Q4B; R75UK, Q4B; R124UK, Q4B; R169UK, Q4B; R313UK, Q4B; UKR370, Q4B; R371UK, Q4B – the presence of additional diagnoses of an eating disorder is associated with changes in the experience and perception of the own body
SC 2.2.4 – clinical anxiety; anxiety disorders (e.g. phobias, generalized anxiety disorder)	R110UK, Q1B – reports of specific rather than general anxiety and worry, which can be associated with an anxiety disorder R134UK, Q1B – reports of tendencies towards avoidance of social situations and interactions, which can be associated with social phobia R240UK, Q2B – reports of specific rather than general anxiety and worry, which can be associated with clinical anxiety and social phobia R307UK, Q5B – report of feelings of anxiety and fear of embarrassment in social situations, which can be associated with social phobia
SC 2.2.5 – post-traumatic stress disorder	R51UK, Q1B, Q2B; R54UK, Q1B; R169UK, Q1B; R199UK, Q1B; R271UK, Q1B – descriptions of emotional numbing, lack of interest, disconnectedness, and dissociation that might be associated with PTSD rather than with depression.

Table 2A: An overview of the responses excluded from the analysis of the DDQ UK

Appendix 4: Responses to the DDQ BG

Respondent 23BG		
Q1A	51	51
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	1981	1981
Q6A	депресивен синдром лечението продължи 1 месец.	A depressive syndrome. The treatment lasted a month.
Q7A	медикаментозно лечение приложено при установяване на заболяването	Medication applied after diagnosing the disorder.
Q8A	Не	No
Q9A		
Q10A	Не	No
Q1B	силна тревожност придружена с безсъние, усещане, че всичко пропада, че не мога да контролирам живота си	Strong anxiety accompanied by insomnia. A feeling that everything is falling apart, that I cannot control my life.
Q2B	да. сякаш съм извън него.	Yes, as if I am not in it.
Q3B	да. враждебни, отдалечени, неразбиращи.	Hostile, distant, not understanding
Q4B	някак олекнало, защото свалям килограми, усещане за слабост.	Somehow lighter, because I lose weight. A feeling of fatigue
Q5B	невъзможност да се съсредоточа и да върша дори и по-дребни неща. усещане за умора.	Inability to concentrate and do even simpler things. A feeling of tiredness
Q6B	като че ли тече по-бавно, но по-скоро не съм се замисляла.	As if it is going slower, but I have not really thought about that.
Q7B	не губя способността за логическо мислене.	I do not lose the ability to think logically.
Q8B	усещане за несправяне, което не съществува, когато съм добре.	A feeling of not being able to cope that does not exist when I am well.
Q9B	повлиявала съм се добре от медикаментите. действали са ми успокояващо. предизвиквали са сън, който ми е давал възможност да се възстановя.	They had a good effect on me. They were calming me down and caused sleep that gave me the possibility to recover.
Q10B	не смятам. когато споделям, хората ми отговарят че в един или друг момент на живота си са преживели същото.	I do not think so. When I have shared, people have told me that they have been through this at some point in their lives.
Q11B	при мен депресията се появява в периоди на някакво неблагополучие което не мога да овладея.	In my case, the depression appears in periods of misfortune that I cannot deal with.
Q12B	Всичко изброено.	All of those listed above.
Q13B	Неотговорен	Not answered
Respondent 36BG		
Q1A	34	34
Q2A	Мъж	Male
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2002	2002

Q6A	Първоначално се смяташе, че е "БАР", впоследствие поставиха диагноза "рецидивираща депресия".	First, it was considered to be a bipolar affective disorder, but later I was diagnosed with chronic depression
Q7A	Лечението включваше различни АД и ривотрил, като в последното си проявление АД не помогнаха.	The treatment included various antidepressants and Rivotril but during the last episode the antidepressants did not help.
Q8A	Не	No
Q9A		
Q10A	Да	yes
Q1B	Емоционално студен съм, не изпитвам удоволствие от нищо, соц. фобия имам, паметта ми е силно неусложлива, концентрацията слаба....	I am emotionally cold, I cannot feel pleasure from anything, I experience social phobia, my memory is highly unreliable, poor concentration …
Q2B	Да, вследствие от замаяността някакси всичко ми е по-нереално.	Yes, because of the dizziness, everything appears somehow less real.
Q3B	Те не, аз се чувствам различен.	No, they do not, I am different.
Q4B	Краката са ми по-студени и имам болежки в гърба и кръста.	My feet are colder and have pain in the back and the lower back.
Q5B	Като инвалид съм!	I am like handicapped!
Q6B	По-бавно като че ли тече, може би ми се струва така от това, че искам по-бързо да отмине депресивния период.	As if it runs slower, but maybe it appears so because I want the depressive episode to be over soon.
Q7B	Страшно много влияе! Мислите са ми объркани, не мога да се концентрирам в/у нищо и най-вече паметта ми е силно засегната.	It affects it very much! My thoughts are very disorganised, I cannot concentrate on anything and my memory is most strongly affected.
Q8B	Не виждам бъдещето пред себе си, всмисъл виждам само черни краски. Когато съм добре, дори не мисля много в/у това.	I do not see any future, in the sense that I see everything only in black. When I am well, I do not even think about this very much.
Q9B	От сероксат съм се чувствал приповдигнат. От ципралекс пък получих много силна тревожност и не можех да стоя на едно място (най-лошия ми период), като преди това ми е помагал ципралекса.	I felt elation from the Seroxat. From Zipralexa I felt very strong anxiety and I was restless (my worst period), while Zipralexa used to help me earlier.
Q10B	Ами един човек който никога не е страдал от депресия, не би разбрал какво усеща човек който е в. Това, че си объркан е неразбираемо, че не искаш да се виждаш с хора които са ти приятни.	Well someone who has never suffered from depression cannot understand what one feels when depressed. Being confused is not understandable, not wanting to see the people you like.
Q11B	Химичен дисбаланс в мозъка.	Chemical imbalance in the brain.
Q12B	Мед. лице и интернет.	Medical practitioner and Internet.
Q13B	Писах за това... имам чувството, че паметта ми е отслабнала вследствие на депресиите. Усещам го дори когато се чувствам добре, не само когато съм в депресивен епизод.	I wrote about this… That my memory has become poorer due to the depressive episodes. I can feel this even when I am well, not only when I am in a depressive episode.
Respondent 38BG		
Q1A	17	17
Q2A	Мъж	Male
Q3A	България	Bulgaria
Q4A	Да	Yes

Q5A	2010	2010
Q6A	През есента на 2010година изпаднах в депресия зя първи път от тогава живота ми си преобърна на 360 градуса постоянно плачех нямах желание за нищо нищо не ме радваше и топлеше чуствах се сразен.След като подействаха хапчетата които ми изписаха след около два месеца изпаднах отново в депресия и получавах паник атаки нямах сила да стана от леглото свалих около 15кг смених много психиатри 3 са общо но са ме объркали и последната ми диагноза след ужасни и жистоки мъки беше биполярна депресия!!!	In the fall of 2010 I was depressed for the first time and my life has turned around since then. I was constantly crying, did not have the desire to do anything, nothing could bring me happiness and joy and I felt defeated. After the prescribed medication worked, about two months later, I again became depressed. I had panic attacks, did not have the strength to get out of bed, lost about 15 kg. I changed a lot of psychiatrist, 3 altogether, but they had it all wrong. The last diagnosis after a lot of suffering was bipolar depression!!!
Q7A	1.10.2010г Есциталон 10мг сутрин, Ривотрил 0.5мг вечер /14.02,2011г Аафранил о.25 мг 2х1, Ксанах о,25мг,Стрезам 2х1,Арапакс 2х1/ 06,02,2012г Ларохин 75мг 1х1 сутрин Флунахол 0,5мг сутрин Ривотрил 0,5мг вечер	1.10.2010 – Escitalon, 10 mg in the morning, Rivotril 0,5 mg in the evening 14.02.2011 – Aafranil 0,25mg, 2x1 Xanax, 0,25 mg Stresam, 2x1 Arapax 06.02.2012 – Larohin 75 mg 1x 1, in the morning Flunahol 0,5 mg in the morning, Rivotril 0,5 mg in the evening
Q8A	Не	No
Q9A		
Q10A	Да	Yes
Q1B	Без отговор	Not answered
Q2B	Без отговор	Not answered
Q3B	Без отговор	Not answered
Q4B	Без отговор	Not answered
Q5B	Без отговор	Not answered
Q6B	Без отговор	Not answered
Q7B	Без отговор	Not answered
Q8B	Без отговор	Not answered
Q9B	Без отговор	Not answered
Q10B	Без отговор	Not answered
Q11B	Без отговор	Not answered
Q12B	Без отговор	Not answered
Q13B	Без отговор	Not answered
Respondent 43BG		
Q1A	34	34
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2008	2008
Q6A	Без отговор	Not answered
Q7A	Ципралекс - веднага след диагностицирането	Zypralex right after being diagnosed
Q8A	Не	No
Q9A		
Q10A	Не	No
Q1B	По време на депресия - преживяване на самота, отделеност от другите, чувство за безнадеждност, нежелание за каквото и да било, преживяване, че си изоставен, необичан от никой,	During a depressive episode – a feeling of loneliness, of being distanced from the others, a feeling of hopelessness, lack of desire for anything, an experience of being abandoned, of not being loved by

	преживяване на страх, ниска себеоценка, липса на вяра в способностите си, порив за плач, голяма тъга. Извън депресия имам цели, мога да изпитвам радост и въодушевление, чувствам се способна да се справя с нещата и съм готова да поема рискове и да правя трудни неща. В депресия всяко нещо е трудно.	anyone, anxiety, low self-esteem, lack of confidence in one's own abilities, a need to cry, very strong grief.
Q2B	Най-вече изглежда като неприветливо място пълно с неудобства.	It mostly looks like an unwelcoming place full of discomforts.
Q3B	Изглеждат незаинтересовани или недоброжелателни, критикуващи, застрашителни.	They look as if they were not caring or ill-willing, critical, menacing.
Q4B	Силно усещане за умора и сънливост. Често имах стомашни киселини, в най-тежките периоди - гадене и повръщане. Тялото е тежко, енергията - много ниска.	An experience of being very tired and sleepy. I often had a sour stomach, in the worst periods – vomiting and feeling sick. The body is heavy and energy is low.
Q5B	Трудно е мисълта да бъде съсредоточена в нещо, което го изисква. Желанието да си стоиш вкъщи и да не правиш нищо е много силно и всяка дейност коства много усилия.	It is hard to focus your thoughts on something that requires it. The desire to stay home and do nothing is very strong and any activity takes a lot of effort.
Q6B	Не.	No.
Q7B	Може би мисленето се забавя, намалява способността за анализиране.	Maybe thinking slows down. The ability to analyse is diminished.
Q8B	Заради липса на цел и вярата, че мога да се справям с предизвикателства, преживяване на безперспективност, изглежда, че животът няма смисъл, а е само едно мъчение. Вън от депресия си мисля за нещата, които искам да постигна, вярвам в тях и се вдъхновявам от идеята да ги постигна, животът изглежда забавен.	Because of the lack of an aim and faith that I can cope with challenges, I experience a lack of perspective, looks as if life does not make any sense, but is just a torture. When not depressed, I think about things that I want to achieve, I believe in them, and get inspired from the idea that I can achieve them, life looks fun.
Q9B	След 20-на дни се появи добро настроение, силна мотивация, радост, вяра в себе си.	After about 20 days I was in good mood, strongly motivated, happy, believed in myself.
Q10B	Когато ти кажат "Хайде стегни се, няма защо да си в депресия", е много трудно да обясниш, че не ти е възможно да не си в депресия. В този момент просто не знаеш какво е добро настроение, сякаш никога не е съществувало и не можеш да си го представиш какво е. Не е възможно да ти стане весело.	When you are told "Come, get yourself together, there is no reason to be depressed", it is very difficult to explain that it is impossible for you not to be depressed. At this moment you just do not know what a good mood is, as if you have never known such and you cannot imagine what it is like. It is impossible to feel joy.
Q11B	Смятам, че съм заела тази позиция от малка, станало е нещо като моя природа. От друга страна също смятам, че е много свързана с биохимията в мозъка, заради начина, по който се влияе от медикаментите.	I think that I have adopted this position as a child. It has become like a second nature for me. On the other hand, I also think that it is linked to the biochemistry of the brain because of the way if is influenced by medication.
Q12B	С психолог - когнитивно-поведенческа терапия, интернет	A psychologist – CBT, Internet.

Q13B	Без отговор	Not answered
Respondent 45BG		
Q1A	28	28
Q2A	Жена	Female
Q3A	Германия	Germany
Q4A	Не	No
Q5A	Без отговор	Not answered
Q6A		Not answered
Q7A		Not answered
Q8A	Не	No
Q9A		
Q10A	Не	No
Q1B	Плача без причина и след това се успокоявам.	I start crying without a reason and then calm down.
Q2B	Ако времето е мрачно, се подтискам.	If the weather is bad, I feel down.
Q3B	Досаждат ми. Понякога ми е тъжно, че не мога да имам нормални отношения с тях.	They disturb me. Sometimes I am sad because I cannot have a normal relationship with them.
Q4B	Губя чувствителност и се занемарявам.	I lose my sensitivity and neglect myself.
Q5B	Отлагам неща, които искам да направя, но нямам сили да започна.	I postpone things that I want to do, but which I do not have the energy to start with.
Q6B	По-бавно е.	It is slower.
Q7B	По-трудните задачи ми тежат, досадни са ми и не мога да се съсредоточа.	Harder tasks are a burden, bothersome and I cannot concentrate.
Q8B	Не се опитвам да променя начина си на живот, въпреки че не ми харесва. Правя едно и също всеки ден, нося се по течението.	I do not try to change my way of life, although I do not like it I do the same things everyday, I go with he flow.
Q9B	Без отговор	Not answered
Q10B	Не мога да обясня чувството за празнота и безсмисленост.	I cannot explain the feeling of emptiness and meaninglessness.
Q11B	Заучено поведение, промяна в мозъчната биохимия.	A learned behaviour, a change in the biochemistry of the brain.
Q12B	Книги, лекции.	Books, lectures.
Q13B	Без отговор	Not answered
Respondent 46BG		
Q1A	41	41
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	1988	1988
Q6A	голяма депресия	Major depression
Q7A	Амитриптилин	Amitriptilin
Q8A	Не	No
Q9A		
Q10A	Не	No
Q1B	подтиснатост, тъга, безнадежност, мисли, че животът няма смисъл, че всичко е напразно, мисли за самоубийство	Low-spirited, sadness, hopelessness, thoughts that life does not make sense, that everything is pointless, suicidal ideation
Q2B	светът е празен, грозен, нищо не ме радва	The world is empty, ugly, nothing makes me happy.

Q3B	близките не ме разбират, чувствам ги далечни, понякога зли, по-точно злонамерени, не знаят как се чувствам	My close ones do not understand me, I experience them as distant, evil sometimes, malicious more precisely, they do not know how I feel
Q4B	отпаднала съм, нямам сили и желание за нищо, не мога да спя	I feel fatigued, I do not have energy and desire for anything, I cannot sleep.
Q5B	почти нищо не мога да свърша, а и не виждам смисъл в това да го върша	I can do almost nothing and I do not see the point in doing anything.
Q6B	времето тече бавно и мъчително	Time goes slowly and painfully.
Q7B	мисля бавно или зациклям на определени неприятни и тревожни мисли	I think slowly and obsess with specific unpleasant and worrisome thoughts.
Q8B	животът ми няма смисъл и не виждам изход	My life does not make sense and I do not see a way out.
Q9B	спя по-добре, по-спокойна съм	I can sleep better, I am calmer.
Q10B	отчаянието и желанието за край на живота, защото са против самото човешко съществуване	The desperation and the desire to end one's life because they are contradictory to human existence itself.
Q11B	болест, която зависи от много фактори, от негативни преживявания в детството, както и от средата в момента, от подкрепата, която получаваш или не получаваш	An illness that depends on a lot of factors, on negative experiences in childhood, as well as on one's surroundings at the moment, on the support that one gets or does not get.
Q12B	медицински лица, интернет	Medical practitioners, internet.
Q13B	Без отговор	Not answered
Respondent 53BG		
Q1A	42	42
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	yes
Q5A	25	25
Q6A	Не съм обърнала внимание какъв вид е но ми изписаха хапчета със зелена рецепта.	I did not pay attention to exactly what type of depression it is, but I was prescribed medication with a green prescription (a specific prescription for the group of psychoactive drugs such as sedatives).
Q7A	предписаха ми хапчета но ме посъветваха да търся и други начини за справяне със депресията.	I was prescribed medication but also advised to look for other ways to deal with depression.
Q8A	Да	Epilepsy, at the age of 25
Q9A	Епилепсия на 25 г.	
Q10A	Не	No
Q1B	Поемам повече отговорности отколкото мога да поема. Чувството е на безпомощност и безнадеждност.	I take more responsibilities that I can handle. A feeling of helplessness and hopelessness.
Q2B	Не. Светът си е наред но не мога да разбера себе си защо се тормозя.	No, the world is alright. But I cannot understand why I bother myself.
Q3B	Не	No
Q4B	Стегнато, сковано, липсва ми усмивката и боксувам в едни и същи мисли.	Tense, stiff, my smile is missing and I obsess with the same thoughts.
Q5B	Върша нещата машинално	I do everything on auto-pilot.
Q6B	Да. Времето спира или се е влачи и аз съм извън него, защото бързам.	Yes, it does. It stops or drags, and I am outside of it, because I am in a hurry.

Q7B	Не влияе на мислите ми, а мислите ми ме вкарват в депресията.	It does not affect my thoughts, but my thoughts send me into depression.
Q8B	Депресията е следствието от моята тревога и притеснение.	My depression is due to me being anxious and worrying.
Q9B	Не съм пила лекарствата, които ми изписаха.	I did not take the medication I was prescribed.
Q10B	Припадъка не мога да го пресъздам. Мога да опиша само какво съм запомнила.	I cannot recreate the breakdown. I can describe what I have remembered.
Q11B	Депресията е временно разочарование от самата себе си, че не мога да се справя с нещо.	Depression is a temporary disappointment with myself, because I cannot deal with something.
Q12B	Книги, приятели	Books, friends.
Q13B	Мразех се.	I hated myself.
Respondent 55BG		
Q1A	28	28
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	23	23
Q6A	депресивно разтройство, панически пристъпи	Depressive disorder, panic attacks
Q7A	лечението започна със седатив ПС + опити за терапия. започнах го 4 месеца след реалните симптои, защото преди това не можах да получа направление за специалист. опитах при 4ма специалисти, никой от тях не беше напълно адекватен на ситуацията. психиатърката ми неглижира проблема, хипнозата и биофийдбекът не помогнаха. полезни бяха само раговорите с последния специалист, който за разлика то другите не беше възприел тактиката да ме убеждава, че нищи ми няма и просто така съм отслабнала или не мога да спя. седатив ПС пих по схема 2 пъти и това помогна също определено. другото беше желанието ми да се справя, спорт, хранителен режим, сън, подкрепа от приятеля ми, справяне с другите проблеми и като цяло стремежът ми да подредя чисто житейски нещата около цебе си.	The treatment started with Sedative PS (a homeopathic product) and therapy attempts. I started it 4 months after the actual manifestation of the symptoms because I could not get a referral for a specialits before that. I tried four different specialists but none of them was completely adequate in this situation. My psychiatrist neglected the problem, the hypnosis and the biofeedback did not help. Useful were only the talks with the last specialist who, unlike the others, did not adopt the strategy of convincing me that I am well and I have lost weight and cannot sleep without a reason. I took Sedative PS according to the directions twice and that definitely helped, too. The other thing [that helped] was my desire to overcome it, sports, dietary regime, sleep, my boyfriend's support, overcoming other problems and generally the aim to arrange existential issues.
Q8A	Да	Yes
Q9A	булимия, в пубертета. причината - тежка семейна среда и отношението на баща ми към мен	Bulimia in puberty, due to a rough family environment and my father's attitude towards me.
Q10A	Не	No
Q1B	депресията ме е карала да си мисля, че съм в безизходица. панирала съм се. чувствала съм се слаба, с фокус върху проблемите, без реалистична представа за собствените си умения и възможностите, които имам. ако не съм	Depression made me think that there is no way out. I panicked. I felt weak, focused on the problems without a realistic estimate of my own abilities and the possibilities I have. When I am not depressed, I am in a better mood, I am

	депресирана - имам повече настроение, увереност, по-спокойна съм, не се тревожа за всичко толкова много, по-отпусната съм в отношенията си с хората	more confident, calmer, I do not worry about everything so much, I am more relaxed in my relationships with people.
Q2B	без изход, не ми е по силите да наредя нещата	Without a way out, it is beyond my abilities to make things right.
Q3B	за различни не знам, но нямат правилен подход - говорят ти наизуст как всичко ще се оправи или че нямаш чак такива проблем, вместо да те изслушат и да ти помогнат просто малко да си повдигнеш настроението	I do not know about different, but they do not have the right strategy – they simply talk about how everything is going to be okay or that you do not have so serious problems instead of just hearing you out and helping you cheer up.
Q4B	не мога да спя, отслабвам силно и бързо, няма апетит, няма настроение, нямам желание за нищо	I cannot sleep, I lose a lot of weight fast, I do not have appetite, I am in bad mood, no desire to do anything.
Q5B	Затруднява	It makes it harder.
Q6B	не помня	I do not remember.
Q7B	влошава способностите, причинява големи нарушения на паметта и панически атаки, които аз лично усещам като "рестартиране" на мозъка и на всички сетива, обикновено придружени със сърцебиене и изпотяване на дланите (които и по принцип са ми често изпотени)	It diminishes my abilities, affects memory very strongly, and panic attacks that I myself experience as a "restart" of the brain and all senses, usually accompanied by elevated heartbeat and sweating of the palms (that are usually sweaty in my case).
Q8B	кара ме да се съмнявам, че мога да успея в това, което се надявам. фокусира ме върху провалите. оставя ме без сили и желание за повече опити и без надежда и позитивни очаквания.	It makes me worry whether I can succeed in what I am hoping to. It shifts my focus to failures. It leaves without any strength and desire for further attempts and without any hope and positive expectations.
Q9B	добър ефект	A positive effect.
Q10B	не разбирам въпроса	I do not understand the question.
Q11B	депресията е изтощение. предизвикана беше от стрес и много неблагоприятни фактори, независещи от мен	Depression is exhaustion. It was caused by stress and a lot of negative factors independent from me.
Q12B	джипи, психиатър и 3ма психотерапевти. също форуми, сецализирани сайтове не само за депресивни разтройства, а като цяло за здравето и здравословния начин на живот. научила съм се да анализирам и да свързвам всички събития и факти, докато не открия решението над задачата, такъв е моят начин на мислене.	GP, a psychiatrist and three psychotherapists. Also forums, websites specialised not only in depressive disorders, but generally in health and healthy lifestyle. I have learned to analyse and link all events and facts until I find a solution of the task, that is my way of thinking.
Q13B	лекарите масово се опитват да втълпят на пациента, че нищо му няма, защото не се намира в състояние на очевидна тежка психоза.. т.е. проблемът е лек. но за пациента това не стои адекватно, защото той няма опит в решаването на подобни проблеми и ситуацията е тежка. не е ясно какви са опциите за контрол над симптомите, усещанията	The doctors always try to convince the patient that there is nothing wrong with her because she is not in a state of severe psychosis, i.e. there is no big problem. But this does not seem adequate to the patient because she herself does not have any experience in solving such problems and her condition is severe. It is not clear what the options for controlling the

	на тялото са непознати, а специалистите неглижират този ефект! като цяло смятам, че не намерих нито един адекватно подготвен човек, който да ми обясни как да се боря с проблема. справих се благодарение на седатива, приятеля си, благоприятно стечение на обсточтелствата в новата работа, които закрепиха нещата.. и също желанието ми да се преборя и да израстна проблемите си. все още се случват от време на време, но знам че вече са в нората и не искам прекалено много от себе си в това отношение.. лека полека си връщам загубената увереност.	symptoms are, the bodily sensations are unfamiliar and the professionals neglect this effect! In general, I think that I did not find anyone who was adequately prepared who could explain to me how to fight the problem. I managed thanks to the sedative, my boyfriend, some fortunate events at my new workplace, which stabilized my situation. And also my desire to fight and rise above my problems. It still happens from time to time, but I know that this is normal and I do not demand too much from myself in this respect. Gradually, I am regaining my lost confidence.
Respondent 56BG		
Q1A	36	36
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2010	2010
Q6A	имах един неуспешен суициден опит и тогава започнаха лечение с антидепресант	I had an unsuccessful suicide attempt and a treatment with antidepressants was started.
Q7A	Ланвексин след суицидния опит	Lanbexin after the suicide attempt
Q8A	Да	Yes
Q9A	параноидна шизофрения диагностицирана през 2007	Paranoid schizophrenia, diagnosed in 2007
Q10A	Да	Yes
Q1B	не знам дали в момента съм депресивна понеже пия тритико от 150 милиграма	I do not know if I am currently depressed because I am taking 150mg of Tritiko
Q2B	да не мога да работя и ме дразни работното ми място и ми се излиза на разходка	Yes, it does, I cannot work and my working place irritates me, I want to go out for a walk.
Q3B	не се различни, но никой не ми вярва	They are not different but no one trusts me.
Q4B	Стегнато	Tight
Q5B	пред мене са нещата които да свърша и нямам волята да ги свърша	The tasks that I have to do are standing in front of me and I do not have the will to do them.
Q6B	много тягостно	Very oppressive
Q7B	мисля си защо са ме спасили да се мъча още повече	I am wondering why they have saved me just to be tormented even more
Q8B	еми не знам сега пък съм в еуфория	Well, I do not know. Now I am euphoric.
Q9B	ланвексина беше по-добър ще искам пак да го пия	Lavenxin was better and I am going to ask for it again.
Q10B	аз не знаех че имам депресия просто не можех да работя	I did not know that I had depression, I just could not work.
Q11B	не мога да отговоря на този въпрос предизвиква я отношението на хората може би	I cannot answer this question. Maybe the attitude of people causes it.
Q12B	с никой, лекаря само ми казва да си намеря гадже и аз като влизам в сайтове	No one, the doctor keeps telling me to find a boyfriend so I am using the dating

	за запознанства и още по-лошо става само ме лъжат	websites but this only makes it worse because everyone is lying
Q13B	сега се чувствам много зле ама не ми се влиза пак в болница пък и този път не съм аз виновна	At the moment, I am feeling very bad but I do not want to be hospitalized again and it is not my fault this time.
Respondent 59BG		
Q1A	37	37
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2005	2005
Q6A	Първа диагноза: Паническо разстройство Втора диагноза: Тревожно-депресивно разстнойства Трета диагноза: Голямо депресивно разстройство Психичните ми проблеми започнаха на 19 години с тревожност и агорафобия, впосвледствие с годините се появи депресията	First diagnosis: panic disorder; second diagnosis: depressive disorder with anxiety; third diagnosis: major depressive disorder; My psychological problems started at the age of 19 with anxiety and agoraphobia, later on, with time, the depression appeared.
Q7A	Предимно антидепресанти. Селективни инхибитори на обратното захващане на серотонина	Mostly antidepressants – selective serotonin reuptake inhibitors
Q8A	Да	Yes
Q9A	Тревожно разстройство. Агорафобия и панически атаки	Anxiety disorder, agoraphobia and panic attacks
Q10A	Да	Yes
Q1B	Нямам сили да стана от леглото, също така и желание. Спи ми се постоянно. Не ми се говори с хора, занемарявам външният си вид, трудно ми е да се справя дори с елементарни ежедневни дейности.	I do not have the energy to get out of bed, and the motivation for it, as well. I am constantly sleepy. I do not want to talk to people, I neglect my appearance, it is hard to deal even with basic everyday tasks.
Q2B	Всичко ми е странно чуждо и нямам желание да съм част от него. Мисли за безнадежност	Everything appears strangely alien and I do not want to be part of it. Despairing thoughts
Q3B	Не	No
Q4B	Безсилие, чувствам тялото си тежко	Lack of energy, my body feels heavy.
Q5B	Когато ми е много зле не върша абсолютно нищо не ставам от леглото, пуша много	When I am very bad, I do not do anything, I do not get out of bed, I smoke a lot.
Q6B	Без отговор	Not answered
Q7B	Имам чувството че главата или по точно мозъка ми е хванат в обърч който ми пречи да мисля, чувствам се глупава и се страхувам че ще полудея	I have the feeling that my head, more specifically my brain, is wrapped by a ring/band that makes it hard to think, I feel stupid and I am afraid I will go insane.
Q8B	Безнадежност, страхувам се, че няма да мога да се справям с живота/работа, дете, семейство/	Hopelessness, I fear that I cannot deal with life, work, child, family.
Q9B	Влияеха ми добре Серопрам и Ципралекс, възвръщаха енергията ми, желанието ми за живот, освободиха ме от паническите атаки но докато ги пиех когато ги спрях депресията се върна, но без паническите атаки и агорафобията	Ceropram and Zypralex had a positive effect, brought my energy back, the desire to live, freed me from the panic attacks, but while I was taking them, when I stopped taking them, my depression

		returned but without panic attacks and agoraphobia.
Q10B	Странното чувство че това не съм Аз	The strange feeling that this is not Me.
Q11B	За съжаление при мен мисля че не е резултат от мислите или чувствата ми, просто се появява и се чувствам безсилна пред нея	Unfortunately, I think that in my case it is not the result of my thoughts and feelings, it just appears and I feel powerless against it.
Q12B	Психиатри, терапевти, книги	Psychiatrists, therapists, books
Q13B	Без отговор	Not answered
Respondent 74BG		
Q1A	55	55
Q2A	Мъж	Male
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2005	2005
Q6A	Без отговор	Not answered
Q7A	2006-2007 Ксанах	2006-2007 Xanax
Q8A	Не	No
Q9A		
Q10A	Не	No
Q1B	Без отговор	Not answered
Q2B	Не	No
Q3B	Не	No
Q4B	Отпуснато	Slack(y)
Q5B	Не съм в състояние да правя каквото и да е	I am not able to do anything.
Q6B	Времето тече много бавно	Time is passing very slowly.
Q7B	Почти не мисля	I barely think.
Q8B	Без отговор	Not answered
Q9B	Положителен	Positive
Q10B	Да - не съм в състояние да преставя и пресъсдам	Yes, but I cannot convey and describe them.
Q11B	Точни трудни и безизходни ситуации	Exactly by difficult and hopeless situations.
Q12B	мед лице- единнствено	Only a medical practitioner
Q13B	Без отговор	Not anwered
Respondent 77BG		
Q1A	47	47
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2000	2000
Q6A	Без отговор	Not answered
Q7A	Без отговор	Not answered
Q8A	Не	No
Q9A		
Q10A	Не	No
Q1B	Безнадеждност, безсилие, тревожни мисли липса на желание за каквато и да е активност, желание да избягам от всички и от всичко, нежелание за разговор	Hopelessness, powerlessness, anxious thoughts, lack of desire for any activity, a desire to run away from everything and everyone, unwilling to talk
Q2B	да - далечен и чужд	Yes – distant and alien

Q3B	Да - твърде обременяващи като изисквания - за внимание към тях	Yes – too demanding – for attention to them
Q4B	Схванато, сковано, с болки на различни места	Stiff, rigid, with aches at various places
Q5B	Костваше ми огромни усилия да извърша каквото и да било - дори неща, които касаят самата мен - да се изкъпя, да се нахраня	It cost me a lot of effort to do anything, even things that concerned only me – to take a shower, to eat.
Q6B	Да - все едно е спряло в лош момент	Yes, as if it has stopped at a bad moment.
Q7B	От тревожни мисли, без да имам сили да ги изключа, до пълна липса на мисъл/или само с една натрапчива/, до бели петна за секунди/но никога не си сигурен колко са продължили/	From anxious thoughts, that I do not have the power to stop, to lack of any thought/or only a single obsessive one, to blackouts for a few seconds/ but you are never sure how long they lasted.
Q8B	Липса на смисъл и желание за живот, безнадеждност	Lack of meaning and desire to live, hopelessness.
Q9B	Леко успокоение и лека еуфория	Mild relief and mild euphoria
Q10B	Да - натрапчивите мисли и белите петна. Не мога да ги опиша - винаги бяха различни	Yes – the obsessive thoughts and the blackouts – they were always different.
Q11B	Предизвика я умора - след много години повтарящи се психотравми от различно естество, усещането, че не това е животът, който съм искала. И осъзнаването, че нищо не може да се промени	Tiredness caused it – after many years of psychological traumas of different character, the feeling that this is not the life that I wanted. And the realization that nothing is going to change.
Q12B	Медицински лица, приятели, книги	Medical practitioners, friends, books
Q13B	Без отговор	Not answered
Respondent 81BG		
Q1A	30	30
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2010	2010
Q6A	умерено тежка депресия	Moderately severe depression
Q7A	Ксетанор + ривотрил, начало януари 2010 година	Xetanor + Rivotril, the beginning of 2010
Q8A	Не	No
Q9A	Отговорих с "не", понеже въпроса е за диагностицирането, но ще си позовля да напиша кратък коментар, че безспорно съм прекарала (или още имам др. заболяване/ния), които не са подлагани на лечение. За пример тежка фобия около 2006г	I answered with "no" to the previous question because it was about being diagnosed but I will allow myself to write a short comment here that I have surely suffered (or I still have other condition(s)) that were not treated. For example, a severe phobia around 2006
Q10A	Не	No
Q1B	Усещам апатия, липса на сили, сякаш си болен от грип. Трудно (чисто физически) извършвам елементарни дейности като например да си измиеш чиниите вкъщи. Чувствам се подтисната, ненужна, чувствам, че аз самата съм товар за близките, за света може би...Чувствам, че нямам изход, че съм безсилна да променя живота си. Различават се от периодите, в които не	I experience apathy, lack of energy, as if one is down with the flu. It is hard (purely physically) to carry out different tasks, as for example, to do the dishes at home. I feel down, useless, I feel that I myself am a burden to my close ones, maybe to the world… I feel that there is no exit, that I am unable to change my life. These differ from periods when I am not depressed exactly with respect to the listed above,

	съм в депресия именно с изброените неща, когато не съм в депресия съм по-оптимистично настроена, вярвам повече в способностите си, имам желание да се боря. Вярвам, че съществуването ми има цел и смисъл. Вярвам, че ще мога да имам нормален живот.	when I am not depressed I am more optimistic, I trust my abilities more, I have the will to fight. I believe that my existence has purpose and meaning. I believe that I can have a normal life.
Q2B	Околния свят не мисля.Трудно ми е да отговоря.	The world around me – I do not think so. It is hard to answer.
Q3B	Не.	No
Q4B	Нямам сили за елементарни неща. Сякаш багер е минал през мен. Чувствам се смазана. Много често внезапно ми става лошо, получавам сърцебиене, вдигам кръвно, припадала съм.	I do not have the energy for basic things. As if I have been run over by an excavator. I feel smashed. Very often I suddenly feel as if I am going to faint, get heart palliations, elevated blood pressure and I have even fainted.
Q5B	Повече от пагубно.	More than fatally
Q6B	Никога не съм се замисляла за това, но може би наистина сякаш времето е спряло.	I have never thought about that, but maybe it is as if time has stopped.
Q7B	Трудно е да преценя сама. Със сигурност не мисля трезво, когато съм в депресия. Нещата/ситуациите ми изглеждат много по-"черни", отколкото са в действителност. Чувствах се постоянно застрашена, страхувах се, че ще ми прилошее навсякъде и понеже живея сама, че няма да има кой да ми помогне. Тук усложняващ фактор е, че като дете си гълтах езика, т.е. за мен - в съзнанието ми губене на съзнание е равно на смърт. Само че аз от години живея сама, както и сега и не ми е бил преди и сега този риск проблем. Докато по време на депресията изпитвах постоянен страх, че ще се случи.	It is hard to judge that by myself. I am sure that I do not think clearly when I am depressed. Things/situations appear far darker than they really are. I constantly felt insecure, I was afraid that I would feel unwell everywhere and that, because I live alone, there would be no one to help me. In this respect, the complicating factor is that as I child as swallowed my tongue once, so losing consciousness, for me, in my mind, equals death. But I have lived alone for years and this risk has never be a problem for me, whereas when depressed I was experiencing a constant fear that it would happen.
Q8B	Когато съм в депресия смятам, че не мога да се справя с живота и с предизвикателствата от живота пред които всички сме изправени. Мисля, че не искам да го живея живота, ако ще е такъв (когато съм в депресия). А иначе съм човек, който ужасно силно цени живота, всеки живот...дори беден, в мизерия, в трудности...смятам, че живота е хубав и трябва да го живеем, да се борим, да сме доволни от него, да си доставяме радости и т.н. Тоест има доста голям контраст явно...	When I am depressed, I think that I cannot deal with life and the challenges of life that we all face. I think that I do not want to live this life, if it is like that (when I am depressed). Otherwise I am a person who values life terribly much … even a poor one, one in misery, one of difficulty … I think that life is good and we have to live it, to fight, to be happy with it, to bring ourselves joys and so on. So, there apparently is a strong contrast…
Q9B	Винаги съм била човек, който може и се усмихва. Много хора дори не подозираха, че съм в депресия. И не е било "насилствено". Но когато започнах да взимам медикаменти започнах да се смея много по-..хм..с	I have always been a person who can and does smile. A lot of people did not even suspect that I was depressed. And it was not “forced”. But when I started taking medication, I started laughing more well… out loud, the joy was much

	глас, много по-силна беше радостта, забавлението. Постепенно (отне доста време) намаляха прилошаванията. Сега все по-рядко имам проблем с кръвното. Първото нещо, което спря беше сърцебиенето. Ще го кажа кратко: буквално усещах прилив на енергия, малко по малко, но се възвръщаше. Аз имам от дете проблеми със съня, не мога да спя нощем, освен това сънувам винаги кошмари. Това не можахме да излекуваме. С тази цел беше ми предписана ремирта мисля се казваше, но дори с 1/4 не можах да стана от леглото, така че веднага го спрях(всичко това е консултирано с психиатъра ми). Антидепресанта, който приемах постоянно ксетанор по никакъв начин не ме направи сънлива или т.н. останалите странични ефекти (освен напълняването :)	stronger, the fun. The fainting decreased gradually (it took a lot of time). Now, I have problems with blood pressure more and more rarely. The first thing that disappeared was the heart palliations. I will put it short: I literally felt an influx of energy, little by little, but it was coming back to me. I have had problems with sleep since I was a child, I cannot sleep at night and I also constantly have nightmares. This we could not heal. For this I was prescribed Remirta, I think it was called, but even with a ¼ I could not get out of bed, so I immediately stopped it (all this was consulted with my psychiatrist). The antidepressant that I was constantly taking, Xetanor, did not make me sleepy and so on, the other side effects (except for gaining weight:)
Q10B	Неспособността да се преборишь с емоциите, дори да осъзнаваш ясно колко са нелепи или преувеличени. Няма как да обясниш това на някой, който не е минал по същият път. Трудно е да опишеш, че думата воля губи смисъл. Тоест няма такова нещо като да впрегнеш сили, воля и да продължиш да вършиш нещата, както преди. Същото си мисля, че е със зависимите хора.	The inability to fight the emotions, even if you realize how ridiculous and exaggerated they are. There is no way you can explain this to anyone who has not been down the same road. It is hard to describe that the word will loses meaning. So to say, there is no such thing as to make an effort, exercise your will and carry on doing things like before. I think that this is the same with addicts.
Q11B	Колко хубаво би било да знам какво я предизвиква... Мога да изброя много причини, които мен са ме докарали до това състояние, но други хора не са. Мислите ми предизвикват депресия. Моето отношение към случващото се предизвиква депресия....незнам...	It would be so nice if I knew what caused it… I can list a lot of reasons that brought me to this condition but not other people. My thoughts cause depression. My attitude towards what is happening causes depression… I do not know…
Q12B	Всичко изброено. С приятелите обаче без да навлизам в подробности за емоциите. Предпоставката ми е била да не ги плаша. Общо взето с близки съм споделяла само реда на лечението.	All of the listed. But with my friends without getting into detail about emotions. My reason was not to scare them off. With close ones I have generally shared only the course of treatment.
Q13B	Без отговор	Not answered
Respondent 83BG		
Q1A	30	30
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Не	No
Q5A		
Q6A	Имах подобно на депресивна диагноза през 2003г. Нещо като биполярно разстройство.	I had a diagnosis similar to depression in 2003. Something like a bipolar disorder.
Q7A	Лечението беше с някакви антидепресанти по здравна каза, които	The treatment was with antidepressant, from the health insurance company, that I

	не ги помня, но ги пих около година и половина.	do not remember, but I took them for a year and a half.
Q8A	Да	Yes
Q9A	Не помня точното име, но беше като форма на биполярно разстройство. (2003г)	I do not remember exactly but it was like a form of bipolar disorder (2003)
Q10A	Не	No
Q1B	Чувствам се отчаяна и нещастна. Понякога се радвам твърде силно на някое събитие и след кратно време започвам силно да страдам, че ми се е развалило настроението. Нямам спокойна среда, а такава, което ме натоварва и се чувствам зле. В моментите, когато не съм депресирана, виждам как същата среда не ми изглежда толкова враждебна. Сутрин се събуждам с недоволство и без желание за действие. Често се улавям в нерадстни мисли. Понякога мисля за самоубийство. В момента не съм в депресия, но наблюдавам други познати, които споделят подобни състояния и мисли.	I feel desperate and unhappy. Sometimes, I am very happy about an particular event but soon after that I start suffering a lot because my mood has been spoiled. I do not have a calm environment, but one that puts a load on me and I feel bad. During times when I am not depressed, I see how the same environment does not appear that hostile. In the morning, I get up with discontent and without any desire to act. I often catch myself having unhappy thoughts. Sometimes I think about suicide. At the moment, I am not depressed, but I am observing other people I know who share similar states and thoughts.
Q2B	Всичко те подтиска, мислиш, че няма изход от една или друга ситуация. Една приятелка на скоро ми сподели, че дори всичките й проблеми да се решат мигновено, тя няма да се почувства по-добре. Просто мъката е станала като част от нея. А тя пие редовно антидепресанти. Когато аз съм била депресирана, съм усещала подтиснатост и безрадостност. Чудела съм се на спокойните и ведри хора защо са толкова повърхностни и не се вълнуват от света и неговите проблеми. Състоянието още се описва с дупка, в което човек е попаднал и не може да види светлина.	Everything makes you down, you think that there is no way out of one or the other situation. A friend recently shared with me that even if all her problems got instantly solved, she would not feel better. It is just that the grief has become like a part of her. And she is regularly taking antidepressants. When I was depressed, I felt down und unhappy. I was wondering how the calm and happy people could be so superficial and not be moved by the world and its problems. This state can also be described as a hole one falls into and cannot see the light.
Q3B	Всеки изглежда като някакъв агресор. Целият свят е враждебен и готов да те нарани или поне да те заплаши. Хората и общуването с тях е по-скоро бреме, отколкото радост. За депресирания човек другият, който не страда, не разбира големите трагедии на света.	Everyone appears as an aggressor. The whole world is hostile and ready to hurt you or least threaten you. People and the communication with them is a burden rather than a pleasure. For the depressed, the other, who is not suffering, does not understand the big tragedies in the world.
Q4B	Тежко, тромаво, мързеливо. Твърде често при депресия полагам неимоверни усилия за извърша нещо, което през другото време върша с лекота и охота.	Heavy, clumsy, lazy. Too often, when I am depressed, I make a lot of effort to do something that I usually do with ease and pleasure.
Q5B	Буквално пречи. Всичко е тежест и мъка, страдание..	It is literally in the way. Everything is a burden and grief, suffering…
Q6B	Не помня.	I do not remember.

Q7B	депресията ме фиксира в някакъв минал момент, когато се е случило нещо, което не мога да приема. Дъжрейки това нещо в съзнанието си, аз по-трудно бих допуснала други, силни мисли там.	The depression sticks me in a past moment, when something that I cannot accept happened. Keeping this thing in my mind it is hard to let other, stronger thoughts in it.
Q8B	Сега не съм депресирана и виждам радост и надежда в повечето ситуации, изпитвам благодарност и смисъл в живота си, ежедневните дейности ми носят удовлетворение и радост, макар че ме измарят физически. Когато съм била депресирана, тези чувства ги е нямало. Предимно съм изживявала мъка и съм чакала някакво чудо да промени миналото, за да не се налага да го приемам. Само че в момента не съм разбирала, че е така. За това всичко ми е изглеждало трудно и тягостно. А щастливите хора като от друг свят.	At the moment, I am not depressed and I see happiness and hope in most situations, I feel gratitude and meaning in my life, everyday tasks bring me satisfaction and pleasure, although they make me physically tired. When I was depressed, these feelings were absent. I felt mostly grief and I was waiting for a wonder that would change the past, so that I do not have to accept it. But at that moment I did not understand that it was like that. Because of this everything appeared so difficult and burdensome. And happy people – as if they were from a different world.
Q9B	Спах повече и по-добре. Тъй като една от причините за депресията беше и внушенията за килограмите ми, малко понапълнях от лекарствата, но и някак се успокоих на тази тема. Станах по-малко изтерична и по-малко фанатизирана на всякакви теми, които бяха от значение за мен. Укротиха буйните ми периоди на неприемане на света около мен, като крещене.. Започнах да намирам желание у себе си да се занимавам с други дейности. Но основният ефект беше, че спя повече и по-добре и виждам света в спокойната отпочинала светлина.	I slept more and better. As one of the reasons for my depression was the excess of weight, I gained some but somehow calmed down about this issue. I became less hysterical and would fantasise less about topics that mattered to me. They calmed down the turbulent periods of inacceptance of the world around me, like screaming… I started finding a desire to deal with other activities. But the main effect was that I slept better and that I saw the world in a better and more peaceful light.
Q10B	Най-трудно за пресъздаване беше вманиячените ми мисли относно различни теми, който бях фиксирала. Също така мислите за самоубийство, затвореността, невъзможността да общувам свободно с другите хора.	The hardest to convey were my obsessive thoughts about different topics that I was fixating on. Also the suicidal thoughts, the seclusion, the inability to communicate freely with other people.
Q11B	Депресията според мен е състояние на съзнанието, при което то се фиксира върху нещо, което не иска да приеме (в миналото), или нещо, което силно го влече (в бъдещето) и което няма в настоящето. По този начин тя пречи да се изживее пълноценен осмислен живот в сегашно време. В моя случай поводът за депресията беше, че се запознах с едно момче и неговото семейство, които имаха себе си за много духовно развити хора и бях приела, че аз не съм такава и имам нужда от духовно развитие, но по техните критерии. Това ме накара да се	Depression, according to me, is a state of the mind, in which it is fixated on something that it does not want to accept (in the past) or on something that it is strongly attracted to (in the future) that it does not possess in the present. In this way it (depression) prevents us from living a valuable meaningful life in the present. In my case, the cause of my depression was that I met a boy and his family who considered themselves very mentally developed and I had accepted that I am not like them and that I needed mental development but with respect to their criteria. This made me doubt my

	осъмня в собствената си стойност и се изрази в желание да променя себе си - да отслабна телесно и да бъда по-морална. Само че не минах през някаква форма на себепознание, за да разбера коя съм аз и така да се променя, а започнах да пазя ненормално строги диети и да разсъждавам върху определени мисли, които бях чула в тази среда. В следствие на това започнах да виждам себе си като лош човек, който трябва да бъде друг. Този идеал беше някакъв неосъществим, неконкретизиран образ, който не можех да достигна. Това беше поводът, а причината е, че дълбоко в мен не съм вярвла в себе си, не съм възпитавана в ценности като себепознание, спокойствие и разбиране за света. Преди няколко месеца моя приятелка ме посъветва да отида на психотерапевт, защото учи психология и разпозна в мен депресивни симптоми. Поводът тук беше, че съм с малко дете и ми беше трудно да приема цяла отговорност на родителството и това, че животът се променя за мен. Разбира се, тук се включват и други фактори - промяна на местоживеенето, избиране на по-малко жилище т.е. условия, в които не съм свикнала да живея. Освен това преди 2 години и майка ми почина. Тъй като не можах да си позволя психотерапия, започнах да си водя дневник, където се опитвам да анализирам себе си и да приемам своите черти - да виждам кои са силните ми моменти и къде са слабостите ми. Разбира се, правя някакви опити за промяна, но все по-често достигам до извода, че волевата промяна е безсмислена. Когато съм осъзнала и приела всички аспекти на някоя моя черта, то тя ще се трансформира в нещо полезно за мен. Гледам да бъда честна със себе си и търся начини да обогатя живота си.	own value and expressed itself in a desire to change – to lose weight, to have higher moral. But I did not get through any phase of self-discovery so that I would find out who I was and change thereby, but started following abnormally strict diets and ponder upon thoughts I had heard in this circle. As a consequence, I started seeing myself as a bad person, who had to be someone else. This idea was some unachievable, undetermined image that I could not reach. This was the direct cause, but the reason is that deep inside me I have not believed in myself, I was not educated to value things like self-discovery, peacefulness and understanding of the world. A few months ago, a friend of mine gave me the advice to visit a psychotherapist, because she studies psychology and recognized depressive symptoms in me. The reason for this is that I have a small child and it was hard for me to take the responsibility of parenthood and the fact that life is changing for me. Of course, other factors have to be included here as well, moving to a different place to live, choosing a smaller apartment, conditions that I am not used to live in. also my mother died 2 years ago. As I could not afford psychotherapy, I started writing a diary where I try to analyze myself and accept my traits – to see what my strengths are and where my weaknesses lie. Of course, I am trying to change, but more frequently I reach the conclusion that the deliberate change is meaningless. When I have realized and accepted all aspects of a trait of mine, then it will transform into something useful for me. I try to be honest with myself and enrich my life.
Q12B	За първи път, когато имах депресия, преди 10 години, слушах съветите на специалистите, говорих с прители и четях книги. Но не съм разбирала депресията в дълбочина, по-скоро съм се опитвала да се излекувам, следвайки съветите на специалиста и вършейки нещата, които правех преди да се разболея. Сега бих потърсила подкрепа от психотерапевт, ако усещам	The first when I was depressed, 10 years ago, I listened to the advice given by professionals, I talked to friends, read books. But I did not understand depression in depth, I was rather trying to heal it, following the professional's advice and doing the things I used to do before I got ill. Now, I would look for the support of a psychotherapist, if I feel the need to. But my friend who studies psychology

	необходимост. Но и приятлеката ми, която учи за психолог, също дава доста креативни идеи за размисъл.	would also give me very creative ideas for thought.
Q13B	Гледах втренчено и се опитвах да бъда над всички и всичко - като някаква натрапчива мисъл за себедоказване.	I was staring and tried to be above everything and everyone – like an obsessive idea to prove myself.
Respondent 84BG		
Q1A	36	36
Q2A	Жена	Female
Q3A	България	Bulgaria
Q4A	Да	Yes
Q5A	2012	2012
Q6A	тревожно -депресивно разстройство	Anxious depressive disorder
Q7A	велаксин и ремирта	Velaxin and Remirta
Q8A	Не	No
Q9A	през 2012г се чувствах много зле, високо кръвно със събиране на границите, болки, гастрит, след което разбрах след много изследвания и лутане че това ми състояние се дължи на тревожно -депресивно разстройство.	In 2012, I felt very ill, high blood pressure with close borders, pains, gastritis, only later, after a lot of tests and consultations I found out that that my condition was due to an anxious depressive disorder.
Q10A	Не	No
Q1B	ами аз съм имала един период, веднъж ми се случи, и през него се чувствах ужасно, това беше най-лошото нещо което ми се е случвало, не вярвах че ще оцелея, мислих че умирам, а и имах страшно много физически симптоми, сърцебиене, безсъние почти неможех да спя, чувствах се без душа.	Well, there was a period, it happened once, and during it I felt terrible, this was the worst thing that has ever happened to me, I did not believe I was going to survive it, I thought that I was dying, and I had a lot of physical symptoms, heart palliations, insomnia, I could barely sleep, I felt without a soul.
Q2B	Да, изглежда много различен ужасяващ, безнадежден, имаш чувството че този ад никога няма да свърши, че ще продължи вечно и че никога няма да излезеш от кошмара. Имаш чвството че сънуваш най-големият си и страшният си кашмар, че ако се ощипеш и ще се събудиш/даже съм го правила, сама не вярвах че съм в Ада./	Yes, it looks very different, horrifying, hopeless, you have the feeling that this hell will never end, that it is going to last forever and that you will never leave the nightmare. You have the feeling that you are having you biggest and scariest nightmare, that if you pinch yourself you are going to wake up/ I have even done this, I myself did not believe I was in Hell.
Q3B	Да, различни са и хората и това е вярно, безразличен си към всичко, а и на теб ти се струва че и те са безразлични към теб. Не чувстваш нищо, съвсем нищичко, само отчаяние и огромна болка и агонизираш всяка секунда.	Yes, people are different, too and this is true, you do not care about anything, and it appears to you that they do not care about you. You do not feel anything, absolutely anything, only despair and enormous pain and you are agonising every second.
Q4B	Аз имах тревожно-депресивно разстройство и тялото ми беше постоянно напрегнато, постоянно в движение, исках постоянно да се движа, неможех да стоя на едно място, сърцебиенето също ме притесняваше, също и безсънието което продължи с месеци.	I had an anxious depressive disorder and my body was constantly tense, constantly moving, I wanted to move all the time, I could not stand still at one spot, my heart palliations were also disturbing me, and the insomnia as well, which lasted for months.

Q5B	Напук и на инат на болестта аз вършех ежедневните си дейности, не се отказах от тях но разбира се не бях в нормална форма, забравих няколко пъти котлона включен и излязох навън чист късмет че не е станало пожар.	In spite of the illness and out of stubbornness, I carried out my everyday tasks, I did not give them up, but of course I was not in a normal shape, several times I forgot the cooking plate on and went out, it was pure luck that I did not set everything on fire.
Q6B	Да времето..разбира се...то сякаш беше СПРЯЛО.или минаваше страшно бавно, едва едва с мъка ..чувствах се толкова безполезна че незнаех с какво да запълня тези празни часове, толкова самотна се чувствах!	Yes, time… of course… it was as if STOPPED. Or it passed by very slowly, hardly, painfully… I felt so useless that I did not know what to fill these empty hours with, I felt so lonely!
Q7B	Мисленето също се променя, трудно следиш логиката и самият ти трудно намираш такава, опитах се да реша задача за 2 клас на синът ми и не успях, можете да си представите как се чувствах а съм с висше образование.	Thinking changes as well, it is hard to follow logic and it is hard for you yourself to find such, I tried to solve my son's math problem for the 2nd grade and I could not, you can imagine how I felt, and I have a university degree.
Q8B	ами разликата е голяма, гледаш на живота изпълнен с отчаяние, без грам надежда знезнаеш дали ще дожевееш до утрешният ден, незнаеш това докога ще продължава и дали ще има спасение. Всеки ден се молих Бог да ми подаде ръка и да ме извади от този Ад, най-кошмарното и ужасно нещо което някога ми се е случвало. Излекувах се и сега живота е съвсем различен, вече не взимам никакви хапчета и съм сравнително добре, остана само сърцебиенето и малко от безсънието, но се надявам с течение на времето и малко повече упоритост и те да изчезнат.	The difference is big, you look at life filled with despair, without any hope, you do not know if you are going to survive till the next day, you do not know how long this is going to last and if there will be any salvation. Everyday I prayed to God to reach out for me and get me out of this Hell, the most horrific and terrible thing that has ever happened to me. I was healed and now my life is completely different, I am not taking any pills anymore and I am fairly well, only the heart palliations are left and a little of the insomnia, but I hope that with time and a little more persistence they will disappear as well.
Q9B	Ремиртата повиши апетита и напълнях, а от велаксина ми опада косата.	Remirta increased my appetite and I gained weight and Velanxin made my hair fall out.
Q10B	Има, защото това състояние неможе да се опиши със всичките думи на света...с две думи накратко..по страшно е от всяка една смъртоносна болест. Ад, който на никой не пожелавам, кошмар от който съм благодарна че се събудих и благодаря за това всеки ден.	There are, because this condition cannot be described with all the words in the world… in a few words, to put it short… it is more horrible than any fatal illness. A Hell that I do not wish to anyone, a nightmare that I am glad I woke up from and I am grateful for this everyday.
Q11B	Предизвикваше при мен физически симтоми, много силно проявени дотолкова че първо се бях заблудила и ходих на кардиолог, после на какви ли не изследвания, тялото реагираше много бурно.	In my case, it caused physical symptoms, expressed very strongly so that I was first mistaken and saw a cardiologist, made any kind of tests, my body reacted very strongly.
Q12B	с психиятър, беше ми много трудно да отида, отидох съвсем сама, съвсем сама и се борих с тая страшна болест, нямам никакви близки, но желанието ми за	A psychiatrist, it was very hard for me to go there, I went all alone and fought this terrible illness, I do not have any relatives,

	живот беше ужасно силно. ИСКАХ ДА ЖИВЕЯ И СЕ БОРИХ.	but my desire to live was very strong. I WANTED TO LIVE AND FOUGHT.
Q13B	Някой който не го е преживял неможе да разбере за какво писах досега,...много е страшно..но има спасение..ето аз съм реален случай на успешно лечение ..съчетание на лекарства плюс воля и имаше резултат, но трябва страшно много борба.	No one who has never been through it can understand what I have written about so far, … it is very frightening… but there is salvation… here I am, a real case of successful treatment… a combination of medication and will and there was a result, but you need to fight a lot.

Table 3A: The responses submitted to the DDQ BG.

Appendix 5: Overview of Sampling Criteria DDQ BG

Criterion for sampling of testimonies (SC)	Responses not included in the sample of testimonies to be studied
SC 1 – no medical diagnosis of depression (excluded from the study of Q1B-Q13B)	R48BG
SC 2 – additional psychiatric diagnoses	
SC 2.1 – personality disorder (excluded from analysis of Q1B-Q8B)	
SC 2.2 – confounding symptoms (similar and depression uncharacteristic experiences) related to additional psychiatric diagnoses	
SC 2.2.1 – schizophrenia	R56BG, Q3B – reports of experiences of paranoia
SC 2.2.2 – psychosis	
SC 2.2.3 – eating disorders	R55BG, Q4B – the presence of additional diagnoses of an eating disorder is associated with changes in the experience and perception of the own body
SC 2.2.4 – clinical anxiety; anxiety disorders (e.g. phobias, generalized anxiety disorder)	
SC 2.2.5 – post-traumatic stress disorder	

Table 4A: An overview of the responses excluded from the analysis of testimonies obtained in response to the DDQ BG

Appendix 6: Classification of the Experiential Phenomena Described in First-Person Testimonies of Depression

Loss of Possibility

Disconnectedness

- *Disconnectedness and disengagement* – experiences of being distant, disconnected, or disengaged from the world, others, and one's own life. Descriptions of perceiving the world as if behind a glass wall, or a barrier, as if moving too quickly, and feeling trapped in a bubble, or as an observer or a spectator also capture experiences of disconnectedness and disengagement.

Examples
I feel disconnected from the rest of the world, like a spectator (R84UK, Q1B)
everything around me seems to carry on with routines and time scheduled activities, it feels like I'm watching it all happen but I am not part of it: as though I'm inside a bubble (R117UK, Q6B)
The world appears to move faster, as if you are moving slowly and they are moving more quickly. It is difficult to keep up with it. (R118UK, Q2B)
It is as if there is a barrier between you and the rest of the world […] (R118UK, Q2B)

- *Numbing of the senses* – descriptions of instances or episodes of decrease or diminishment of the intensity of sensory perception, like, for instance, muffling of sounds, colours appearing dull and bland, light as dim, etc.

Examples
It's like my vision is tinted grey. I can still see everything in normal colours […] What I mean is...it's like everything just feels grey and dull. (R51UK, Q2B)
My perceptions seem blunted. Everything is duller. (R192UK, Q2B)
I see things on a grey scale when depressed – colours don't really register and my hearing seems dulled too. (R237UK, Q2B)

- *Emotional numbness* – descriptions of episodes characterized by the marked diminishment or absence of affective experience, whereby this absence is itself felt. Some resort to metaphorical descriptions of this failure to affectively respond by describing the world as colourless, bleak, or uniform or oneself as empty, dead (on the inside), or black.

Examples
[…] I have no feeling at all and I am just numb to everything and everyone. (R16UK, Q1B)
I have no feeling's inside except feeling sorry for myself and feel totally dead inside. (R28UK, Q1B)
The worst part is the feeling of numbness, where the thought of going on just seems unbearable. (R49UK, Q1B)
a: no emotion, hollow black hole (R89UK, Q1B)
Emotionally it felt like a great big insurmountable nothingness (R350UK, Q1B)

Loss of hope

- **Hopelessness**
  - *Lack of significant future* – experiences of anticipating or imagining the future as merely a continuation of the present, as lacking significant prospects for a change or a continuation of meaningful engagement with the world. The descriptions can emphasize the failure to envision any possibilities in the future, to anticipate a future, or merely a feeling of hopelessness.

Examples
You can't see far into the future so you can't see aspirations or dreams. Everything I ever wanted to do with my life before seemed impossible now. (R22UK, Q8B)

Also I feel like there is no positive future for me […] (R105UK, Q7B)

There seemed to be no future, no possibility that I could ever be happy again or that life was worth living. (R160UK, Q8B)

There is little hope. I see more darkness in things around me. (R180UK, Q8B)

If I'm really low I can't see a future, I feel like I'm at a dead end and can't find any way out. I feel stuck in a rut. (R288UK, Q8B)

- *Suffering will last forever* – descriptions of the present state of suffering and (emotional) torment as lasting forever, never changing, or ending, of life as unbearable as it does not offer any prospects for change, improvement, or alleviation. Unlike instances of descriptions of feeling as if one lacks a significant future (*lack of significant future*), the authors emphasize the permanent and everlasting nature of present suffering.

Examples
When I am depressed, however, life seems so overwhelmingly unbearable. (R51UK, Q8B)

I think that my life will never change and that I will always be depressed. Thinking about the future makes my depression even worse because I can't bear to think of being depressed my whole life. (R75UK, Q8B)

Life will never end, or change. Everything is negative. I lose my imagination, in particular, being able to imagine any different state other than depression. (R169UK, Q8B)

The short term is also filled with the greatest amount of emotional pain that feels as if it will be permanent. (R232UK, Q8B)

- *Inability to induce change* – descriptions of experiences of the future as lacking significant prospects (for improvement), which, unlike the former cases (*lack of significant future, suffering will last forever*), centre around the own failure to induce such and include descriptions evaluations, judgements, etc. that one is responsible for lacking the prospects for a significant or better future or is unable to induce such.

Examples
When I am depressed I feel as if there is no future for me.
[…] I hate everything about myself and wish I could change but I know that I never would be able to. (R16UK, Q1B)

I feel hopeless, as though there is nothing I can do that will ever truly improve my life. (R171UK, Q1B)

- **Loss of point and purpose**
  - *Activities are pointless* – many, if not all, activities of everyday living are experienced as pointless and meaningless. The descriptions often refer to their lack of significance, point, and purpose as the present essentially lacks an orientation towards a significant future.

Examples
Eating, getting dressed etc. seem pointless. (R24UK, Q5B)

Getting out of bed is a struggle, I feel I have nothing to get up for, presuming I actually wake up. (R85UK, Q5B)

Things either appear to be useless […] to make myself do it. I stop caring about cleaning - my usual obsessive cleanliness gnaws on me, but I can't justify doing a task I have to repeat. (R124UK, Q5B)

[…] I often have a complete inability to perform regular routine tasks and have no interest in any of them. There seems to be no point in doing anything. By performing everyday tasks nothing is achieved, they will only have to be done again and again. (R154UK, Q5B)

Appendix 6: Classification of the Experiential Phenomena Described in First-Person Testimonies of Depression

- *Life as it is now is pointless* – descriptions of experiencing life and existence as meaningless, pointless, and lacking purpose. Frequently, in such cases life also might be described as not worth living. Unlike experiences of individual activities as pointless (*activities are pointless*), here, one feels that existing in general and leading a life does not have any purpose or meaning in itself.

Examples
Life seems pointless (R24UK, Q8B)

Yes. It feels pointless, there's no future and no hope. (R28UK, Q2B)

I forget what my life is like when I'm not depressed and feel that my life and future is pointless. (R75UK, Q8B)

I think about how my life seems empty, unsuccessful, lonely, limited, poverty stricken, grief stricken, unfulfilling and pointless: especially when compared with other people's lives around me. (R113UK, Q8B)

Life is not enjoyable, it has no meaning. (R166UK, Q8B)

- *Low mood* – the characteristic low or depressed mood that is commonly described as feeling down, feeling low, but also as colouring one's evaluation so that everything appears negative

Examples
I am […] generally low. (R20UK, Q1B)

My mood just feels very low a lot of the time […] (R47UK, Q1B)

I think these dark times are very individual depending on triggers and experiences of each person but broadly the same low outcome and low feeling is the same. (R60UK, Q1B)

I see everything negatively […]. (R93UK, Q1B)

- *Emotional instability* – the lack of stability of affective experience characterized by mood swings and rapid changes in mood that may even seem ungrounded.

Examples
I wasn't in control of my emotions. (R40UK, Q4B)

Much more extreme – I'm either happy or really down – there's no middle ground. […] The analogy I'd use is when I'm depressed my emotions/moods are like fierce storm out at sea whereas when I'm not the sea is calm with small waves and ripples. (R147UK, Q1B)

My mood is on a hair-trigger when I'm depressed, it feels like nothing in the world is going right (R168UK, Q1B)

My moods can change at a drop of a hat […] (R239UK, Q1B)

- *Lack of pleasure* – the failure to experience pleasure and enjoyment, which might for some transform activities (especially recreational ones) into burdensome duties. Unlike instances of having lost the capacity for affective experience (*emotional numbness*), the focus in these descriptions is on the failure to enjoy various formerly pleasurable activities, occurrences, etc. rather than on the loss of affective excitability or diminishment of affect.

Examples
I never want to go out and do things so my friendships and relationships get effected and hobbies that I used to love hold no appeal to me anymore. (R16UK, Q5B)

don't get any enjoyment from any activities (R115UK, Q8B)

Engaging in normally pleasant activities feels like being required to climb Mount Everest. (R137UK, Q5B)

I have no specific periods of extremely low mood but I generally take less enjoyment from things and seek out enjoyable situations less frequently. I am less enthused or inclined to see friends or do things I like doing. Whilst things become less enjoyable they do not STOP being enjoyable. […] I take less and less enjoyment from things, generally to the point where I can't enjoy the things I like doing and everyday things become a chore. (R166UK, Q1B)

- *Crying* – reports of often uncontrollable crying outbursts and episodes, which might or might not be related to specific events and occurrences

Examples
I would cry most days, without any apparent reason. (R53UK, Q4B)
[…] tearful most of the time (R66UK, Q1B)
You feel like crying and do cry constantly and are unable to stop. (R112UK, Q1B)
I often just find myself tearing up and crying, not sobbing but just crying with an overwhelming feeling of sadness. (R231UK, Q1B)

- *Sadness* – reflective feelings of sadness that might be either not grounded in particular events or states of affairs or an exaggerated reaction to such and are usually not subjected to emotion regulation and control

Examples
I used to not be able to sleep at night because I was so sad. (R22UK, Q1B)
sad all the time (R115UK, Q1B)
But I come home from work or school and I'm angry and sad […] I can't be happy no matter what I do […] (R130UK, Q1B)
I feel I have no reason to be upset and can not think of why I am upset but that I just am. (R162UK, Q1B)

- **Lack of security**
  - *Hostile world* – descriptions of feeling threatened by others and the world, of experiencing fear and anxiety that are responses to some threatening or fearful characteristics of the world and various events.

Examples
The world is against me and is very frightening. (R8UK, Q2B)
Yes. It seems to be full of more hatred, evil and fear. When I am depressed, the world is a truly awful place to be. (R14UK, Q2B)
convinced everyone hates me and wants me to die. (R37UK, Q1B)
It [the world] is bleak, threatening, full of horrid people I want nothing to do with. (R270UK, Q2B)

  - *Impending sense of doom* – the general experience of free-floating anxiety that is not directed at particular events or states of affairs in the world (e.g. the world is not experienced as threatening due to some of its characteristics or properties but the anxiety one feels is rather disconnected from it and has a more mood-like character).

Examples
I'm terrified that something has or will go irreversibly wrong and I'll be doomed to misery and failure (R21UK, Q1B)
Constant worrying made me feel like something bad was always going to happen. (R53UK, Q1B)
I am paranoid and pessimistic, convinced something bad will happen to me or others (R85UK, Q2B)
Depression makes things unsafe, unsecure […] (R118UK, Q1B)
I feel […] anxious […] (R212UK, Q1B)

  - *Withdrawing from an insecure world* – reports of avoidance of particular situations, occasions, or patterns of active engagements with the world, as these are encountered as threatening, fearful, etc.

Examples
I tend to lock myself away (become very anxious about social situations) […] (R259UK, Q1B)
I become reluctant and almost afraid to go out so I isolate myself (R347, Q5B)
Withdrawing - most of the time I am reclusive but the worse my depression gets the more terrified I am of having to deal with people or things such as bills or other everyday situations. (R357UK, Q1B)

- Cognitive manifestations of the loss of hope
  - *Downward spiral* – a general negative focus and a process of reflection and deliberation on the negative aspects of the predicament one inhabits. This pattern of thinking can often be (experienced as) outside the bounds of one's control.

Examples
When I am depressed it builds and builds from a low moment that triggers something that then accelerates through a thinking process that is eternally negative that links one bad thought/experience to the next until you try and shake yourself out of it. (R60UK, Q1B)
Ii become preoccupied with negative thoughts […] When they are particularly persistent, my coping strategies to distract me from these thoughts […] no longer work and I can't concentrate. (R129UK, Q7B)
Insane whirling repetitive thinking which is completely incapable of finding a solution and over complicates and throws up road blocks at every turn. (R224UK, Q7B)
The thinking process becomes circular and spiral. On waking – the first thought is 'how do I feel today' and continues to analyse each little thought throughout the day. Trying to assess its meaning. Rumination replaces intellectual thinking. Thinking goes nowhere, only back round where it started. (R253UK, Q7B)

  - *Irrationality* – patterns of evaluations, judgements, and affective responses, which the authors identify as not rational, misguided, etc.

Examples
It makes you think all sorts of things about life and yourself that aren't true. (R22UK, Q8B)
Thinking becomes effortful. I don't want to think because my thinking is either slowed or negative. My ability to think logically or realistically or from an outside perspective is challenged because everything is jaded. (R124UK, Q7B)
Depression completely clouds my judgement, I can't think straight. (R292UK, Q7B)
[…] my thinking becomes much more narrow, as if I have mental 'blinkers' on and lose the ability to see the bigger picture, to stand back from a situation and rationalise. (R334UK, Q7B)

Temporal experience and loss of possibilities

- *Stuck to the present* – the feeling of being stuck to or locked in the present, of the present moment as if lasting longer or forever. The future also might be described as impossible or improbable. Passages describing this experience, unlike those depicting feeling as if one lacks significant future prospects (*lack of significant future*) or that one's current suffering will last forever (*suffering will last forever*), explicit refer to temporal flow, i.e. how time is felt, not the quality of future anticipation and its impact on the quality of current experience like the latter two.

Examples
I live minute to minute and can't plan ahead at all. (R160UK, Q6B)
Time seems to run slower and hang when depressed. The word oppressive comes to mind and fear grows as to when and if any respite will come. (R231UK, Q6B)
My perception of time when I'm depressed is definitely that it passes slower than when I am not depressed. […] days and weeks seem much longer, and contemplating a year in advance seems ludicrous given it seems so far away. (R307UK, Q6B)

- *Waiting for alleviation* – the experience of the passage of time leading to a particular event that might bring alleviation as if radically decelerated, lasting longer, never ending, etc. The descriptions of this experience frequently explicitly refer to the anticipation of a particular event, occurrence, or time of the day (unlike such of decelaration of temporal flow that are captured by the code *time drags* or such focusing on the permanent nature of present moment captured by the code s*tuck to the present*).

Examples
It goes very slowly. Like I remember lying awake […] and it was going so slowly, all I had to do was to get through to the morning so I could get some help and it seemed almost impossible just to get through those few hours because it was taking so long. (R49UK, Q6B)
I feel I am experiencing time much slower than others. The day seems to stretch out, and I get frustrated that it's not ending soon enough (R169UK, Q6B)
It drags interminably. I wish for the night to come just to be able to black out life. (R253UK, Q6B)

- *Time drags* – the general experience of time dragging, slowing down, stopping, or standing still. Commonly, the reports that do not provide any detail on time slowing down when waiting for a particular time of day or a particular event (*waiting for alleviation*), of being stuck to the present (*stuck to the present*) and not being able to appreciate or imagine the future or a substantial change in one's present condition (*lack of significant future*).

Examples
Slooooooow. Time goes so slowly when I'm depressed. Painfully slow. (R14UK, Q6B)
Time slows down and I feel like the bad feelings will last forever (R147UK, Q6B)

- Bodily experience of loss of possibilities
  - *Changes in appetite* – the changes in appetite include both the decrease or lack of such and its increase.

Examples
I no longer feel hungry […] (R38UK, Q4B)
I couldn't eat unless I was force fed. (R40UK Q4B)
I notice a decrease in sex drive and have problems with appetite – sometimes I have none and other times all I want to do is eat. (R190UK, Q1B)

  - *Weight on my shoulders* – the experience of being weighted down or pressed down by the world without the explicit reference to the experience of the own body as being heavy.

Examples
Everything feels different … like a weight on my shoulders (R14UK, Q1B)
The mood is dark, heavy – often physically too as if there is a literal weight on your shoulders pressing you down and you are drowning. (R118UK, Q1B)
I feel like gravity is pushing me down (R66UK, Q4B)

Being suicidal

- **Death as a relief**
  - *I am failing at life* – experience of suicidal thoughts, wishes, and feelings, which are directly related to one's self, its shortcomings and failures and one's general inability to deal with life

Examples
I almost always feel suicidal for at least some of the time when I am feeling depressed. My life feels hopeless, as if there is no point in continuing because I'm never going to get better or be able to change. (R47UK, Q8B)
I feel more down and sometimes suicidal. As if I can't go on and that I am worthless. (R145UK, Q8B)

- *No relief from suffering* – experiences of suicidal thoughts, wishes, and feelings that are related to the lack of prospects for relief from present suffering and intolerable torment and pain. Unlike experiences captured by the codes c*urrent suffering will last forever* and *life is pointless*, descriptions of these experiences explicitly mention a wish or desire to bring the intolerable mode of existence to an end.

Examples
It is as if I am being suffocated and I feel trapped with no escape apart from death but I don't actually want to die but at times it feels as the only option I can choose. (R16UK, Q1B)
[…] I feel like my life is not worth living and I would rather be dead! (R23UK, Q1B)
My mind is in complete turmoil and everything feels hopeless and I don't want to live anymore. (28UK, Q1B)
[…] you can't bear the pain of the feelings, you feel tempted to end the suffering – however this is not a calculated decision (to end the suffering), it is a feeling as if though it's a natural next step to take (just like animals seek solitude to die). (R117UK, Q1B)
I feel it is not worth carrying on with my life. I want to hurt myself. (R157UK, Q1B)

Loss of Ability and Agency

Disturbed skilful engagement

- **The resistant body**
  - *Lack of vital powers* – experiences of diminished energy, tiredness, and (physical) exhaustion.

Examples:
I experienced massive exhaustion, where my body wouldn't cooperate, as though I'd been very physically active for a long period and needed to rest. (R17UK, Q4B)
Tired, no energy, just want to sleep or lie down all the time. (R28UK, Q4B)
Completely exhausted. I never stop feeling tired. (R53UK, Q4B)
Tired – really really tired – the stairs in my house seem like a mountain. (R147UK, Q4B)
Tired, achy, unwell. (R155UK, Q4B)
Tiredness, both fatigue and with the whole process of living, take over. (R282UK, Q1B)
Lack of energy to do even the basic requirements of daily life. (R316UK, Q1B)

  - *Heavy body* – experiences of the own body as being heavy, leaden, burdensome. Unlike experiences of being weighted down (*weight on my shoulders*), these experiences are centred around the potential inaccessibility of the world due to bodily inability or a corporealization of the body. Here, the own body is experienced as heavy and primarily in terms of its failure thereby to make active engagements with the world possible.

Examples
Lethargic, like it's full of lead. My legs felt heavy all the time and I felt ridiculously tired. (R22UK, Q4B)
Like a burden. Like somebody has filled your legs with lead and walking is so much harder than it used to be. (R112UK, Q4B)
Depression for me is a heaviness, a weight that I carry that manifests itself physically in my shoulders or on my chest. (R118UK, Q4B)
Huge, an appendage (R224UK, Q4B)

  - *The unreliable body* – the body might also be experienced as unreliable, as if it does not function properly anymore, is likely to give up on one, or of being slow.

Examples
If it is particularly bad I my limbs go numb and I become convinced that I might physically fall to pieces (R21UK, Q4B)
My body feels alien most of the time, like it colludes with my mind. […] It feels like my body gives up as much as my mind does (R54UK, Q4B)
[…] empty (R80UK, Q4B)
Non-responsive in every way. (R168UK, Q4B)
My body feels like it isn't my own, that it is controlled by the depression (R240UK, Q4B)

- **The ailing body**
  - *Physical ailments* - various physical complaints and ailments that are more characteristic or symptomatic of somatic illness. These include general feelings of being unwell or sick, experiences of being feverish, as if having the flu or a cold, and more specific bodily complaints such as aches and pains (e.g. headache, back and joint pain, chest pain).

Examples
I often feel sick […] (R24UK, Q4B)
I get headaches with stress. I am sick and feel sick. (R85UK, Q4B)
[…] achy, unwell (R155UK, Q4B)

- **Effortful routine**
  - *Körper and effort* – experiences of (increased) bodily effort or strain, especially when performing actions and activities that were formerly effortlessly and automatically carried out. The descriptions can focus on the effortful, demanding, and straining nature of the task and the experience of being bodily challenged by these, so that they appear more difficult, demanding, overwhelming, etc.

Examples
I had to do everything in such tiny steps. Just the simple task of getting out of bed or leaving a building would be a huge deal. I would have to tell myself "first get into a sitting position. Then we will worry about the rest of it afterwards." (R22UK, Q2B)
Making tea takes so much effort I have to go back to sleep to recover as soon as I've drunk it. (R89UK, Q5B)
I feel as though I can't complete simple tasks. The most simple tasks seem insurmountable, as though washing up is suddenly the equivalent of scaling the empire state building. (R118UK, Q5B)
I find it very difficult to face normal duties when very depressed and sometimes sheer exhaustion takes over but I find being at work and keeping extremely busy helps. (R150UK, Q5B)
Everything seems to be a strain or I just act my way through a day, every small task wears me out. (R225UK, Q5B)
Tired and lethargic – too much effort needed to do the simple task of walking. (R308UK, Q4B)

  - *Chores have to be done* – experiences of various everyday or routine activities as normatively binding, so that they are encountered as chores or duties, as something one has to do, rather than something, which is merely part of everyday life.

Examples
When at home and I had finally forced myself through everything that had to be done I would finally realize that I could stop pushing and I would normally fall to the ground and lay motionless for a while. (R166UK, Q4B)
Not as much enthusiasm for work and household chores, but I do them because I have to. (R200UK, Q5B)
[routine tasks and everyday activities are] unbearable burden. (R253UK, Q5B)

- *Postponing routine tasks* – reports of abandoning routine activities, commonly due to their strenuous and effortful nature. Some descriptions refer to abandoning particularly routine activities as due to decreased motivation, because one does not seem to care anymore. Motivation (or caring) to perform routine tasks that are usually automatically carried out has a very strong bodily component and the responses that include these descriptions include reports of altered bodily experience such as lack of energy, physical complaints, etc. For these reasons, I consider such descriptions as depicting instances of impaired agency in terms of loss of skills rather than of motivation.

Examples

The thought of small tasks like washing-up seems enormous, and unfortunately for my partner I stopped doing housework. (R21UK, Q5B)

I try to keep my home very clean and tidy because I know when I am depressed everything will be too hard. (R134UK, Q5B)

And how! I become less concerned with the tasks of daily living, I take less care in my personal hygiene and cleaning at home. (R166UK, Q5B)

I also lose motivation for even the most routine household, family or work tasks […] (R259UK, Q5B)

When depressed, I become unable to carry out simple day to day tasks – cooking, cleaning, etc. (R347UK, Q5B)

Incapacitation

- *Unable to deal with life* – experiences of oneself as failing to deal with the requirements of daily living, so that one might feel overwhelmed by the tasks of daily living, which can commonly be described as struggling to start the day, or get out of bed (unlike in cases of experiences of bodily effort (*Körper and effort*), though, here getting out of bed is described like a struggle and not as physically effortful). The task of leading everyday life can be described as difficult, beyond one, impossible, etc.

Examples

When I'm depressed I feel as though life is really difficult, I view it in a very negative way. Everything feels too much to cope with. There have been times when it felt too much to do anything. (R93UK, Q5B)

First time – difficult to get out of bed in the morning, insomnia made it difficult to concentrate at school, when did sleep, overslept, was late for school.

Second time – very difficult to get out of bed in the morning, just wanted to sleep so I didn't have to face life, could sleep for hours on end. (R218UK, Q5B)

Everything becomes hard work, on waking up you feel "ugh I really don't want to face the day, getting out of bed is an effort, having breakfast is effort, etc. the smallest things knock you back. (R361UK, Q8B)

- *I cannot function* – descriptions of (experiences of) a general failure to function or perform to a particular (evaluative) standard. Unlike the experiences captured by the code *unable to deal with life*, they focus on one's inability to perform various tasks (due to decreased capacities such as concentration, attention, etc.) and function (a notion that implies an evaluative standard of performance). Moreover, motivation or desire for performing non-routine activities can also be understood as a general capacity and some of the responses refer to a lack of motivation for non-routine activities that results in a failure to function (in a normal manner).

Examples
Sometimes it felt impossible to live normally. I would often go through life not really sure of what I was doing or why, almost on automatic pilot. (R17UK, Q5B)

As I explained before, I can't and don't function at all, I just sit string into space thinking or crying. (R101UK, Q5B)

I find it hard to concentrate on every task I try and do. I give up, put everything off. I won't go to the shops, I won't do housework. I can't do my job/lose my job. I can watch TV and not have a clue what is happening. I get confused and find my memory really suffers. (R157UK, Q5B)

I've quit three jobs which I desperately needed. […] It slowly gets worse, and worse, until I eventually do nothing. (R124UK, Q5B)

Makes everything massively harder. At its worst, you don't want to do anything, or can't do anything even. […] You just get by doing the minimum to survive. Eat, sleep, work, if possible. (R361UK, Q5B)

- *Diminished performance* – experiences of the own performance as diminished, as not efficient, or effective. Unlike the codes *I cannot function* and *I cannot deal with life*, these experiences are of declining capacities, which make certain tasks more difficult or even impossible anymore.

Examples
I have trouble concentrating and more often than not drift off topic. I often forget what I'm talking about mid-sentence. My short-term memory is almost always affected. (R20UK, Q5B)

I become incredibly indecisive and lack concentration, which leads to a lack of motivation as I don't feel I can do my job properly and that I'm not good at it anyway. (RR246UK, Q5B)

Definitely – things that should be easy to work out are really hard. Quite often I can't make decisions but get annoyed if anyone else tries to help by making them for me. (R190UK, Q7B)

Loss of agency and temporality

- *Time is irrelevant* – experiences of time as irrelevant, as having no significance, or of one as simply not noticing time and how it passes.

Examples
When I'm depressed I don't seem to notice time, it just doesn't matter to me, it all seems to blend in to a mass of nothing. I always wear a watch, when things are bad to try and regulate my days into some sort of order, but I never seem able to manage it. Time loses significance. (R54UK, Q6B)

Time becomes insignificant. It passes and that's all that matters. (R112UK, Q6B)

I go vacant. I have no idea about time passing. Hours can go past without me realizing as I'm sat in front of a TV. (R192UK, Q6B)

- *Everything takes forever* – the experience of time as slowing down, specifically in terms of various tasks, activities, and actions requiring more time to complete or carry out. Unlike the experiences of time decelerating captured by the codes *time drags, waiting for alleviation,* and *stuck to the* present, here time is experienced as decelerating specifically in terms of disturbed agency and agentive performance.

Examples
Quite as one would expect, time seems to drag – everything takes longer to do because it requires a greater portion of my available concentration. (R166UK, Q6B)

If I'm trying to perform a task, time will drag though. (R168UK, Q6B)

But things also seem to take forever to do, even the kettle boiling takes forever and makes me angry and upset. (R237UK, Q6B)

- *Running out of time* – one might experience oneself as not having time at disposal as everything seems to take much longer than usually.

Examples
Yet at the same time when I look at my past it seems to have passed me by without me noticing. (R14UK, Q6B)
Then other times I'll open a book, look at the clock, and next thing I know it's 20 minutes later and I've read one line over and over. (R53UK, Q6B)
I wonder what I've done all day when the children suddenly burst through the door from school. Time has gone by, but I have done nothing, even to think one thought seems to have taken all day. (R117UK, Q6B)

Loss of Intersubjectivity

Loss of fundamental intersubjectivity

- **Loneliness**
  - *Inability to socialize* – an (experienced) inability to engage or interact with other people, encountering intersubjective interactions as more difficult and demanding, or as beyond one.

Examples
When I felt bad at this time of my life, I was very withdrawn, couldn't handle social situations, didn't want to talk to anyone, when I did talk to people, I was smiley and positive. (R161UK, Q1B)
Any time of interaction with other human beings is difficult on a really bad day. (R212UK, Q5B)
Find people alien and can't join in with smiles or laughter. (R224UK, Q1B)

  - *Avoiding others* – a desire or tendency to avoid engaging and interacting with others based on a lack of enticement towards social interactions, to distance oneself from others, or not wanting to socialize with other people. Unlike descriptions of experiences of a failure or inability to socialize (*inability to socialize*) the focus in the passages this code was derived from is on a lack of desire to socialize or engage with others or a desire to avoid this.

Examples
I didn't want to see anyone, I just wanted to stay in bed all day. (R22UK, Q1B)
If people are involved, I avoid doing it. (R124UK, Q5B)
Very tearful and closed off. Don't want to be around people or be sociable at all. Don't want to enter into conversation. (R343UK, Q1B)

  - *Craving contact*- the experience of desiring or craving interactions or contact with others, a desire to not be alone.

Examples
I can be clingy and desperate for attention, so feel upset when I can't have their attention. (R85UK, Q3B)
But in the same way you don't want to be alone because then you have only your thoughts which you cant switch off. (R112UK, Q1B)

  - *Others do not understand* – experiencing others as failing or not being able to understand one, one's perspective on the world, and how one experiences the world. These instances, though, do not refer to others as failing to empathise with one or understand one and one's experience during depressive episodes as the result of a stigmatized conception of depression.

Examples
It seems like everyone is having an amazing time and you're the one missing out. It is so easy to beat yourself up and think there's something wrong with you. It feels like no one else has ever experienced anything like this before, like you're all on your own. (R22UK, Q3B)
Somewhat. I'll see them laughing, my friends and family, and just think 'How can they be so happy and carefree' (R51UK, Q3B)
Other times it feels as if they are ignoring my obvious suffering, my plight or what I am experiencing – things that I feel deeply, that are raw within me appear to no longer be obvious to them. (R118UK, Q3B)
I feel isolated and that no one understands me. (288UK, Q3B)

- *Others do not care* – experiencing others as not emotionally invested in or caring about one and one's well-well-being or as being hostile. Similarly to the instances of experiences captured by the code *others do not understand*, this should not be the result of social stigmatization. Moreover, these experiences also do not refer to encountering others as hostile, aggressive, or threatening.

Examples
Yes – nobody cares and I deserve to sit and suffer in silence alone because the world doesn't want to know me (R65UK, Q2B)
Also it does feel like no one is on my side. If a friend doesn't return a message, I think they don't like me or care about me. (R134UK, Q3B)
Typically, people are more distant, less caring and generally more unpleasant when I'm depressed. (R307UK, Q3B)
Even though family often checks to see how I am doing, I feel as if they don't care. I feel separated from them. I may even feel like they never ask them how I am doing. (R323UK, Q3B)

- **Hostility towards others**
  - *Perceptual hypersensitivity* – reports of being hypersensitive to perceptual stimulation and of experiencing things as brighter, noisier, etc. than usual.

Examples
My perception of sound and light was greater, everything is too noisy or too bright. (R112UK, Q2B)
Everyone seems noisier and I find it hard to tolerate people, everything is too busy. (R143UK, Q2B)
Yes. I am more sensitive to noise and less patient. (R259UK, Q2B)

  - *Impatience and irritability* – being and feeling impatient and irritable, encountering other people, events, and occurrences as irriting and annoying.

Examples
I get a lot more irritated with them when I'm depressed […] Sometimes everything just seems really trivial. (R49UK, Q3B)
When I'm with friends they seem more annoying than usual and I become very irritable and desire to be left alone. (R129UK, Q3B)
I become very irritable and see the negative side of every situation. (R160UK, Q1B) I am very irritable by my own actions and those of others. (R228UK, Q1B)

  - *Anger* – experiencing anger, which might appear as not triggered or caused by or directed at anything in particular. Moreover, such diffuse and specific feelings of anger can be often merely reported in lists of emotions and moods (especially in the responses to Q1B).

Examples
I get angry with my partner and children for any reason, yet really they are being themselves. (R42UK, Q3B)
I was so angry but I didn't know why. (53UK, Q1B)
Anger. (R334UK, Q1B)

Appendix 6: Classification of the Experiential Phenomena Described in First-Person Testimonies of Depression

- **The disembedded self**
  - **Shame**
  - *Feeling useless, worthless, a failure* – the experience of oneself or the own self in terms of its negative characteristics. Descriptions of lack of self-confidence, of feeling 'second-rate' or inferior to others, feeling ashamed for one's personal shortcomings and negative characteristics, etc. are also captured by this code.

Examples
[…] how well I did my degree was important to me, and despite the fact I got a first, I still felt like a failure. I had no sense of achievement or accomplishment without finding a way to undermine or undo it. (R21UK, Q1B)

Worthless […] (R85UK, Q1B)

Everyone else has what they want, I have failed compared to everyone else. (R134UK, Q2B)

It makes me feel that I have no place in life… that I'm not good enough…that nothing I've ever done is good… it's very frightening. (R316UK, Q8B)

  - *Avoiding socialization because I am worthless* – tendencies towards avoiding social interactions that are related to feelings of shame.

Examples
I feel hopeless and useless and my self-confidence drops so low that sometimes I cannot even leave the house to buy food as I don't feel worthy to be taking up any space or time. (R367UK, Q1B)

  - *Others do not like me* – encountering others as judgmental, critical, and not approving of one.

Examples
Yes, the world looks like an evil place where people just judge you and don't understand you. (R30UK, Q1B)

Friends seem to avoid me and even if they tell me they are not avoiding me, I don't believe them. (R109UK, Q3B)

It seems like they don't like me. I think people are just being nice out of guilt or obligation. I take offence at random comments and see these as purposeful digs at me because I am inadequate and they're getting annoyed with me. (R166UK, Q3B)

My best friends and family could appear to be enemies, I would fear them sometimes, that they would hurt me, that they no longer liked me. (R331UK, Q3B)

  - *Self-hate and disgust* – experiencing self-hate and disgust at oneself or at one's deficient self (sometimes related explicitly to one's own bodily appearance).

Examples
I hate my body. I look in the mirror and I can't stand what I see, it's disgusting. (R49UK, Q4B)

My only preservation of concentration or thought is on self-hate. (R166UK, Q7B)

- **Guilt**
  - *Feeling a burden* – experiencing oneself as a burden on others in terms of one's negative characteristics or shortcomings, as harming or potentially harming others

Examples
Think I am not a good mum, wife, friend, daughter and all would be better off without me. (R37UK, Q8B)

I feel like I'm being a burden and that they only put up with me because they feel they have to. (R107UK, Q3B)

But mostly I feel guilty for the pain it causes to my family and because I feel I'm week and pathetic and self-absorbed for having the illness. (R150UK, Q1B)

Sometimes I recognise I am still part of the world but everything is ugly, all positivity disappears, and I fail to see the good in anything and feel I am a burden and that the world would be better off without me. (R271UK, Q2B)

Appendix 6: Classification of the Experiential Phenomena Described in First-Person Testimonies of Depression

- *Guilt and self-blame* – feelings of guilt and self-blame (often for alleged transgressions as well)

Examples
If something goes wrong, I automatically assume it's my fault. (R200UK, Q2B)
The short term is full of guilt for not taking care of my responsibilities. (R323UK, Q8B)
Everything is negative, you find reasons for the way everything is, either because I am shit, or worthless, or trouble, or boring, or incapable, etc. (R361UK, Q7B)

- *Fixating on the past* – ruminating on past episodes and transgressions

Examples
I think too much over and over and over about things that may have happened in the past even a long time ago. (R93UK, Q7B)
ruminate on the past (R253UK, Q1B)
I think about all the mistakes I have made and feel full of regrets. (R291UK, Q8B)

- *I do not deserve living* – feeling suicidal in terms of not deserving to live because of (alleged or real) transgression or others

Examples
Life becomes unbearable and not worth living. The world would be a better place without me. I am not only worthless, but I make things worse by being here. (R259UK, Q8B)
Thoughts of suicide, brought on by feelings of worthlessness and guilt are commonplace. (R282UK, Q1B)

Interpersonal disconnectedness

- Pretence – descriptions and reports of pretending that one is not experiencing emotional distress, acting as if one were feeling well, continuing to pursue the normal course of everyday life in spite of incapacitation and suffering, which are related to a desire to conceal and not disclose that one is depressed

Examples
I worked very hard to ensure that it didn't interfere with my routine – I didn't take any time off work, I tried to make it to the gym, etc. but in some ways I think it would've been more sensible if I'd not tried so hard to pretend everything was 'normal'. (R21UK, Q5B)
Family and friends very rarely know when I am depressed, because I am extremely good at slipping on a mask and acting normally/hiding my true feelings […] (R23UK, Q3B)
I always go round smiling at people so nobody thinks there is anything wrong with me […]. (R84UK, Q10B)
I feel that I have to put a brave face on it most of the time otherwise everyone will think I'm malingering. (R186UK, Q1B)
I pride myself on the fact that I always get up, shower, dress smartly, and try to function normally as much as I can. (R282UK, Q5B)

- Others reacting to depression
  - Master narratives of depression – others present one with inappropriate or misguided models, conceptions, and ideas of what depression is. These commonly present the condition as not a 'real' illness, as resulting from being associated with psychological instability, which is within the bounds of one's voluntary and volitional control, remarks, advice, and suggestions as to how one improve one's mood, all which can be broadly characterized as socially stigmatizing in various respects.

Examples
Lots of people I talk to say unhelpful things like "just pull yourself together" or "you've got plenty to be happy about". They don't understand that it's not that I want to be depressed, I just can't control it. (R20UK, Q10B)
A lot of people I know think that depression is just an excuse to get attention. They think that it's just a game I'm playing […] They think that I purposefully do these things. (R51UK, Q10B)
Also some people assume that if you have depression, you lie in bed all day – most people don't understand that everyone's experience with depression is different and no less valid. (R53UK, Q10B)
I find it hard to express what depression feels like – people so easily dismiss these feelings as being over-emotional, as being a woman or of just being "that time of the month". I don't know how to express to others that I am ill – that this is as serious as any other illness […] (R118UK, Q10B)
Others have often interpreted my behaviour as sheer laziness and selfishness. (R367UK, Q10B)

- Withdrawal due to stigma – avoiding interactions with others in general and in particular such pertaining to one's emotional well-being and experience that commonly are motivated by the social stigmatization of depression

Examples
I become hyper-sensitive when depressed and over the years there are very few people I trust enough to open up about my illness. I withdraw from people when I'm ill and feel an outcast but even when I'm better I feel an outcast because it's always there and I find it hard to trust people enough to let my guard down. (R150UK, Q3B)

- Others are patronising – others engage in patronizing behaviour, which restricts one's agency, such as being overly careful when around one, treating one as a child, etc.

Examples
Feel they walk on egg shells around you not knowing what to say or do. (R115UK, Q3B)
There is an increasing sense that people patronize you. (R180UK, Q10B)

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