MAJOR DEPRESSIVE DISORDER: AN EMBODIED DISRUPTION OF AGENCY AND A DISRUPTION OF A FORM OF LIFE

By
Rachel G. Everett

Dissertation

Submitted to the Faculty of the

Graduate School of Vanderbilt University

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

in

Philosophy

May, 2013

Nashville, Tennessee

Approved:

Professor José Medina

Professor David Wood

Professor Lucius Outlaw

Professor Linda Manning

To Eric with deep gratitude

TABLE OF CONTENTS

Page

Dedication iii

Preface vii

Chapter

I. MAJOR DEPRESSION: FIELDWORK IN PHILOSOPHY 1

Introduction 1
Major Depression' 3
Problem of definition 3
Depression, estrangement, and loss 12
Justification: Fieldwork in Philosophy 16
Methodology and Literature 21
Wittgenstein 23
Phenomenology 25
Psychotherapy 26
Philosophy from the borders 28
First-person accounts 30

II. FORM OF LIFE AND ITS DISRUPTION 38

Introduction 38
'Form of Life' 39
Wittgenstein's use of 'form of life' 39
Affective agreement and affective disruption 50
Familiarity and 'feeling at home' in a form of life 55
The Disruption of a Form of Life 58
Loss of ease 58
Defamiliarization 61
Marginalization in a form of life 65
Conclusion 68

III. DEPRESSIVE PERCEPTION 70

Introduction 70
Seeing-through Depression 72
Depression and problems of perception 72
Seeing-through 77

Attunement....82
Spatiality....87
Non-depressive and depressive spatialization....87
Depressive spatiality....90
Temporality....96
Non-depressive and depressive temporalization....96
Depressive temporality....100
Omnipresence of the present....100
A living-death....100
Conclusion....112

IV. ALTERED SENSE OF SELF AND DISRUPTED RELATIONALITY....114

Introduction....114
Part One: Sense of Self and Depression....118
Illness and identity....118
Loss of self....127
Loss of 'me'....128
Intrapsychic conflict....132
Depression embodied....142
Disrupted cognitive attachments....148
Depressive Identification....155
Identifying 'depression'....155
Identifying *with* depression....161
Part Two: Depression and Sociality....165
Depressive Identity....166
Depressive withdrawal....167
Interpellation and depression....171
Cultural oppression of deviance and the normativity of mental health....177
Flight from authenticity....181
Social Structuring of Depression....185
Diversification of *the* depressive experience....186
Gender, sex, and sexual orientation....189
Class....192
Race....193
Silence and Disclosure....198
Conclusion....202

V. Discursive Disruption and the Estrangement from Affective Meaning....204

Introduction....204
Part One: The Estrangement from Meaning and Language....206
‘Language’ and ‘language-loss’....206
Meaning....213
Language and its inadequacies....222
Language as co-existence....230
The body and speech....235
Part Two: Recovery of Discursive Agency....245
Rebuilding and revitalization....245
Recognition and receptivity....250

VI. CONCLUSION....257

BIBLIOGRAPHY....264

PREFACE

Never to be rid of oneself, this is the curse of depression. Never to have a self, this is the plight of the depressed. To be both rid of oneself and to become a self, this is suicide. Lost to others in isolation, present to self in pain; silence or scream is the choice of the depressed. It is absolute separation and omnipresence. The self is a symptom, a cure, and a source of depression, all excess and loss, never quite a self and never not a self. Neither fully a protest against the loss of a beloved object, nor fully a protest against the structures that constitute objects, depression is a protest of the self that one has become, that one has lost, and that one cannot escape.

Depression uproots the familiar terrain of living and unearths internal discord. It comes as an earthquake, without warning. Or can slowly descend like a cloud, growing ever larger, darker, and heavier on the horizon. Depression confuses the mother tongue and obfuscates meaning. The aftershocks of depression leave behind shards of selves and enervated cells of life. The depressed is never speaking and never silent.

CHAPTER I

MAJOR DEPRESSION: FIELDWORK IN PHILOSOPHY

Introduction

This dissertation aims at giving a philosophical account of the phenomenon of language-loss[1] that accompanies major depression. While the dissertation has this particular and relatively narrow aim, most of the philosophical work takes place in establishing the necessary context for understanding this problematic phenomenon. Language-loss in depression, like language-use in general, belongs to a larger context. Language-use and language-loss function in a complex living network of social practices and material conditions. They operate at the level of the physical body, discursive agency, and personal identity. They are conditioned by intellectual and affective meaning structures. They belong to a distinct historical time and a particular temporalization. Language is meaningful only within a form of life; major depression, however, entails the disruption of a form of life and the disordering of language.

Ultimately this dissertation reveals that language-loss is a complexly structured symptom – a surface phenomenon – that belongs to an overall disruption of agency and a form of life. While the conceptual work of the dissertation moves outward from the

[1] 'Language-loss' refers to the multiplicity of discursive practices disrupted in depression, such as: reading, writing, speaking, conversing, and thinking.

phenomenon of language-loss to the disruption of a form of life, the performative structure of the dissertation inverts this process. In the next chapter, I begin at the level of the form of life and in the following chapters I incrementally narrow the focus to the depressed individual's estrangement from language. In the final chapter I will show that what is experienced as discursive disruption by the depressed individual is not in itself an exclusively linguistic problem. Rather, language-loss sits on top of a more pervasive estrangement from affective meaning in general.

A part of what this dissertation accomplishes is a phenomenological account of depression. I provide an account of the depressive experience in terms of the depressed individual's relation to a few central phenomenological structures: perception, time, space, self, and others. Another central feature of what this dissertation achieves is a reevaluation of the philosophical concepts of 'agency' and 'personal identity' through the lens of major depression. The main claim that I make in this dissertation is that affective disconnection and affective disordering are the principal sources of the depressive's[2] disruption of language, agency, sociality, and her way of living.[3]

In this chapter I provide a general account of 'major depression,' a brief justification of a philosophical investigation into depression, and an introduction to the various sources that will be used through the dissertation. In the second chapter I assess the Wittgensteinian idea of a 'form of life' and the implications of depression's disruption of a form of life. In the third chapter, I evaluate the depressed individual's

[2] My use of "the depressive" and "the depressed individual" or "depressives" does not indicated a unified depressive perspective or experience. I will explain further on pp. 16-17 and 29-30.
[3] Throughout the dissertation I use feminine personal pronouns when referencing the depressed individual. This use of feminine pronouns is a matter of style and does not reflect an exclusively feminine form of depression or an exclusively feminine perspective.

altered perception, temporalization, and spatialization. The fourth chapter focuses on the depressive's loss of self, disrupted agency, and socialization. Finally, in the fifth chapter I consider the depressed individual's loss of language as an estrangement from meaning, and provide an account of the depressive's recovery of discursive agency.

'Major Depression'

Problem of definition

One of the challenges to a philosophical analysis of depression dwells with the imprecision of the concept 'depression.' The main difficulties that underlie an attempt to provide a comprehensive definition of depression lie with the variability of symptoms and causes, the subjective nature of the malady, cross-cultural disparities, and the history of related dejected states like *melancholia*. The criteria that are used to arrive at a definition of depression are polemical. For example, the Diagnostic Statistic Manual primarily focuses on symptomatology, but many contend that etiology should also be taken into account in defining 'depression.' In the field of psychopharmacology, 'depression' is for the most part delineated according to symptoms alleviated by antidepressant medication. While general agreement about the key features of depression does exist within mainstream fields of clinical psychology and psychiatry, widespread disagreement persists when it comes to its treatment and etiology. One aspect of depression that tends to unite clinicians, theoreticians, and researchers is the critical outcome of depression. Depression will soon replace heart disease as a worldwide

leading cause of morbidity,[4] and the people that survive serious depressive episodes still face the threat of relapse and the life-altering effects of a single episode.

While 'depression' emerges as a more-or-less unified illness in the 20th century, symptoms associated with today's depression have been associated with various other maladies throughout history. From the "noonday demon" of the Psalmist to the "black bile" (*melaina chole*) of Hippocrates and Aristotle; from the sinful *acedia* of Aquinas to the noble melancholia of the Renaissance; from the sweet melancholy of the Romantics to the nausea and despair of the existentialists; one would have to admit that at least the essential moods of depression are recurrent throughout history. In *The Noonday Demon: An Atlas of Depression*, Andrew Solomon gives both a personal and comprehensive perspective of depression, and reflects on depression's recurrence throughout history. He writes:

> The shape and detail of depression have gone through a thousand cartwheels, and the treatment of depression has alternated between the ridiculous and the sublime, but the excessive sleeping, inadequate eating, suicidality, withdrawal from social interaction, and relentless despair are all as old as the hill tribes, if not as old as the hills.[5]

However appealing, or perhaps discomforting, it might be to consider depression as a cohesive illness cartwheeling through time and space, there are many epistemological and ethical problems with equating today's clinical depression with past conditions such as melancholy and acedia. Jennifer Radden, a contemporary philosopher of psychiatry, claims that only a "superficial continuity links today's *clinical depression* with

[4] Radden, The Philosophy of Psychiatry, a Companion, 2004, 3
[5] Solomon, 2002, 286

melancholy and *melancholia*."[6] She claims that the differences between depression and melancholy outweigh the similarities and that they should not be considered one and the same. Nevertheless, a wealth of insight has been passed down from the many firsthand accounts of melancholia that can help provide an understanding of the nature of clinical depression. While most of the literature analyzed in this paper is limited to 20th and 21st century narratives, I also include writings on melancholia and related disorders from other periods.

While the melancholia of the 17th century might present quite differently from clinical depression of the 20th century, within the 20th century, especially in psychoanalytic literature, 'depression' and 'melancholia' appear to be used interchangeably. Kristeva speaks to this "confusion in terminology" and claims, "The terms melancholia and depression refer to a composite that might be called melancholy/depressive, whose borders are in fact blurred."[7] However, conceptual confusion does not only exist between 'depression' and 'melancholy,' for 'melancholia' also has a complicated conceptual history. In *The Anatomy of Melancholy* (1621), Robert Burton emphasizes the multifariousness of melancholy appearances: "…as the Philosophers make eight degrees of heat and cold: we may make 88 of *Melancholy*, as the parties affected are diversely seized with it, or have beene plunged more or lesse into this infernall gulfe."[8] Foucault explains that at "the end of the eighteenth century, all forms of madness without delirium, but characterized by inertia, despair, by a sort of dull stupor,

[6] Radden, Is this Dame Melancholy? Equating Today's Depression and Past Melancholia?, 2003, 37
[7] Kristeva, 1989, 10
[8] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 132

would be readily classified as melancholia."[9] Despite these difficulties, throughout the dissertation I often use melancholy and depression to refer to a composite pathological condition.

That "depression" is used in both an everyday and clinical way further complicates an already tentative process of diagnosis, treatment, and conceptualization. The common usage of "depression" to represent a mood or emotion falls within the range of *normal* affective states rather than pathological. People frequently use the expressions "That's depressing" or "I feel depressed" to indicate feelings of sadness or remorse. Often depression is equated with the blues or being down in the dumps. The everyday use of "depression" is *everyday* precisely because it is such a familiar emotional state. Similar to the confusion of whether "depression" refers to a normal affective state or an affective disorder, Stanley Jackson points to the conceptual confusion associated with melancholy:

> During the 17th and 18th centuries *melancholia* seems gradually to have become restricted once again to the disease, while *melancholy* remained both a synonym for melancholia and a popular term used with a breadth and diffuseness not unlike our use of the term *depression* today."[10]

The difference between depression as a mood and depression as a disorder partly rests on the intensity and duration of a depressed state. The intensity of a major depressive disorder can be understood in relation to the degree of disruption to a person's ability to function in day-to-day life. Disruption is characterized by features such as debilitating physical symptoms, psychological distress, and extreme social unease. While more

[9] Foucault, 1988, 124
[10] Jackson, 1986, 5

transient depressive moods do touch on the alienation, loss, and grief of severe depression, the fact of their relatively brief appearance in contrast to a depressive episode precludes them from equaling the strength and devastation experienced by the severely depressed.

Advocates of biomedical approaches to major depression typically contend that the distinction between depression as a mood and depression as a pathological disorder is a qualitative one. According to this view, there is a discontinuity between a *normal* depressed mood and clinical depression. On the other hand, the psychologist James C. Coyne points out that advocates of "psychoanalytic, cognitive and behavioral, and interpersonal and social perspectives on depression have generally assumed a continuum between a normal depressed mood and clinical depression."[11] In other words, the difference between the mood and the disorder from these perspectives is a quantitative difference. While I do not consider major depression to be reducible to an exclusively physiological cause, I do agree with the biomedical assessment of major depression as being qualitatively different from a depressed mood. My reason for appealing to the difference as being qualitative is not exclusively based on a biomedical framework. Taking into account the social and intrapersonal dimensions of depression, it is my assessment that the disruption of a form of life is the basis of the qualitative difference between a major depressive disorder and depressive mood states. The difference in a severe depressive episode and a depressed mood does not simply dwell in having more of the attendant emotions for a longer period of time; rather, the difference is a matter of the sustained disruption of a person's ability and desire to live.

[11] Coyne, 1985, 4

Although I argue in favor of a qualitative distinction, the ability to distinguish between 'normalcy' and 'psychopathology' is relatively limited and subjective. There are many resemblances between the everyday occurrences of a depressed mood and major depression such as feelings of sadness, inertia, etc. Commonalities also exist between depression and other *normal* affective conditions, in particular, mourning and grief. In addition, many of the emotions, thoughts, and behaviors that accompany a major depressive disorder and a depressive mood state do in fact exist on a continuum. Many, if not all, people who never experience major depression can nevertheless experience various aspects of severe depression without having the wholesale decontextualization that accompanies a major depressive disorder. Likewise, major depression resembles other illnesses that impair basic functioning and well-being. Depression and other mental disorders share many common features such as the alteration of affectation and cognitive disruption. However, even if one could give a lengthy list of the features of major depression, some of which are common to other phenomena and some of which are more-or-less unique to depression, this list would still not provide the basis for an adequate and comprehensive *definition* of major depression.[12]

In a way, by simply providing the defining features that delineate depression as a disorder opens up as many problems as it closes off. To narrow down the type of illness that depression is to the category 'mental illness' also poses conceptual problems. Often the classification of disorders such as depression, bipolar disorder, and schizophrenia under this heading of "mental illness" obscures the differences among them. Yet, is not

[12] From this point on in the dissertation I will use "major depression," "severe depression," and "depression" synonymously, unless otherwise specified.

the difference between the schizophrenic person and the depressed person as qualitatively different from the difference between the depressed person and a "normal" person in a *depressed mood*? The presumption of commonality among different types of mental illnesses is largely based on how the illness is treated medically and how people with mental illnesses are treated culturally.

In a related manner, while there are emotions associated with depressive mood that often accompany a major depressive episode (e.g. grief, sorrow, sadness, hopelessness, despair, guilt, etc.), they are neither necessary nor sufficient conditions for defining a depressive mood or a depressive disorder. No single emotion is unique to depression and no single emotion is a necessary condition for a diagnosis of depression. These emotions are features that have a family resemblance to one another and do not necessarily appear in conjunction with each other or in the same category of mental illness. For instance, grief is characteristic of other mental states and can be considered to be a mental state itself. In addition, grief might commonly accompany depression without appearing in every case of depression. Even emotions commonly perceived to be fundamental to depression do not necessarily appear in each case of depression. For example, it might come as a surprise to most people that around ten to fifteen percent of individuals diagnosed as having major depressive disorder "deny feelings of sadness (Whybrow, Akiskal, & McKinney, 1984)."[13]

Another distinguishing characteristic between depression as a mood and a disorder is that *normal* depressive emotions are often accompanied by an identifiable reason or cause, whereas pathological depression can arise when no apparent cause can

[13] Coyne, 1985, 5

be detected. For example, depressive symptoms experienced due to the death of a loved one might not signal a depressive disorder, whereas depressive symptoms that occur as if "out of nowhere" usually signal a depressive disorder. A factor in designating depression as pathological is the inability to identify the causative event in a particular instance of depression. Freud contrasts the inexplicable nature of melancholy with mourning: "It is also most remarkable that it never occurs to us to consider mourning as a pathological condition." He explains, "The only reason, in fact, why this behavior does not strike us as pathological is that we are so easily able to explain it."[14] Though mourning and severe depression are distinct conditions, prolonged mourning can for some people morph into major depression. In addition, just because a person has an identifiable, exogenous trigger does not therefore preclude the experience from being a severe depressive disorder.

The Diagnostic Statistic Manual for Mental Disorders does set out to delineate the criteria for what counts as a major depressive disorder. The most recent publication, DSM-IV, lists the following conditions:[15]

> Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
>
> 1. Depressed mood,
> 2. markedly diminished interest or pleasure,
> 3. significant weight loss when not dieting or weight gain,
> 4. insomnia or hypersomnia,
> 5. psychomotor agitation or retardation,
> 6. fatigue or loss of energy,
> 7. feelings of worthlessness or excessive or inappropriate guilt,

[14] Freud, Mourning and Melancholia, 2005, 203-4
[15] American Psychiatric Association, 2000. A a final version of the DSM-V is expected to be released in 2013.

8. diminished ability to think or concentrate,
9. recurrent thoughts of death/ suicidal ideation

The DSM-IV also indicates that most of the above symptoms need to last most of the day and/or nearly every day, and points out which symptoms need to be observable by others (e.g. psychomotor retardation) in addition to a subjective account (e.g. depressed mood). Also, depression can be diagnosed only if the aforementioned symptoms cannot be explained by another general medical condition or drug and alcohol abuse. Here it is important to note that in the method for determining what counts as depression, 'depression' is not explained and defined, but rather diagnosed and described. Also, as is the case with most mental illnesses, the DSM-IV classifies depression based on symptoms, not causes. The DSM-IV also lists several features that can accompany a major depressive episode: with or without mood-congruent or mood-incongruent psychotic features; with catatonic features, postpartum onset, melancholic features, atypical features, and so forth.

Despite the progress made by the psychiatric community in providing a diagnostic categorization of depression, Coyne notes that we are

> far from an adequate diagnostic system for depression. If one is to be achieved, it will have to come to terms with the enormous heterogeneity in the signs and symptoms, level of severity, causal factors, and clinical course that has been subsumed under the term 'depression.'[16]

Furthermore, the assessment of depression as an illness is not a normative-free, purely scientific form of judgment. Those with the power to provide definition to depression are not immune to political and economic pressures. For instance, how depression is defined influences whether insurance policies should provide mental health coverage. The

[16] Coyne, 1985, 14

definition of depression also affects pharmaceutical sales and funding for scientific research. There is a deep ethical and political dimension to the diagnosis and treatment (and not just the medical use of 'diagnosis' and 'treatment') of depression.[17]

In this dissertation I use first-person accounts of depression written by individuals who have experienced one or more major depressive episodes, as opposed to dysthymic disorder or chronic low-grade depression. Typically, but not always, severe depression is considered to be endogenous rather than reactive. While major depression can apply to both reactive and endogenous forms of depression, by far the majority of the examples that I use are from people who experienced a sudden onset of endogenous depression. Also, many people with an endogenous major depressive disorder experience a recurrence of depressive episodes.

Depression, estrangement, and loss

In this dissertation, I focus on the experiences of dislocation and estrangement that often accompany depression, but which are not listed in the DSM-IV among the common symptoms. Dislocation and estrangement can and do occur with other types of experiences and conditions, some of which are sought after and are not intrinsically damaging to one's health such as aesthetic and mystical experiences, as well as certain drug-induced states. It is not the case that the meaning of the concept 'estrangement' is essentially different in depression from how it might be in an aesthetic experience, but its meaning does take on a different force and does function differently in major depression

[17] I address these concerns in more detail in chapter 4.

from how it functions in an aesthetic experience. The difference resides in how estrangement is experienced, felt, and how one reacts to it. For example, one might find that a feeling of being estranged from the meaning of familiar objects or words can accompany a viewing of David Lynch's films. However, one experiences this estrangement differently from the way a depressed person feels when she wakes up and the objects in her room look unfamiliar. In depression, estrangement is typically accompanied by persistent anxiety, fear, isolation, and disillusionment, which belong to an overall pattern of withdrawal, insomnia or hypersomnia, and/or suicidal ideation. In contrast, while a film can bring about an intense feeling of estrangement, this experience is more-or-less short lived, possibly intellectually stimulating, and accompanied by less deleterious behavior. Another aspect of the difference between an aesthetic-based estrangement and depressive-based estrangement is a matter of whether the sense of estrangement is perceived to be brought about by an external event. A film, for instance, is experienced as the source of the feeling of dislocation, whereas in endogenous depression one can simply find oneself unexpectedly feeling estranged from her surroundings.

While trauma or loss can ignite depression, no identifiable trauma or loss is necessary to trigger or explain depression's emergence, duration, or intensity. Nevertheless, the depressed person does suffer a form of trauma *in* loss – a loss of meaning, a loss of language, and a loss of self. While 'loss' usually implies possession, a having once had yet no longer having, many of the things taken to be lost in depression lack an identifiable object and do not easily fit the spatial-possessive way of viewing loss. The loss that accompanies depression need not be a literal loss. After all, the experience

of loss can arise when and where nothing ever was. A depressed person might speak of losing a certain ability or disposition that was never as intact as it appears to have been in its apparent absence. Also, the depressive's sense of self-loss presumes a whole that was not necessarily a whole, and a loss that is not a complete loss. When a depressed individual says, "I feel as though I've lost myself," or "I am no longer the same person," the overwhelming feeling of loss tends to cast an image of a simple, coherent, and unified self that has only now been disrupted by depression. It is from the perspective of loss that one remembers and projects connection and cohesion even if one did not do so prior to depression. Since the loss that one feels is totalizing, it appears as though a *whole* is missing.

Loss can be understood as estrangement and *feeling lost*, which speaks to a loss of familiarity and relationality. The loss of a sense of self in depression is primarily experienced as an estrangement from language, other people, meaning, and one's own past and futurity. The depressed individual can also find herself *at a loss* in as much as the body can no longer adequately respond to the demands of everyday living. The journalist John Falk captures the amorphous quality of loss in his account of his first experience of depression. In his memoir, he recalls being a twelve year old boy trying to explain to his mom why he could not leave his room and go to school: "I sometimes tried to tell her what was happening, but the best I could do was keep repeating what I felt, that something was just *gone*."[18] Loss for the depressive points to a general lacking or waning of something that was *once* more or less working, more or less present, and more or less meaningful. The loss that comes out of depression reflects something that is *now* more or

[18] Falk, 2005, 50-51

less absent, more or less dysfunctional, more or less nonsensical, and felt to be "*just gone*."

With regards to language specifically, the depressed person loses what language once provided – overlapping language games that, for the most part and most of the time, generated and sustained meaningful communication. Language is a familiar and familiarizing mode of human existence. One counts on it to always be around, always be handy, and always be useful. It is always *there* and rarely *present*. In other words, most people, most of the time, use it without attending to it. Depression can make what was unreflectively there all along notable by dislocating it. For instance, a depressed person, who otherwise had no substantial problem conversing with other people prior to depression, can feel that conversations are increasingly laborious and that speaking demands excessive emotional energy. Not only does depression affect speech, but all forms of verbal comprehension often become difficult and dense. Depressives report the struggle to read, write, listen, and think coherently. In depression words no longer present themselves, but rather hide, disguising themselves as other words or morphing into ticks and tears. Words tease the depressed, at one moment comprehensible, at the next, nonsensical or forgotten. Words can lose their meaning and meaning can lose its expression. The sign, along with meaning, drifts and slips from the depressed. In this cloudy way, language and meaning are lost in depression, and when one is estranged from that which provides a meaningful framework for living, one feels as though one is cut off from even being a self.

The loss of language in depression is bound to a loss of one's identity and a loss of the affective constitution of words. When someone feels estranged from language she is left homeless. At home one typically functions easily and without having to consciously dwell on the familiarity of her surroundings. She is *at* home *in* her home. Similarly, the sound or sight of one's own language is familiar. It is the space where things are known, and if not known can be easily assimilated. Heidegger equates language to "the house of being,"[19] and as a house, language grounds, encloses, and protects its inhabitants. Language provides epistemic protection and order; it integrates and makes sense of experiences. However, while a house protects against both nature and other people, one can face great violence and insecurity in one's home. We are still susceptible to trauma in the house, and we are most vulnerable when the house itself is disrupted.

Justification: Fieldwork in philosophy

Even if we had unproblematic criteria in place for determining what counts as depression, the question still remains as to whether any general philosophical patterns can be distilled from such a deeply subjective experience. While despair, anxiety, and the phenomenon of suicide have been accepted as being of philosophical interest and being *philosophical*, in these cases angst and despair are commonly given the status of fundamental, existential modes of being, and suicide is presented as raising fundamental

[19] Heidegger, The Nature of Language, 1971, 63

questions about the value of and moral commitment to life. In contrast, major depression falls under the category of mental illness and is therefore not deemed to be essential to what it is to be human. Given the fact that mental disorders are defined in terms of their deviance from normal mental structures, the attempt to look at mental disorders philosophically poses methodological problems for what many academicians consider to be the universal aims of philosophy.

The subjective nature of mental illness can easily evade consistent theorizing and is wrought with exceptional cases. In "Mourning and Melancholia," Freud relinquishes any claim to universalizable theories emerging from his essay due to the small sample he analyzes and also because of the variability of the forms and symptoms of melancholia. He explains:

> Melancholia, the definition of which fluctuates even in descriptive psychiatry, appears in various different clinical forms: these do not seem amenable to being grouped together into a single entity…We shall therefore relinquish all claim to the universal validity of our results.[20]

Likewise, while I use the terms 'depression' and 'the depressive' in a way that suggests that it is a generalizable condition, albeit not a universalizable condition, I concur with Jeffrey Smith who writes in his memoir that depression "is minutely particular to each, perfectly adapted to its time, to its place, to its host."[21] Despite the heterogeneity of symptoms and causes within a particular depressed individual, as well as among depressives in general, the experience of depression does appear to have a similar pattern of disruption for most depressives.

[20] Freud, Mourning and Melancholia, 2005, 203
[21] Smith, 1999, 116

In a significant sense, the main philosophical problem of assuming generality in the case of depression is not an ontological problem, but rather an ethical concern. Rollo May speaks of the practical difficulty of understanding and treating individuals according the same conceptual scheme:

> May not just this particular person require another system, another quite different frame of reference? And does not this patient, or any person for that matter, evade our investigations, slip through our scientific fingers like seafoam, precisely to the extent that we rely on the logical consistency of our own system?[22]

May's self-questioning about the relation of theory to the actual patient is applicable to this project as well. Philosophy struggles to account for a subject matter that is so deeply dependent on the psychological life of an individual. Despite the preemptory denials of universalizability by the likes of Freud and Rollo May, they, as well as countless others including me, proceed to speak of the malady as if it is a comprehensible entity with common identifiable traits.

Even if one does not hold the view that philosophy should be restricted to universal human conditions and phenomena, one still might question the appropriateness of 'depression' as the object of philosophical reflection, and claim that it falls under the purviews of other disciplines. However, it is my contention that whether depression is considered to be a problem for psychology, philosophy, or the medical sciences depends on, in Wittgenstein's words, "what we do with it, say about it."[23] Depression is an appropriate field for philosophical investigation, not because it is inherently philosophical, but because of the way that I am treating it. The context and questions of

[22] May, Ellenberger, & Angel, Existence: A New Dimension in Psychiatry and Psychology, 1958, 3
[23] Wittgenstein, Remarks on the Foundation of Mathematics, Revised Edition, 1996, §161

the dissertation make depression into a "*fieldwork in philosophy*."[24] In this dissertation, the *work* is the philosophical analysis of the disruption of a form of life, loss of agency, and estrangement from language, and the *field* is major depression.

In this dissertation, unlike most dissertations in philosophy, I neither pursue a single, narrow philosophical problem, nor do I explore a single philosophical text or philosopher. I am interested in the problem of how a form of life can be disrupted by major depression. In particular, I am concerned with the way in which a person can become estranged from language and meaning as a result of mental illness. This dissertation proceeds from the vantage point of depressed individuals, rather than starting from a theoretical framework. It is my position that for philosophy to be equipped to address the problems associated with the depressive's estrangement from language and meaning, it needs to be integrative and interdisciplinary.

A relatively new field has emerged within philosophy dedicated to the study of the philosophical foundations and concepts within psychiatry and psychopathology. A philosophy of psychopathology is at its early stages and has been significantly advanced by the research and theoretical insight of Jennifer Radden and George Graham, to name a few. In addition, Matthew Ratcliffe and Jennifer Hansen have already paved the way for a phenomenology of depression. The venture of professional philosophy into questions of mental disorders can prove to be philosophically productive, both critically and constructively. Unlike philosophy of psychology, which focuses on traditional philosophical questions regarding cognition, language, perception, and the relationship of

[24] Austin writes, "…we should be certain of what we are after: a good site for *field work* in philosophy" (Austin, 1970, 183).

the mind and brain in normal mental functioning, philosophy of psychiatry and psychopathology almost exclusively attends to the questions in relation to mental disorders. One of the main recurring concerns within philosophy of psychiatry deals with the classification of what counts as mental health and mental illness. Contemporary philosophers in this field, such as George Graham, claim that a coherent and comprehensive philosophy of mind requires an investigation into mental illness, and likewise, that theories of mental illness require a basic understanding of philosophy of mind. I contend that philosophical theories of meaning, language, and agency must be able to account for the philosophical problems that mental disorders expose, such as problems related to the depressive's estrangement from language and a form of life. Jennifer Radden affirms the relevance of mental illness to philosophical work and the critical vantage that such a study can provide:

> At least in Western philosophical traditions, our conceptions of agency, personhood, self-identity, memory, desire, affectivity, character, and rationality are rooted in, and presuppose, certain psychological and social norms concerning subjectivity and behavior: these are the norms of mental health. Psychopathology exposes these norms, their incumbent limitations – their very normativity – and the gaps in our understanding that result from those limitations.[25]

The investigation of the disruption of agency, a form of life, and language-use in depression does brush up against many traditional philosophical problems: problems dealing with perception, the construction of meaning and identity, and the mind-brain dilemma. A philosophical analysis of depression provides a different context from the

[25] Radden, The Philosophy of Psychiatry, a Companion, 2004, 7

assumed context of mental health in which these problems arise and a different way of framing the problems.

Moving beyond the rational subject to the embodied, emotional, and conflicted agent helps to expand the parameters of what academic philosophy has traditionally counted as intelligible beings. Philosophy can and should attend to the voices and epistemic standpoints of individuals with mental illnesses. The expansion of the fieldwork of philosophy into psychopathology provides philosophy with a practical context for understanding the limitations of concepts such as agency, meaning, and language. Rather than viewing the mind-brain relation in terms of a computational model or understanding it in relation to artificial intelligence, a philosophy of psychopathology takes the questions of philosophy of mind and language into a field of messy, complex, contradictory, and embodied lives.

Methodology and Literature

In this dissertation I bring in a variety of disciplines and speakers to the conversation. I consult the work of neuroscience, psychology, psychiatry, psychoanalysis, sociology, and first-person narratives to provide a comprehensive picture of depression; nevertheless, my approach and goals are unmistakably philosophical. Each disciplinary conceptualization of depression has epistemic limitations. To view depression from the standpoint of objective socio-economic relations fails to account for the subjective and

intersubjective quality of the depressive experience. A sociological analysis of depression cannot account for the variability, intensity, and duration of depressive disorder, and furthermore cannot adequately differentiate between the presence of depressive symptoms and the presence of a major depressive disorder. Psychotherapeutic approaches have recovery as their aim, which can be too mechanistic in their attempts to influence behavioral change to provide an adequate account of the various social factors at play. Neuroscience assesses the symptoms of depression based on neurological functions and malfunctions and cannot account for the intersubjective and complex personal level experiences of depressives. Yet if one attempts to dissolve these limitations through an eclectic methodology, a synthesis of disparate disciplines often leads to conceptual confusion, a leveling of distinctions, and a superficial coherence.

The integration of different disciplines, as well as non-academic writings, in this dissertation does pose several methodological problems. The philosopher José Bermúdez points out that in the social sciences the primary problem facing an interdisciplinary approach is that "what appears to be a single concept is not really a single concept after all."[26] Concepts such as 'self,' 'loss,' and 'depression' often represent divergent ideas and serve competing aims. Philosophy can help navigate and point out the conceptual disparities and similarities among the different methods. As Bourdieu explains, philosophy can be a "means of deciding between competing accounts of the same practices."[27] While philosophy can help mediate between competing accounts and clarify overlooked conceptual differences, a philosophical approach divorced from actual experiences of depressives runs the risk of interpellating depressive identities. For this

[26] Bermúdez, Philosophy of Psychology: A Contemporary Introduction, 2005, 13
[27] Bourdieu, Structures and the habitus, 1977, 30

reason, I draw from the theoretical and practical resources of various disciplines while also attending to the actual voices of depressed individuals.

I use a hybrid philosophical approach that combines a phenomenological account of depression based on firsthand accounts of depression along with a more-or-less Wittgensteinian investigation into to the language and agency, and lack thereof, of depressives. Ultimately this dissertation proceeds from a series of objectives, rather than a coherent, singular methodology. Perhaps the best description of my hybrid-methodological orientation, or lack of a singular methodology, comes from Wittgenstein's remark, "There is not *a* philosophical method, though there are indeed methods, like different therapies."[28] In order to treat the philosophical problems that come to light in a phenomenological account of depression, this dissertation addresses the need for a view of agency that can account for and incorporate the extreme alterations and disruptions of meaning, identity, and language that take place in depression.

Wittgenstein

Wittgenstein's methodology is more performative than systematic. He never articulates a guiding theory; rather, he implements a nuanced orientation to the treatment and diagnosis of philosophical problems. While Wittgenstein primarily gives examples of how to treat philosophical problems rather than asserting "hard and fast claims,"[29] he

[28]Wittgenstein, 2001, 133

[29] Referring to the tendency of readers of Wittgenstein to ascribe certain theories to him, Oswald Hanflig claims that readers "look for hard and fast claims where what one is given is only tentative investigation…for answers where only questions are given" (Hanfling, 2002, 12).

does in fact make certain *claims* – at times only performatively – about the scope and methods of philosophy. I read Wittgenstein as making a *claim* about the essential interconnection of meaning and practice within particular social contexts composed of complex social relations and heterogeneous practices. Wittgenstein attempts to wrestle meaning and concepts from their intellectualist contexts and understand them in their natural surroundings – *ordinary language* and practice. In this dissertation I use Wittgenstein to lay the groundwork for interpreting language and meaning in the context of social practice and a form of life.

While philosophers have tried to restrict the "homes" of language to logic, certain speakers, or rarefied contexts, in line with Naomi Scheman's following remark on Wittgenstein, I agree that the "homes" to which we should "bring our words are precisely the messy places from which the philosophers thought they needed to be extricated."[30] To view depression as a possible *home* for a philosophical investigation into language, however, is to investigate where language is in fact *not at home*. I contend that Wittgenstein's concept of 'form of life' and how it is involved in his understanding of language-use serves as an entry point for addressing the question of how one can come to be estranged from meaning and language. A loss of language in depression belongs to the disruption of a form of life. One can understand how discursive disruption functions in the depressive experience by looking at the various overlapping domains of disruption to a form of life: meaning, identity, social relations, temporality, perception, etc. From the perspective of doing Wittgensteinian research, I am defending a position regarding the use and understanding of 'form of life' and how a form of life is intertwined with one's

[30] Scheman N., 1996, 401

sense of time, space, oneself, and others. In this dissertation I show that the *pragmatic context* of meaning and language also crosses the planes of various phenomenological domains.

Phenomenology

In this dissertation I use Wittgenstein and Merleau-Ponty to represent two poles of contextualization, a form of life and the body respectively. The key feature of the body that I attend to is the affective dimension. In particular, I provide a phenomenological account of the roles of affective disconnection and disordering in the depressive's perception, temporalization, spatialization, thought, social relations, and linguistic activity. While I set out to give a phenomenological account of depression, I am more interested in the depressive's relationality rather than intentionality. An individual is not only *directed towards*[31] the things and beings of her world, for the things and beings of the world can be said to push back against, cooperate with, and construct the individual's experiences. The concept 'form of life' speaks to this mutual relationality and multi-directionality between the individual and her natural and social environment that is often missing in a phenomenological account. In contrast to Husserl, I do not try to account for experience based on a *general* first-person perspective. Also, I do not approach experience from the perspective of *being* as do Sartre and Heidegger. In *Phenomenology of Perception*, Merleau-Ponty uses medical case studies to evaluate the interrelation of particular individuals with their surroundings. He looks to exceptional cases, such as a

[31] In Chapter 3 I will discuss how this ability to be *directed towards* is damaged in depression.

man with a phantom limb and a neurotic woman with language-loss, to highlight the complexity and multiplicity of embodied life. In contrast to his predecessors, Merleau-Ponty argues that philosophers "have no right to level all experiences down to a single world, all modalities of existence down to a single consciousness."[32] In addition to Merleau-Ponty's use of empirical data and interest in the field of psychology, his attention to perception and the body make his philosophical work pertinent to the project of this dissertation.

Psychotherapy

My use of phenomenological concepts is also based on the practical application of phenomenology in the field of psychotherapy. The psychodynamic theoretical frameworks that I incorporate include psychoanalysis, existential psychotherapy, and phenomenological psychotherapy. The fields of philosophical therapeutic practice alluded to in this dissertation (existential psychotherapy, Gestalt psychotherapy, and phenomenological psychotherapy) are diverse in both their methodology and content and do not garner much approbation in academic psychology or philosophy. Nevertheless, there are two aspects common among therapeutic practices based on existential and/or phenomenological approaches, which are: a) their adherence to a broadly psychodynamic model of human psychology, and b) their insistence on the significance of a person's relationship to and involvement in her world. The main contribution of philosophical psychotherapy to this dissertation is the emphasis on a person's involvement with her

[32] Merleau-Ponty, 1992, 290

world, which centers on the principle that a person's subjectivity is partially constituted by and partially constitutes the things of her world and her relationship with others.

The use of philosophical psychotherapy in this dissertation poses some conceptual difficulties. First and foremost, one must confront the problem of interpreting psychotherapeutic writings in a purely theoretical manner, rather than in the context of therapeutic practice. Another problem with trying to integrate psychological concepts into a philosophical discussion is that many of the authors of the psychological texts (who are also practicing psychotherapists, psychoanalysts, or psychiatrists) are writing to communities unfamiliar with the history of many philosophical concepts. Given the lack of historical perspective about philosophically weighted problems, these writers often use philosophical concepts casually and fail to provide rigorous analysis to conceptual schemas that one finds prevalent in strictly philosophical texts. For example, I will be juxtaposing the writings of J.H. van den Berg, a phenomenological psychotherapist, with that of Wittgenstein. While van den Berg's approach to therapy can be seen as sympathetic to my interpretation of Wittgenstein, the reader must hold in check the usual problems we associate with some of the terms that van den Berg uses such as 'objects,' 'mental states,' and 'world.' Van den Berg adopts a phenomenological schema for the purposes of therapy, not for the purposes of philosophical clarity for its own sake. Take for example van den Berg's following assertion:

> …mental states never stand by themselves and are never abstractions, but they ceaselessly reveal themselves in the reality of the surrounding world, in the reality of the objects, in the reality of personal relationships and in the reality of body and of

time.[33]

For the most part, van den Berg appeals to a common sense understanding of concepts like 'reality,' 'time,' 'world,' and 'objects,' and he neither defines nor problematizes these concepts. For example, his claim that mental states "never stand by themselves" is not an ontological claim about sense data or an epistemological assertion about tokenism. The significance of his view of mental states is that it shows that mental states are infused in every aspect of one's way of living and it reinforces a holistic view of a person. Like other philosophical psychotherapists, van den Berg describes the psychological condition of the patient by means of her relation with various phenomenological domains such as time, space, and other people. This attention to the interrelation of multiple phenomenological domains in therapy corresponds to the emphasis of contextualism in philosophical analysis. A psychological evaluation of depressed individuals within the contexts of their involvement in the world provides a practical field of application for addressing a 'form of life' as it is lived out and disrupted in depressed individuals' lives.

Philosophy from the borders

A philosophical investigation into depression can perhaps find its home on the margins of philosophy where philosophy is motivated by the ethical imperative to include the perspectives and voices of people who are often not taken into consideration in traditional philosophy. In particular, critical race theory, gender studies, and queer theory help to draw attention to the use of false binaries underlying many philosophical

[33] Van den Berg, 1972, 109

concepts. They also expose political bias and show us where social categories of identity are hiding. However, the status of a depressive identification differs from other social categories of identity. The nature of depression as a marker of identity is qualitatively different from race, gender, and sexuality, which is not to say that these *markers of identity* are experienced in the same way or have the same status. Depression is intrinsically peripheral because it is a deleterious condition with harsh and devastating symptoms. Although depression can contribute to the personal identity of an individual, it is first and foremost a malady. Consider the difference that people of color have faced in the history of the United States in contrast to the mentally ill. While invidious discrimination and racism are the sources of pain for people of color, 'race' itself is not the cause of suffering. On the other hand, depression is the source of suffering for depressives. The social acceptability, and lack thereof, of mental illness is not the primary site of suffering for people with mental disorders. Depression is characterized by mental pain and suffering, even if the depressive is in a supportive and accepting social environment.

Depression is a socially marginalizing experience regardless of one's material and symbolic capital, and a reform of social structures would not eliminate depression. Depressives are marginalized not only by a hegemonic symbolic structure, but by the depressive's tendency towards withdrawal and disengagement. The depressive's disrupted agency is in part a matter of social withdrawal without being exclusively the product of social structures. While I do touch on the social structuring of depression, I do not primarily focus on the social and economic conditions of the depressive. It is not the

aim of this dissertation to elucidate the social subjugation of depressives or the forms of social marginalization that can lead to depression.

First-person accounts

This dissertation makes a performative avowal about philosophical clarity and its relation to *actual* everyday language use by looking at the statements, writings, and interviews of depressive individuals, rather than appealing to a general, abstract idea of 'ordinary language.' I ground this investigation on how depression is talked about from the perspective of the depressed individual. I do not *listen* to depressives, as it were, by conducting surveys or interviews, in part because philosophical analysis typically does not deal directly with data collection. Also, not having been properly trained to conduct surveys and interviews, as well as not being trained for a clinical setting, any results would likely be insufficient. Given these limitations to a philosophical investigation into depression, I have found that the best method for obtaining a comprehensive picture of the depressive experience is through written first-person accounts of depression. In addition to depression memoirs, I also use transcripts of interviews, published letters, and a few case studies. While I have relied on a relatively small sampling of firsthand accounts, which are confined for the most part to the United States in the 20th and 21st centuries, this sampling does include people of different genders, sexual orientations, racial and ethnic backgrounds, and ages. This dissertation only looks at individuals with developed and relatively *normal* linguistic abilities and not at individuals with pre-existing linguistic disorders or young children and infants. All of the writers that I

reference claim to have suffered from major depression for a long period of time, usually for more than a year, and most have had recurring episodes. The majority of the writers also report having experienced suicidal ideation and/or attempting suicide.

Since William Styron's publication of his memoir on depression, many individuals have detailed their experience of depression through this highly accessible and revealing format of the depression memoir. Some critics argue that William Styron was ill-equipped to write from the perspective of Nat Turner in his novel *The Confessions of Nat Turner* and question his ability and reasons for writing from the perspective of a slave while never having experienced the affects of racism towards himself. In contrast, Styron's account of his personal experience with depression created a sense of both validation and identification with depressives. Up to that point, other than literary works, accounts of depression usually originated from professional observers.

Interestingly, although words and speech are often on the front line of depression, many writers suffer from depression and many depressives write about their experience with depression. Could it be the case that language-loss is most recognizable in individuals with a highly developed discursive agency and with a high degree of symbolic mastery? Many of the authors of depression memoirs and first-person accounts of depression do have highly cultivated linguistic capacities as well as a highly developed *personal* relationship with language. Several of the authors of the memoirs had occupations prior to depression as writers. It makes sense that individuals who spend a lot of time thinking about words would have a profound visceral experience of the disruption of language in depression. The estrangement from language could simply be an

expression of a particular depressed individual's alienation from her particular world – a world of words, journals, literature, philosophy, etc. While it is likely the case that the highly literate depressive feels and notices the effects of depression on language more than the depressive who does not have a highly developed linguistic capacity, linguistic retardation is nevertheless common among depressives with varying levels of education and various occupations. Accounts of linguistic retardation and confusion are recurrent throughout the narratives. I pay particular attention to descriptions of the disruption of language and meaning. I evaluate the repetition of particular words, phrases, and grammatical structures, while also attending to what is not being said.

By speaking of the memoirs in terms of a *first-person account of depression*, I do not want to give the reader the wrong idea that a *first-person account* means a contemporaneous record of the depressed person's experience of depression during a depressive episode. The act of writing almost never takes place during a depressive episode. One of the writers, John Bentley Mays, acknowledges the incongruity inherent in a depression memoir: "To be chronically depressed and to tell of it is, in one sense, a contradiction."[34] Most of the authors admit to not being able to undertake the task of writing about depression during the suffocating days of depression, and for many of them, the simple tasks of reading and writing anything while depressed proved formidable. In addition, many of the authors write their accounts after dealing with depression over a long period of time, often years after the initial experience. While neither I, nor the authors for that matter, are in a place to judge mental stability, it is significant to note that the authors considered themselves to have arrived at what they felt

[34] Mays, 2003, xvii

as being a more stable condition when they wrote their account of depression. For example, Mays describes writing in a "clearing":

> This book is a life with the black dogs of depression. I have written it in a clearing bounded by thickets roamed by the killing dogs, sometimes, wondering, in the writing, whether I would complete it before they returned on silent paws to snatch the text away.[35]

In this clearing and reprieve from depression's morbid grasp, the authors of the memoirs give us a picture of, and even an *acting out*, of the depressive experience.

Even though the memoirs were not written when the authors' were in the deepest throes of depression, they need not be written during a depressive episode in order to provide a meaningful testament to the depressive experience. These self-narratives do, however, pose a few philosophical problems. The first problem comes from the false appearance of narrative unity. Memoirs often rely on rhetorical devices like a unifying theme or image, which only come to be realized in the writing itself. This sense of unity gives the wrong impression of closure, although the author, all-the-while, is still living *that* life. This form of unity is reinforced by the impression that many of the authors give of their stories taking place in a time past, when they *were* depressed. However, as indicated by Kristeva, the trace of depression never really leaves and can be noticed in the speech of the depressive between episodes.[36] The way that depression alters one's form of life cannot be erased, and depression continues to speak through the depressive authors' writing even if they are not in a deep depressive episode as they write.

[35] Mays, 2003, xi
[36] Kristeva, 1989, 55

The second concern arises from the author's tendency to reframe and forget the past. In addition to the function of reframing that exists in the dynamic of reflection itself, because the written accounts occur from the standpoint of a self-described, relative mental stability, the experience of depression is subject to revisions. The writer not only remembers the experiences for herself, but also forms it in such a way as to be accepted by a reader. Radden addresses the methodological difficulties in providing a philosophical analysis of first-person accounts of mental illness: "…we must alert to the inevitable reconfigurations imposed on all self narratives in their retelling, but very often heightened, here, by efforts to explain or excuse states so extreme, unsought, unwelcome, and stigmatized."[37] While Radden expresses concern that the authors attempt to "excuse states," it is important to note that the authors presented in this dissertation give neither a glorified view of depression nor a glorified view of themselves. Their descriptions are raw and emerge from the pain of the depression and the pain of trying to make sense of it.

Narrative reframing, for Radden, poses the problem of "epistemic indeterminacy."[38] However, this self-redaction only poses a problem if we read the depression memoirs as purely descriptive self-observations and make the false assumption that the authors had a pure, direct, and therefore accurate picture of their own depressive experience. Even if we had a direct line into the mind of the depressed during a depressive episode we would not have epistemic clarity; similarly, neither can the depressed. Self-observation is not an unmediated 'knowing.' The act of describing depression, as one does in writing the first-person account, does not introduce the

[37] Radden, Moody Minds Distempered: Essays on Melancholy and Depression, 2009, 172
[38] Ibid, 178

problem of epistemological indeterminacy that was not already there from the beginning, that is, in the depressive episode. Although the main difference between a contemporaneous account and an after-the-fact reflection on depression dwells in the passage of time and forgetting, the problem of narrative reframing can take place at any moment, not just in the act of writing.

The objective of this dissertation does not depend on complete and accurate reporting on the part of the writers, as if the initial inner-thoughts themselves could be the standard. That being said, I proceed with trust rather than skepticism with regard to the authors' intent of giving an honest view of the experience of depression. The reflective description given in a firsthand account, which in the case of depression is made possible by recovering from the initial experience, provides an epistemological viewpoint as informative as the experience of the depressive episode itself.

While no individual's experience of depression can be said to be prototypical, throughout the dissertation I do use the expressions "*the* depressive," "*the* depressed," and "*the* depressive experience," etc. The perceptive of "the depressive," if not in reference to a particular person, is constructed from the common experiences shared by depressives. Where I do not explicitly preface statements about "the depressed" with the conditionals like "typically," "usually," or "more often than not," these qualifications are always implied. Epistemologically speaking, there is no prototypical standpoint of *the depressive*, so I admit to the inevitable oversimplification of the diverse and divergent perspectives of depression by my use of the term "the depressive." Where I have found evidence to contradict a claim I make about "the depressive," I do make that known. I am

well aware that there are exceptions to what I attribute to "the depressive experience," and one might even characterize the experience of depression as necessarily exceptional and irreducible to theorization. Even if I abandoned the use of a singular "depressive," the plural form does not resolve the problem or presumption of homogeneity and unity assumed in the label "depressives."

Even though individuals who suffer a debilitating depressive episode can come to appreciate their particular orientation to the world, this appreciation does not make depression an asset. While some cultures and individuals may praise those afflicted by mental anguish for their insight and creativity, these attributes do not make depression inherently valuable. Suicide, self-inflicted wounds, terror, panic, unyielding grief – these are just a few of the negative effects of major depression and other mental illnesses. Depression steals and destroys relationships, talents, dreams, and even language. It is my position that major depression is a malady to be treated and prevented. All of the first-person accounts that I have encountered testify to the fact that depression is a malevolent, deleterious condition with no intrinsic benefit. Major depression does serious and often irreparable harm to a person's ability to thrive and function. Mays describes depression as "the most obstinate experience this side of malignancy and death, a deadly presence in language and thought as inextricable as an inoperable tumor."[39] John Head, author of *Standing in the Shadows: Understanding and Overcoming Depression in Black Men*, writes: "Untreated clinical depression is modern-day slavery. It robs people of their freedom and limits their choices as effectively as the 'peculiar institution' ever did."[40] For

[39] Mays, 2003, 123
[40] Head, 2004, 160

this reason, it is my position that while we can celebrate the lives and work of people suffering from depression, as a culture we should strive to find depression's causes and cure as well as striving to ameliorate its symptoms.

CHAPTER II

A FORM OF LIFE AND ITS DISRUPTION

Introduction

Major depression changes a person's perception and judgment of the world. The prereflective agreement that undergirds the meanings made possible through a form of life no longer holds true for the depressive. This disruption of a form of life does not *cause* the dislocation of agency; it occurs along with it. In this chapter I look at depression as a general disruption of a form of life and a loss of familiarity. In the first part of the chapter I evaluate Wittgenstein's conceptualization of a 'form of life' as a "pragmatic contextualism"[41] and examine its relation to agency and affectivity. In the second part of the chapter I argue that, in the case of the depressive, the disruption of a form of life is first and foremost an expression of the decontextualization of the depressive individual and can be expressed in terms of a loss of familiarity. I contend that Wittgenstein uses a 'form of life' to qualify the way that language and judgments are situated in a broader context of shared practices and shared attitudes. The concept 'form of life' helps me to advance the idea of the situatedness of agency and language in a

[41] Medina, Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency, 2006, 14

social environment. By establishing the pragmatic contextuality of agency and language in a form of life, I can then show how major depression disrupts the sense of familiarity and the meanings previously made possible through a form of life. A 'form of life,' with an emphasis on *life*, helps elucidate the pervasiveness of depression as it severs the depressive's social relations and shared meanings. Ultimately, depression disrupts the lived meaning of a form of life.

'Form of life'

Wittgenstein's use of 'form of life'

Lebensform, traditionally translated as "form of life,"[42] only occurs a handful of times[43] in Wittgenstein's writings.[44] Wittgenstein even seems to express his

[42] One of the disagreements over how to interpret 'form of life' begins with how to translate it. Some scholars have blamed the translation of the German "*Lebensform*" into the English "form of life" as being the reason for the concept's ambiguity and therefore the source of incongruent interpretations. Sharrock and Anderson argue in favor of the translation "ways of life" to be used in place of "form of life" (Sharrock, 1985) and E.F. Thompkins asserts that there should be no philosophical confusion over 'forms of life' because Wittgenstein never actually used the term, that is, the *English* term "form of life" (Thompkins, 1990). Thompkins insists that philosophical problems only develop from a poor translation of Wittgenstein's "*Lebensform*" and asserts: "Wittgenstein says nothing about 'form of life' and that consequently the problem of what he means by it does not exist…What he means by '*Lebensform*' is a different problem but since what he means is quite clear from what he says, that is no problem" (Ibid, p. 197). Thompkins proposes to dissolve any philosophical problems with the concept 'form of life' by translating '*Lebensform*' into "pattern of living." He asserts that this translation avoids the overly biological connotation of life-form and thus averts the wrong-headed implication that a form of life has a particular referent. Also, he alleges that his translation of '*Lebensform*' into "pattern of living" makes Wittgenstein's remarks remarkably clear and, evidently, self-evident. One specific problem with the translation "pattern of living" is that Wittgenstein refers to the numerous "patterns in the *weave of life*," which suggests that patterns tend to occur within a form of life, rather than being equivalent to a form of life (PI, p. 174 and Z, §569)

The main difficulty with the attempt to clarify the concept '*Lebensform*' with a different English translation alone is that '*Lebensform*' is not a simplistic concept and its conceptual ambiguity does not

dissatisfaction with the concept 'form of life' in a parenthetical remark he makes on the inadequate expression and conceptualization of the role that certainty plays within a form of life. He remarks, "Now I would like to regard this certainty, not as something akin to hastiness or superficiality, but as a form of life. (That is very badly expressed and probably badly thought as well.)"[45] Even though Wittgenstein does not use "form of life" often, its repetition by Wittgenstein scholars – as well as in this dissertation – can give it a misleading sense of autonomy and discreteness that Wittgenstein attempts to avoid. In Wittgenstein's use of "form of life," *form* does not refer to an immutable shape and *life* does not imply a universal concept of human life. A "form of life" does not have a

---

solely arise in the problem of translation. Secondly, the problem with changing the traditional translation of *"Lebensform"* into "form of life" is that Wittgenstein does in fact use "form" ('*-form'*) and not "pattern" ('*-musters'*) in these passages. Nevertheless, the idea of relating 'life-form' to 'pattern of living' is helpful and Wittgenstein does actually use "patterns of life" ('*Lebensmusters*') in several other passages in a similar way to his use of 'form of life' (LWI, §206 ['*Lebensschablone'* – also "pattern of life"], 211, 365; LWII, 26 & 40; RPPII, §652). However, Wittgenstein's use of "patterns of life" ("*Lebensmusters*") in other passages does not confirm that it is a correct translation of '*Lebensform.*' In fact, by not using "*Lebensmusters*" (patterns of life) in these passages and using "*Lebensform*" instead, this choice shows that there is some significance to his use of "*-form,*" even if only literary, and that the traditional translation should stand. Likewise, while it might be helpful to conceive of forms of life as 'ways of life,' as argued by Sharrock and Anderson, which is also the translation used in *Last Writings on the Philosophy of Psychology, Volume II* (translated by C.G. Luckhardt and Maximilian A.E. Aue), Wittgenstein does not use this term "*Lebensweise*" ("way of living") in these particular passages, although "*Lebensweise*" is used in other places ("*Lebensweise*" occurs twice in LWII, pp. 43-4; "*Art de Lebens,*" occurs three times in *Culture and Value*, pp. 31, 69, and 73, and once in *Remarks on the Foundation of Mathematics*, VI, §34). While I contend that "*Lebensform*" should be translated as "form of life," the main philosophical significance dwells in how the concept is used. Also, I argue that the philosophical emphasis should be placed on Wittgenstein's use of "*Lebens*" (life) rather than on the terms that accompany it: "*-musters,*" "*-form,*" "*-weise,*" etc.

[43] "*Lebensform"* occurs five times in the *Philosophical Investigations* and once in each of the following: *On Certainty*, *Remarks on the Foundations of Mathematics*, *Philosophical Occasions*, and *Last Writings on the Philosophy of Psychology, Volume II*. "Form of life" can also be found once in *Lectures and Conversations on Aesthetics, Psychology and Religious Belief.*

[44] When I refer to Wittgenstein's "*writings*" I include all of his published works translated into English and exclude any *Conversations*, *Lectures*, and *Letters*, unless otherwise specified. The *writings* that I include and their abbreviations are as follows: *Notebooks 1914-1916* (NB), *Tractatus Logico-Philosophicus* (TLP) , *The Blue and Brown Books* (BBB), *Philosophical Remarks* (PR), *Philosophical Grammar* (PG), *Remarks on the Foundations of Mathematics, Revised Edition* (RFM), *Philosophical Investigations* (PI), *Zettel* (Z), *Remarks on the Philosophy of Psychology, Volumes I and II* (RPPI and RPPII), *Last Writings on the Philosophy of Psychology, Volumes I and II* (LWI and LWII), *On Certainty* (OC), *Remarks on Color* (RC), *Culture and Value, Revised Edition* (CVre), and *Philosophical Occasions* (PO).

[45] OC, §358

singular referent. "It" is neither a *thing* nor is it an identifiable and repeatable *form*; rather, a form of life is the living community. A form of life refers to numerous, overlapping, and sometimes incongruent practices shared by a community. "It" is lived out and lived through in shared practices. Despite the fact that a form of life is not an identifiable entity, I do use the term "form of life" as a substantive throughout this dissertation to refer to the shared practices and attitudes of a particular culture.[46] In one sense to use 'form of life' as a central concept of this dissertation, as well as my attempt to describe it, alters the way Wittgenstein uses it. Yet the very diffuseness of the concept captures the tacit interconnectedness that infuses a way of living, a way of acting, a way of communicating, relating, perceiving, feeling, and interacting. In this dissertation I am trying to encapsulate the pervasiveness of depression's disruption, not just to a person's life, but to a person's entire way of living. I invoke Wittgenstein's idea of a form of life in order to speak to the layers of relations that are implicated and disrupted in major depression.

I interpret Wittgenstein's use of "form of life" and other related terms (see below) to demonstrate that linguistic and social practices are embedded in the interrelated elements that constitute and are constituted by the individual's and a community's relation to its social, historical, and biological environment. It is significant that Wittgenstein does use other terms in similar ways to "form of life" such as "weave of

[46] I use form of life in three different ways and distinguish among them by three different notations. When *form of life* is written without quotation marks it denotes the actual living form of life. When *form of life* appears with double quotations marks I am referring to the term "form of life" as it appears in Wittgenstein's writing. Lastly, I place *form of life* in single quotation marks in order to indicate the concept 'form of life.'

life" (*Lebensteppich*),[47] "stream of life" (*Fluß des Lebens*),[48] "way of living" (*Lebensweise/Art des Lebens*),[49] and "facts of life" (*Tatsachen de Lebens*).[50] Also Wittgenstein often uses "our life," "life that is like ours," "life of these people," "human life," and "our whole life." Given the fact that the common element to all of these concepts is "*Lebens*" (life/living),[51] more philosophical emphasis should be placed on what Wittgenstein means by 'life' and 'living' rather than 'form' or 'way' or 'pattern.'[52] The focus on life and living draws attention to the fact that a form of life is not a single, monolithic entity; rather, it is temporally embedded, pragmatically constructed, and heterogeneous. A form of life is expressed in what we do, how we do it, and what we believe. It is also infused in the way we see and the way we feel. Wittgenstein shows that

---

[47] "So we are talking about patterns in the weave of life" (LWII, 42); "'Grief' describes a pattern which recurs in the weave of our life" (LWI, §406); and "For pretence is a (certain) pattern within the weave of life. It is repeated in an infinite number of variations" (Ibid, §862).

[48] "(Only in the stream of thought and life do words have meaning.)" (Z, § 173); and "The stream of life, or the stream of the world, flows on and our propositions are so to speak verified only at instants" (PR, §48).

[49] "Language, I should like to say, relates to a *way* of living" (RFM, VI, §34); "Should I say: Our concepts are determined by our interest, and therefore by our way of living?...The basic concepts are interwoven so closely with what is most fundamental in our way of living that they are therefore unassailable" (LWII, 43-4); and "Hence although it's belief, it is really a way of living, or a way of judging life" (CVre, 73). "Way of living" also appears in LWII, 95; CVre, 31and 69-70.

[50] In *Remarks on Philosophy of Psychology Volume I*, Wittgenstein uses "*Tatsachen de Lebens*" ("facts of life") in the same context where he uses "*Lebensform*" ("form of life") in the *Philosophical Investigations*: "What has to be accepted, the given—it might be said—are facts of living [*Tatsachen de Lebens*]" (RPPI, §630) and "What has to be accepted, the given, is – so one could say – *forms of life* [*Lebensform*]" (PI, p. 192).

[51] G.E.M Anscombe almost always translates "*Lebens*" as "life," except in the cases of "ways of living" and "facts of living" (PI, OC, and RFM). C.G. Luckhardt and M. Aue translated *"Lebensform"* as a "way of living" (LWII) and P. Winch also translated "*Lebensformen*" as "ways of living" (PO). Thus, it would seem that "life" and "living" are equally acceptable translations.

[52] In his later writings, those post-dating Part I of the *Philosophical Investigations*, Wittgenstein does lean towards the term "pattern" more than "form." Four of the eight occurrences of "*Lebensform*" occur in his writings that date prior to 1945. While "form of life" only occurs four times after Part I of the *Investigations*, "pattern of life" occurs eight times (LWI, §§206, 211 - twice, and 365; LWII, 40 – twice, and 42; RPPII, §652); "stream of life" appears six times (Z, §173; PR, §48; LWI, §913; LWII, 30; RPPII, §§504 and 687); "weave of life" also appears six times (LWII, 42; LWI, §§406 & 862; RPPII, §672; PI, 174 and 228-9); and "way of living" occurs five times (LWII, 43-4 - twice; CV, 69 and 73). "Way of living" also appears twice prior to 1945 (RFM, VI, §34 and CV, 31). In each of these cases the term refers to similar ideas, all of which can be applied to the concept of 'form of life.'

it is only in the context of a form of life that words have meaning, emotional and mental states are recognized, types of behavior are learned and expressed, social agreement of attitudes are forged, and correctness/rightness/truth of concepts are justified. While all of the aforementioned ideas reflect the *dependence* of various elements on a form of life, it should be said that all of these elements help to make up the very form of life to which they belong.

Wittgenstein does not introduce the concept 'form of life' in order to explain what a form of life is and how it functions. Wittgenstein always uses 'form of life' in order to qualify something else. He uses the concept 'form of life' as a means for explaining the contextualization and mutual embeddedness of language and meaning along with the interrelation of judgments, attitudes, and social practices. Wittgenstein first uses "form of life" in the *Philosophical Investigations* in order to draw attention to the interconnection of language-use with a form of life. He writes, "…to imagine a language means to imagine a life-form."[53] In this remark, form of life qualifies what he means by language, and throughout his writings form of life functions more as a role player than a central concept. In other words, Wittgenstein does not develop a theory of a form of life, and 'form of life' is not the central concept of his investigation. A 'form of life' also does not play a structural role and is not an organizing idea for Wittgenstein. Despite its ambiguity, I insist on appealing to a form of life because the notion of 'life' is central to the concept 'form of life.' The idea of a disruption of a form of life best captures the way that depression does not merely disrupt a particular social context, but the very life of the depressed individual.

[53]PI, §1

As hard as one might try or wish to glean a clearly definable concept from Wittgenstein's use of the term "form of life," the best way to understand what Wittgenstein meant by a form of life, and consequently how it will be used in this dissertation, is to understand what he wanted to accomplish with the concept. Part of what Wittgenstein achieves with his notion of a form of life is a critique of philosophies of language that limit 'sense' to atomic names and simples, sentence units, speaker/authorial intention, background theories, and speech-acts limited to a specific time, space, and audience, etc. He replaces these contexts that are limited to a few *primary* constructs with the idea of a 'form of life.' Rather than appealing to meaning as it is constructed within a limited context, Wittgenstein's use of form of life shows that meaning belongs to a multidimensional and heterogeneous context of shared social practices. What the concept 'form of life' helps to advance in this dissertation is an understanding of how the disruption of meaning and language in depression belongs to an overall disruption of a form of life.

José Medina refers to Wittgenstein's expanded context of meaning as an "action oriented holism"[54] and a "pragmatic contextualism."[55] Wittgenstein's "pragmatic contextualism" does not exclusively pertain to the role of a form of life in language-use and vice-versa. Rather than asserting the primacy of language, Wittgenstein emphasizes the centrality of social action and interaction in the formation of meaning. In the context of a remark on foundational propositions, Wittgenstein notes Goethe's riposte to John

[54] Medina, Language: Key Concepts in Philosophy, 2005, 91
[55]Medina, Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency, 2006, 14

1:1[56] – "In the beginning was the deed." [57] With this comment, Wittgenstein highlights the foundational role of action in the formation of meaning rather than language (*Logos*).

In the second appearance of "form of life" in the *Philosophical Investigations*, Wittgenstein emphasizes the dynamic nature of a life-form by connecting it to a practice. He writes, "Here the term 'language-*game'* is meant to bring into prominence the fact that the *speaking* of a language is part of an activity, or a life-form."[58] In this comment Wittgenstein compares a form of life to an activity. A form of life is characterized by an active and living quality in contrast to having a static and uniform nature.

The concept 'form of life' points to the normative context of meaning and practice. While a form of life is not static and homogenous, it does reinforce *regularities*. The regularities of a form of life concern behavior, emotion, perception, cognition, and language-use. They are constituted by the forms of agreement and truth that are contextually embedded in shared practices. A form of life pertains to the shared judgments and attitudes that make meaningful communication possible. Wittgenstein writes, "If language is to be a means of communication there must be agreement not only in definitions but also (queer as this may sound) in judgments" and this agreement is not "in opinions but in form of life."[59] According to Wittgenstein, judgments are not grounded in presuppositions and beliefs; rather, they are grounded in a "way of acting."[60] The pragmatic agreement within a form of life does presuppose but cannot guarantee or secure individual assent. On this point Wittgenstein writes, "'We are quite sure of it' does

[56] "In the beginning was the Word, and the Word was with God, and the Word was God."
[57] OC, f.n. §402
[58] PI, §23
[59] Ibid, §§241-2
[60] OC, §110

not mean just that every single person is certain of it, but that we belong to a community which is bound together by science and education."[61] By highlighting science and education as (*re*)producers of accepted judgments, Wittgenstein introduces the historical and material embeddedness of a form of life in a particular culture, which contradicts interpretations of Wittgenstein's use of 'form of life' as referring to a single, human form of life.[62] Thus, when Wittgenstein writes that "What has to be accepted, the given, is – so one could say – *forms of life*,"[63] the status of the "*has to be accepted*" does not refer to an ontological necessity; it refers to the normative regularity of a community.

Naomi Scheman notes that Wittgenstein's "emphasis on agreement can mislead us into thinking of Wittgensteinian forms of life as internally homogenous." [64] In contrast, she claims that a form of life is heterogeneous. I interpret this *internal* heterogeneity as applying to both the structure and content of a form of life. The structural heterogeneity refers to the different elements that make shared meaning possible, and the heterogeneity of content refers to the possibility of disagreement within a form of life. Related to the idea of internal heterogeneity, José Medina uses Meredith Williams' concept 'heterogeneous holism' to explain the qualitative difference between the context of language-use and its component elements.[65] However, it can be misleading to use the terms "internal" and "holism" in reference to the heterogeneity of a form of life, given that there are no distinct and static boundaries between multiple forms of life. Likewise,

---

[61] OC, §298
[62] For instance, O. Hanfling argues in favor of understanding a form of life as "the human form of life" (Hanfling, 2002, 5).
[63] PI, 192
[64] Scheman, N. , 1996, 386
[65]Medina, Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency, 2006, 17

the individual elements which constitute and are constituted by a form of life can change or dissipate over time, and new ones can emerge.

In this dissertation I highlight a few elements of social agreement that function in a form of life such as temporalization, spatialization, and language. While the elements of a form of life are interconnected, that does not mean that they are harmoniously connected. The *weave of life* can have holes, loose ends, and knots. These *knots* can develop from multiplicity, overlapping forms of life, and from areas of a form of life that are more-or-less undefined or under-defined. A form of life not only reinforces the meaningfulness of practices and the intelligibility of its practitioners, it also defines meaninglessness and unintelligibility. Likewise, silence, incommunication, and confusion are constituted by a form of life. A context defines by what it excludes as well as what it includes. What is unintelligible in one form of life could be meaningful in another.

The aforementioned remark in *On Certainty* about social agreement, "*we are quite sure of it*," calls attention to the "we" – the game players. The recurrence of the "we" in Wittgenstein's writings raises the question of who Wittgenstein assumed belongs to the "we," or if he overlooked this question altogether. Sarah Lucia Hoagland argues that Wittgenstein fails to "address questions of power" and "he never asks who is this 'we' who distinguishes sense and nonsense."[66] While she correctly assesses Wittgenstein's lack of direct engagement with "questions of power" and politics, Wittgenstein's challenges to various forms of foundationalism do indirectly implicate the role of social systems in defining meaning, as well the role of social structures in defining

[66] Hoagland, 2002, 132

the 'we.' In contrast to Hoagland's critique of Wittgenstein, Wendy Lee-Lampshire argues that Wittgenstein calls into question the epistemological status of the speaker and knower. Wittgenstein does not overtly shift the focus from shared meaning to communal identity, but Lee-Lampshire points out that many of his examples do "raise important questions about what it means to be in a position to know, to name, to command, to instruct, and so forth…"[67] She claims that the questions about the position of the knower "in turn raise questions concerning the possible disparities of power legitimated by and reinforced through the play of such games."[68] Furthermore, by invoking the roles of science and education, as well as the teacher and the apprentice, in the reproduction of meaning, Wittgenstein indirectly exposes the roles of the practitioners as well as the practices of a form of life.

While Wittgenstein does not articulate a theory of selfhood (or any of its variants, personal identity and agency, etc.), Wittgenstein's method of inquiry and topics of investigation do gesture towards some of the conditions under which meaning, agency, and practices are produced and reproduced in the individual and the community. Although Wittgenstein does not systematically address the objective and subjective conditions through which agency is constructed and organized, Lee-Lampshire points out that he does give us the tools for reassessing "*relationships* and *identities.*"[69] The closest Wittgenstein comes to accounting for *how* a form of life is incorporated in the life of an

[67]Lee-Lampshire, 1999, 410
[68] Ibid
[69] Ibid

individual is in his remarks on teaching.[70] Likewise, he only occasionally points out modes of individuation, such as temperament.[71] Wittgenstein does not view the relationship between a form of life and agency as a causal one. Just as a context plays a *defining* role rather than a *causal* role, a form of life has a defining relationship with meaning and identity.

A form of life is the familiar way that people participate in, define, understand, perceive, and emotionally encounter their shared environment. A form of life is the way one moves about one's environment. Different cultures have different forms of life. People both shape and live in a form of life. Material conditions, geography, and history all have an effect on a form of life. Cultural institutions such as science, education, religion, and government perpetuate a form of life. A life-form pertains to the relations among people and people's intersubjective relationship to the many elements of life. A form of life pertains to the familiarity and knowability of the world. A form of life pertains to a way of understanding, both reflectively and pre-reflectively, the things and beings of a world. A form of life is a way of acting and a way of being an actor. It is a way of seeing oneself and other people. A form of life plays a defining role in how one finds herself in the world, how one participates in practices, and how one uses her body.

[70] "I cannot describe how (in general) to employ rules, except by teaching you, training you to employ rules" (Z, §318).
[71] "If it is said on occasion that (someone's) philosophy is a matter of temperament, there is some truth in this. A preference for certain comparisons is something we call a matter of temperament & far more disagreements rest on this than appears at first sight" (CVre, 17-18).

Affective agreement and affective disruption

A form of life, like language, is first and foremost shared. Just as there can be no private language, one also cannot have a private form of life. The social agreement that coalesces in a form of life is not exclusively an intellectual agreement; practices are also predicated upon certain forms of emotional agreement and shared attitudes. Agreement operates on varying levels of consciousness such as habitual ways of moving one's body, sensory perception, one's emotional responses, and so forth. Wittgenstein refers to the meaningfulness of emotions as being understood within a way of living. In the context of remarks on pain and pretense, Wittgenstein comments, "What goes on *within* also has meaning only in the stream of life."[72] How one processes, identifies, and expresses emotions have meaning only in so far as they participate in a way of living. Shared practices give meaning to emotions and emotions also participate in the meaningfulness of practices. That fact that emotional and mental states are recognized as such is dependent on their place within a form of life. Wittgenstein contends that what we take to be fundamental human emotions, such as grief and hope, can only be identified and understood within a "weave of life." He writes, "'Grief' describes a pattern which recurs in the weave of our life"[73] and "phenomena of hope are modes of this complicated form of life."[74] In the passage that precedes his comments on hope, Wittgenstein addresses the various emotional responses one can imagine an animal to have (i.e. anger, fright, and happiness) and contrasts those with the capacity for hopefulness. Hope, he claims, can only have purchase for speaking beings. That is not to say, however, that hope belongs to

[72] LWII, p.30 (emphasis added)
[73] LWI, §406
[74] PI, 148

a single *human* form of life, but rather that hope belongs to a complicated form of life that can only occur where complex linguistic practices are in place. He asserts that the form of life (in which hope has meaning) can only belong to human beings (leaving open the possibility that some human beings may not have the capacity for hopefulness); however, he does not assert that there is a single human form of life in which hope is an essential element.

Emotions participate in the normative structures of a form of life. Normative judgments operate in what is considered to be an appropriate expression of an emotion, as well as what are considered to be appropriate emotions for a particular circumstance. Emotions are interpreted, named, distinguished, analyzed, tamed, encouraged, suppressed, and ignored. Merleau-Ponty describes emotions and emotional behavior as cultural products. He writes, "It is no more natural, and no less conventional, to shout in anger and kiss in love than to call a table 'a table'. Feelings and passional conduct are invented like words."[75] A person's inability to conform his or her emotions to social expectations can have serious consequences, both social and psychological. Certain emotional responses and emotional dispositions can secure one's place in a practice or exclude one as an unsuitable practitioner. In her research on depression among Flathead Indians in North America, Theresa O'Nell refers to the work of the anthropologists Lutz and Abu-Lughod who speak to the way that "power relations determine what can, cannot, or must be said about self and emotion, what is taken to be true or false about them, and what only some individuals can say about them."[76] For example, in some communities

[75] Merleau-Ponty, 1992, 189
[76] O'Nell, 1996, 186

anger is not viewed as an acceptable emotion and if someone reacts in anger it would not simply be imprudent; it would not make sense. Also, some people are considered to be entitled to anger while other people are not.

While Wittgenstein remarks that joy and grief are not "kinds of behavior," emotions are nevertheless bound up with behavioral regularities.[77] A form of life is infused in the so-called "outward" expression of emotions as well as the "inner" emotions themselves. Children are taught which emotions are acceptable in which circumstances, and the circumstances have as much to do with *who* is present as *what* the practice is. Social norms guide who should and should not express this or that emotion, and to whom. Consider the ways that children are trained to restrain or show emotion: "Don't you get angry with me!" "Tell your sister you are sorry." "You may be upset, but you still have to go to school." "If you're lonely and bored why don't you just go outside and play?" Later in life similar tropes persist, although they are usually less direct: "I know you're upset about losing your job, but it's at times like these that we need to be grateful for what we do have." "Don't let your ex' get you down, he's not worth it." "Look at those people rioting, why do they think they have the right to destroy other people's property?"

Despite the pervasive enculturation of affectivity, social agreement cannot always quell emotions, foster emotions, or make sense of emotions. In particular, social norms cannot control the depressive affect of the severely depressed. The depressive affect exceeds the normative limitations embedded in a form of life. Depressive emotions are

[77] "(This does not mean that joy or grief are kinds of behavior.)" (LWI, §406).

deemed abnormal in their intensity, duration, lack of a clear object, and/or negativity. Not only can the depressive affect overwhelm a deeply inculcated way of living, it can also trigger suicide. If affectivity has the power to disrupt an individual's form of life, then what relation do emotions and emotional disorders have with meaning and identity? Depression opens up a window through which we can assess the relationship between intra-personal, affective, and bodily changes of the depressed individual with the disruption of a form of life. If a form of life can be disrupted by an affective disorder, then the functioning and health of one's emotions is also interconnected with the coherence, as well as the disruption, of a form of life. Depression calls attention to the fact that not only language and a form of life subtend emotions, but also emotions subtend a form of life and language-use.

While a form of life defines emotions, emotions also inform and define a form of life. How one feels affects how one sees and acts. O'Nell remarks that "emotion not only depicts a particular vision of the self and its relation to the world, but its usage actually defines or redefines that social reality."[78] Similarly, Heidegger remarks that *mood* "determines what and how one 'sees.'"[79] Rather than clarifying "what and how one 'sees'" depression appears to obscure the world.[80] The intensity, duration, and negativity of the emotions that accompany depression disrupt a form of life. They do not flow within the stream of life; they disrupt meaning. Depressive affect can block a person's

[78] O'Nell, 1996, 214
[79] Heidegger, Being and Time, 1996, 169
[80] I will speak at more length on Heidegger, mood, and the possibility of depressive *attunement* in chapter 3.

ability to give meaningful expression to emotions as well as understand them as having meaning.

Depression ultimately has two main sources of affective disruption. The first source pertains to the *presence* of emotions and the second source refers to the *absence* of emotional connection. I call the first source of disruption "affective disordering." I use affective disordering in a specialized way to indicate the presence of unwanted and deleterious emotional states, which can exist independent of any identifiable intentional objects. I label the second sphere of disruption "affective disconnection," which refers to the depressive's disengagement from her natural and social environment. Depressive affective disordering refers to the exaggerated intensity and duration of unwanted and uncontrollable emotional states that inhibit one's ability to act and think, and disturb physiological processes. Depressive affective disordering is characterized by emotional and physical suffering. Affective disordering can also pertain to the absence of identifiable intentional objects of emotions. In this case, the depressive's affect, mood, or emotion does not connect with and is not directed at a clearly identifiable object ('object' here means situation, person, task, ideal, etc.). Often the depressive emotion is not *about* or *over* something; depressive affect is disordered because it can be unattached. For instance, depressives often experience an inexplicable and sudden onslaught of deep grief or penetrating anger without an identifiable trigger. Along with the presence of unwanted, unwieldy, and unattached emotions, depression is also accompanied by a loss of affective connection. The depressive's affective disconnection manifests itself in the depressive's estrangement from objects, projects, practices, ideals, other people, language, and

oneself. These two horns of depression exist in a feedback loop and neither one appears to have temporal or causal priority.

While depression is capable of disrupting a form of life, it does not develop into a new form of life. A form of life belongs to shared practices, whereas depression disrupts those practices. Given the depressive tendency towards withdrawal, suicidal ideation, and self-consuming feelings of grief and pain, the depressive position is isolating and the depressive person is overwhelmingly alone. While the depressive lacks the psychological resources to develop a new form of life, a new form of life and its practices cannot be created privately regardless of an individual's mental "health." An individual's *disrupted* form of life does not constitute a *different* form of life, because a form of life is not merely a subjective, intrapsychic formation. Depression brings about a disjunction between the individual and her form of life that does not intrinsically lead to a *different* form of life. In other words, depression is not a *counter form of life;* rather, it is counter *to* life. Whether a depressed individual at some point either enters into a new form of life or is eventually resituated within a form of life depends on how his or her community assesses depression and whether she has access to a language game that makes depression intelligible.[81]

Familiarity and "feeling at home" in a form of life

For the most part, one's form of life constitutes and is constituted by a sense of familiarity and ordinariness. The way in which a person can move about her environment

[81] This idea will be addressed in more detail in chapter four.

unquestioningly – seeing objects, performing tasks, conversing with friends – belongs to the overall sense of familiarity that a life-form entails. Wittgenstein describes familiarity as consisting in "things like our feeling at home in what we see."[82] This *at homeness* highlights a level of ease and proficiency that accompanies a long-familiar acquaintance with something. Wittgenstein likens familiarity and *at homeness* to "the feeling of well-being."[83] However, being in one's actual home may not conjure feelings of well-being and ease for everyone. For many people, *home* is the site of discomfort, violence, and strategic rather than effortless behavior. The phrase "feeling at home" means and is used by Wittgenstein to indicate familiarity and well-being. Well-being, however, does not exclusively pertain to states of comfort and happiness; it pertains to the appropriateness of things, the way that things appear to be in their place, and a familiar way of taking to things.

Wittgenstein characterizes this at homeness as being an uninterpreted, unthinking, and unnoticeable way of seeing familiar things. He remarks, "No one will say that every time I enter my room, my long-familiar surroundings, there is enacted a recognition of all that I see and have seen hundreds of times before."[84] The feeling of being at home is one in which "as we should say, we do not *think*."[85] In another sense one could say that we do not respond or react to the impression of familiarity; we merely *continue on with what we were doing.* A form of life entails a more-or-less automatic way of behaving and Wittgenstein compares the effortlessness of performing daily tasks with the almost

[82] PG, 126
[83] RPPI, § 122
[84]PI, §603
[85] Z, §231

passive way that something can strike one as familiar. For example, Wittgenstein remarks that it is not the case that one "ordinarily tries to move one's mouth as one eats, or aims at moving it."[86] He points out that "While I'm writing, walking, eating, talking, gazing here and there (normally), I no more *try* to perform these actions than the face of an old friend '*strikes* me as familiar.'"[87] Here we see that one performs many everyday actions in an unthinking manner and that these actions are performed *successfully.* By stating that he does not "*try* to perform these actions," Wittgenstein also intimates that without trying, he does not *fail* to perform these actions. The very performance of these actions means a *successful* performance; if I eat, I do not *fail* to eat. However, Wittgenstein also parenthetically remarks that these actions are perfunctory under *normal* conditions. While "normally" he walks and eats successfully without *aiming* at doing these things, Wittgenstein suggests that there are times when, abnormally, he does in fact *try* to do these things, and perhaps in his trying he actually fails. One could think of various examples when a person *tries* to do these basic things *in a certain way* and fails (trying to eat spaghetti without slurping, trying to walk on a wet floor without slipping). It is rare, however, to try to eat and fail to eat (this is not a matter of wanting to find food and not finding it). In other words, the rarity comes from the mental act of *aiming at*, as well as the possibility of failing. The types of conditions that turn walking, eating, and talking into tasks that require effort and thought are those that prevent these actions from being automatic, such as illness and injury. That is not to say that all illnesses and injuries, which complicate previously habitual ways of functioning in the world, lead to a disruption of a form of life. A form of life is infused in one's habitual bodily acts, and

[86] PI, 166
[87] LWI, §848

when a form of life is disrupted one's ease of functioning is also disrupted. In depression, both a prereflective sense of familiarity with one's surroundings and an automatic ease of functioning dissipate. The depressive does not feel at home in a form of life or in her own body.

The disruption of a form of life

Loss of ease

The claim 'depression disrupts a person's form of life' means that depression invades the most banal as well as the most profound aspects of one's way of living. For the depressive, the disrupted form of life is often accompanied by a loss of basic functioning and deepens into a profound estrangement from life itself. It is important to keep in mind that while the effects of depression that garner the most attention relate to mental disturbances, depression is a malady that affects the entire body. The body cannot be isolated from a form of life and vice versa.

Wittgenstein touches on two of the fundamental losses that occur in depression, although he does not formulate them as such: the loss of basic functioning and the loss of familiarity. The loss of functioning involves the physicality of depression. He writes, "Yet still I mustn't forget that joy goes along with physical well-being, and sadness, or at

least depression, often with being physically out of sorts."[88] Being "physically out of sorts" in depression involves a wide array of somatic symptoms. Martha Manning describes the physicality of depression in her memoir. She writes, "Every inch of me aches. I can't believe that a person can hurt this bad and still breathe."[89] Similarly, in *Shoot the Damn Dog: a Memoir of Depression*, Sally Brampton writes, "Why do they call it a 'mental' illness? The pain isn't just in my head; it's everywhere, but mainly at my throat and in my heart."[90] Depression not only affects how the body feels, it also impinges on what the body can accomplish. The depressive is unable to count on herself to perform simple everyday tasks. Her body no longer functions in a reliable and predictable way. The simple tasks of caring for oneself such as getting out of bed, showering, and talking prove to be challenging if not insurmountable for the depressive. Manning recounts her inability to perform these basic and life-sustaining acts in depression: "I can't sleep. I can't eat. I can't read or talk or concentrate for more than several seconds."[91] Depressives describe this loss of functioning as ensuing from a paralyzing depletion of energy. Brampton, for example, describes the arduous task of eating. She writes, "I must eat, I know, but it seems such a laborious process, to pick up the sandwich, to bite, to chew, to swallow."[92] William Styron describes the sudden loss of his ability to perform these perfunctory acts while he attended an award ceremony honoring his writing. He refers to his lost abilities in terms of a failure, a "failure to have an appetite for the grand *plateau de fruits de mer* placed before me, failure of even forced

[88]RPPII, §322
[89] Manning, 1994, 99
[90] Brampton, 2008, 34
[91] Manning, 1994, 104
[92] Brampton, 2008, 32

laughter and, at last, virtually total failure of speech."[93] Here we see examples of depressives who *aim* at tasks that used to be automatic and fail to accomplish them. Unremarkable acts suddenly become remarkable in their broken form. In Manning's words, "What was once so smooth, so automatic, is now forced and effortful and unpredictable."[94]

With regards to language specifically, depressives struggle with the mental and physical aspects of speech, reading, listening, and concentrating. Andrew Solomon recalls the frightening experience of being unable to talk: "I lay very still and thought about speaking, trying to figure out how to do it. I moved my tongue but there were no sounds. I had forgotten how to talk."[95] In Solomon's description of his painstaking attempt and subsequent failure to speak, we must keep in mind the fact that linguistic disruption does not exclusively pertain to a cognitive failure. In his example of being unable to speak, we see Solomon's loss of the sheer familiarity of feeling at home in his movements and abilities. The loss of language in depression is not limited to a loss of speech; depression affects a person's ability to process meaning and language in all forms. John Bentley Mays speaks of his inability to read while depressed, "The words seemed to blur, or burn themselves painfully into the back of my eyes. I could write nothing, keep no notes in class, because I could not hear."[96] Sally Brampton describes the experience of words becoming nothing "more than patterns on a page."[97] Similarly, Kay

[93] Styron, 1992, 19
[94] Manning, 1994, 56
[95] Solomon, 2002, 49
[96] Mays, 2003, 51
[97] Brampton, 2008, 33

Redfield Jamison points out in *An Unquiet Mind: a Memoir of Moods and Madness* that one of her most distressing symptoms of depression was her sudden inability to read.[98]

Defamiliarization

Depression functions as a decontextualizing force. It dislodges meaning from its familiar environment. Depression disturbs the depressed individual's relationship with the things and beings of her world. The journalist John Faulk details the sudden defamiliarization that occurred with his first experience of depression as a twelve year old boy:

> I recognized everything in my room, but at the same time it was foreign to me…my friendly cockatoo, was now just another bird. I knew he was mine. Intellectually I knew I *owned* him and that we had a history, but I no longer *felt* connected to him. Or any of the other crap in my room, living or otherwise. It was all somehow outside me. The intimate familiarity I had with everything the night before, the warm-blooded sense of belonging here, was gone. Feelings so ordinary that I never realized they could change were missing. I had become a stranger in my own room, like I had been banished into some nether land outside and was now looking back in on my life through a very thick window.[99]

Faulk's memory of depression as an adolescent captures the nuances of depressive decontextualization. For Faulk, everything appeared different, unfamiliar, and distant. His perception changed, but it was not primarily or exclusively an intellectual change. In fact, he begins the description of the experience by stating "I recognized everything" and "Intellectually I knew." So what can account for the sudden flattening and exsanguination of his surroundings? What does it mean to recognize one's familiar belongings, yet no

[98] Jamison, 1996, 95
[99] Falk, 2005, 45

longer recognize them as being familiar? The form of *unrecognizability* for the depressive is a matter of no longer recognizing something *as* it had previously been recognized – as familiar and imbued with personal significance. As a depressed boy, Faulk lost a sense of history and belongingness with his environment. Such an *unrecognizable* thing, "living or otherwise," is one that was previously meaningful and in depression is conspicuously lacking significance and emotional connection for the depressive. The familiar taking on an unrecognizable dimension occurs when the affective connection to the familiar is lost.

The loss of familiarity for Faulk and other depressives can best be understood by Faulk's expression, "I no longer *felt* connected." The significance of a loss of familiarity is the absence of feeling and the inability to ever feel at home. Here we see that meaning has as much to do with *affective* recognition as it does with *intellectual* recognition. As mentioned earlier, Wittgenstein describes the feeling of being at home as one in which "as we should say, we do not *think*."[100] The association of familiarity with a prereflective quality does not necessarily mean that the feeling of *not* being at home is one in which we *do think*. The feeling of *not* being at home is first and foremost a feeling of discomfort. In this case, unfamiliarity is not the contrary of familiarity. Something can be *not* unfamiliar and still not give an impression of familiarity. The shift in affective connectivity fosters a lack of agreement between the depressed person's perception and the ways of perceiving embedded in a form of life. In addition, a psychological discontinuity develops between how a person sees things when she is depressed and how she saw things before depression, including how she perceived herself. In Kay Redfield

[100] Z, §231

Jamison's words, "Nothing once familiar to me was familiar."[101] The depressive's perception of her environment no longer stands in agreement with the form of life in which she once felt at home. It is in the context of this *mental homelessness*, so to speak, that depressives lose meaning, speech wanes, and communication dwindles.

The lack of agreement between the depressive and her form of life is neither the initial cause nor the reason for the continuation of depression; it is a symptom. Also, even if it were possible, a reversal of the lack of agreement would in no way end depression. In other words, a lack of agreement does not cause depression and the realignment of agreement would not resolve depression. Since the lack of agreement is only one among many symptoms of depression, a realignment of agreement could not, on its own, completely ameliorate all of the symptoms of depression. Depression disrupts the weave of life, no matter how it is woven.

Depression does not have a unique claim on the disruption of a way of living. In fact, some people aim at disrupting life by intentionally causing a sense of dislocation and fostering a feeling of unfamiliarity through art or use of intoxicants. In these cases the effect is often transitory and uncanny. Individuals and groups of people can also undergo trauma, illness, violence, and war, experiences that can dislodge a deeply entrenched way of functioning in the world. However, not all losses, even significant losses, precipitate the disruption of a form of life. Even when everyday life is unraveled by the death of a loved one, the destruction of a home, or loss of a job, often a person still relies on familiar structures of meaning to cope with the loss. The places and things

[101] Jamison, 1996, 82

around her are still familiar, although imbued with feelings of grief and sadness. In a case of bereavement, a kitchen chair can become more than a chair; it becomes a reminder of the person who used to sit there. The chair has taken on a new aspect, yet it has not lost its familiarity. It is no longer merely present and familiar; it is a marker of time and especially of a time past. For most people the death of a loved one does not lead to a disrupted form of life. That is not to say, however, that it does not utterly disrupt a person's life and fill a person with a sense of meaningless and grief. While there are many situations in which the death of a loved does in fact lead to a disrupted form of life, it is simply not the case that it always, or even usually, does so. A person's *life* can be deeply disrupted without disrupting his or her *form of life*. Not all life disruptions lead to estrangement from the familiar way of functioning within a life-form.

Let's consider two categories of disruptions and losses, the first type of disruption/loss (with all the pain and grief that it encompasses) does not lead to a disrupted form of life, and the second type of disruption/loss does lead to a disrupted form of life. I contend that severe depression belongs to the latter category; it necessarily leads to a disrupted life-form. Depression is not, however, the sole occupier of the second category and there are no static forms of loss in the first category that cannot possibly shift into the latter. So in reference to the first category – losses that do not lead to a disrupted form of life – in these cases the objects surrounding the bereaved can take on new aspects while still remaining familiar. In depression, however, the objects surrounding the depressive lose their meaning and their familiarity without gaining any newly familiar significance. In the first category, objects can take on a new significance *because* the original familiarity has not been lost even though the circumstances have

changed (e.g. a loved one has died). For example, the chair in which the person now deceased typically sat used to be just an ordinary chair among other similar chairs that got dirty and scratched the floor. It is in light of these previous aspects that the chair takes on the new aspect; it becomes the chair that will never again be used by the deceased.

Marginalization in a form of life

The familiarity and feeling of being at home in one's form of life does not mean that one experiences the positive feelings one might associate with the feeling of being at home. Something can feel familiar and also feel wrong. People can feel uncomfortable and out of place in their form of life prior to its disruption in depression. In addition, depression can develop in an already disrupted form of life. Take for example refugees experiencing major depression after a civil war. In this case, depression can deepen and compound an already disturbed existence and would not be the initial or sole disruption of a person's form of life. In addition, some depressives recall being depressed throughout their entire lives. In the case in which a person cannot remember a time when he or she was not severely depressed, then it would suffice to say that she never felt at home in a form of life.

It is not the case that a person or group of people who do not feel at home in one form of life necessarily operate outside of any form of life. First, a form of life is not a consistent and coherently constructed schema; it is a way of living that often involves contradictions and ambiguities. Secondly, multifarious forms of life can overlap each

other. Wittgenstein gives an example of a group of people using coins in a seemingly meaningless exchange, which results in the shopkeepers accepting whatever coins the customers decide to give. While the *normal* observer might find the actions of these people to be nonsensical, Wittgenstein cautions, "And yet we don't call everyone insane who acts similarly *within the forms of our culture*…"[102] In this retort, Wittgenstein highlights the fact that some practices are simply accepted "within the forms of our culture," while others are not. This example can be interpreted as indicating that there are heterogeneous meanings and practices happening within a form of life, as well as marginal forms of life operating within a more widespread form of life.

In the essay "Forms of life: Mapping the rough ground," Naomi Scheman addresses the misconception that the concept 'form of life' fails to account for social marginalization. While most interpretations of Wittgenstein paint a picture of a person securely at the center of a life-form, Scheman points out that many people who are "neither stranger nor native, who for the widest range of reasons, within and beyond their own choosing, live somewhere other than at the centers of the forms of life they inhabit."[103] Many of the people who inhabit the borders of a form of life face a threat of unintelligibility. Scheman uses the example from the film *Torch Song Trilogy* in which a mother and her gay son Arnold are in the cemetery visiting the graves of both Arnold's father and Arnold's lover. Arnold's mother is "furious at what she (correctly) perceives as his sense of commonality in their losses."[104] Scheman points out that Arnold's mother feels that she, a heterosexual, has the right to her grief and love and that 'grief' and 'love'

[102]RFM, I, §153 (emphasis added)
[103] Scheman N., 1996, 403
[104] Ibid, 392

do not appropriately fit the context of a homosexual relationship. Even though both the mother and son share a form of life – for instance, they are both reciting a Jewish prayer for the deceased – the mother feels that only she is sanctioned (by God, the state, and society) to feel at home in this form of life. Arnold's love is rendered unintelligible to his mother due to his sexual marginality.

While social marginalization can trigger severe depression for some people, the unintelligibility that accompanies the disruption of a form of life is not the same as the unintelligibility associated with marginalization in a form of life. Depression defamiliarizes and desynchronizes an entire way of living. It does not affect only a few features; it disrupts language-use, sociality, temporalization, sense of self, and perception of one's surroundings.[105] Brampton explains, "You are, quite literally, broken down. To me it felt like the total disintegration of everything I had ever known about myself."[106] "Disintegration" aptly describes the disruption of a form of life, in that one is no longer integrated into her familiar environment. Regardless of one's sense of being at home in one's form of life prior to depression, depression obscures the meanings and familiarity previously made possible by a form of life. While the mentally ill are generally marginalized in most cultures, the depressive experiences a marginalization that does not exclusively pertain to social positions and power structures. Depression damages the depressive's ability to find the world around her, as well as herself, intelligible. Depression alienates the depressive from her social and natural environment by disordering her capacity to affectively engage with life.

[105] Not an exhaustive list.
[106] Brampton, 2008, 42

Conclusion

By looking at depression in terms of a disruption of form of life, one runs the risk of assessing depression only in terms of its deviation from normalcy and not seeing the experience in and of itself. In a remark on color-blindness, Wittgenstein addresses the problem of only understanding something in terms of what it is not: "Someone who describes the 'phenomena of colour-blindness' describes only the ways in which the colour-blind person *deviates* from the normal, not his vision in general?"[107] Unlike the color-blind person and the normally sighted person, who both typically retain their way of seeing color, most depressives experience what it is like to be depressed as well as what it is like not to be depressed. Also, the depressive assesses depression in terms of how it deviates from normalcy, whereas the color-blind person cannot make this assessment based only on the experience of being color-blind. John Bentley Mays describes his onset of mental illness as the breaking of "one's fidelity to a set of social codes and behaviors defined as 'normal', 'natural.'"[108] Depression is marked by what one used to be able to do and feel and what one no longer can do or feel. In the "The Phenomenology of Mood and the Meaning of Life," Matthew Ratcliffe describes depression as a "shift in the kinds of significant possibility that shape experience of self, other people, and the surrounding world."[109] He characterizes the depressive's disconnection as an "invisible but impenetrable barrier."[110] This metaphor aptly depicts

[107]RC, §165, p. 39
[108]Mays, 2003, 82
[109] Ratcliffe, 2010, 359
[110] Ibid

the depressive's loss of affective connectivity that normally undergirds a person's relation to others, herself, time, and language as meaningful and familiar.

The lack of affective connection to one's previously familiar surroundings impacts the depressed person's perception such as the perception of time as standing still, the impression that everything looks grey and removed, and the feeling that social interaction is threatening. In the next chapter I will look at the relationship between affect and perception and how this relationship plays out in depression. In addition, I will examine the depressive's deviation from familiar modes of time and space. In the following chapters, I will further explore how the estrangement from a form of life unfolds in the depressed person's relation to herself and other people, and how depression diminishes a person's ability to find meaning.

CHAPTER III

DEPRESSIVE PERCEPTION

Introduction

The view of depression as a disruption of a form of life forms the background for my account of the depressive's estrangement from language, meaning, and herself. In spite of this background, however, I will not explicitly dwell on the concept 'form of life' in the next three chapters. In the remaining chapters I will look at specific phenomenal domains and how they are altered in depression. Many of the meaning structures that buttress a form of life are implicated in the depressive's orientation to time, space, others, and oneself. In this chapter I look at depressive perception, temporality, and spatiality. In the next chapter I address the depressive's agency, loss of self, and intersubjective relations. In the final chapter I focus on the depressive's linguistic disturbances, which emerge from an affective disconnection from and disordering of meaning. While I refer to these phenomenological dimensions as differentiated domains ('time,' 'space,' 'intersubjectivity,' etc.), it is important to keep in mind that they are interconnected with each other and interdependent with a form of life. These domains are divided for heuristic purposes and not because they are experientially and ontologically separable spheres.

This chapter focuses on the depressive's altered perception of her surroundings, in particular her altered perception of time and space. The changes that take place in depression to perception, temporalization, and spatialization can be understood in terms of affective disengagement and affective disordering. Based on various descriptions, analyses, and reports from depressed individuals, we discover that in depression physical objects appear different, familiar spaces feel strange, and time itself seems to stand still. The distinctions that I highlight are based on the depressive's articulation of the differences that occur between one's perception while depressed and the ways in which perception typically functions outside of a depressive episode.

In the first part of the chapter I look at how depression alters perception and what the status of altered perception is for the depressive. In this section I draw on the Wittgensteinian discussion of 'seeing' and 'seeing-as,' and introduce the idea of *affective seeing* to show how emotion can condition how one perceives. In the second part of the chapter I evaluate a depressive spatiality and use Merleau-Ponty's idea of the spatiality of a phenomenal body as a template for understanding normal spatialization. In the third part of the chapter I evaluate depressive temporality as a desynchronization from ordinary, directed, and shared time. I conclude the chapter with a discussion of the depressive's relation to death and experience of being trapped in a living-death.

Seeing-through depression

Depression and problems of perception

Perception is on the front line of a person's relation to the world. As Merleau-Ponty notes, "All knowledge takes its place within the horizons opened up by perception."[111] A person's involvement in the world is opened up through various forms of sensory perception that function as a unified and typically pre-reflective engagement with the world. Perception functions within and through a person's habitual absorption of her environment. Perception is imbued with shared meanings and is a person's primary means of entry into a meaningful world.

The crux of the philosophical 'problem of perception' pertains to the subjective indistinguishability of illusions and hallucinations from veridical perception. In an illusion one mistakenly takes something, X, for something, Y, and in a hallucination one takes something to be X, when X does not exist. Depression, however, poses problems pertaining to perception that cannot be adequately characterized as illusions or hallucinations. In depression one's perception is significantly altered by depressive affect and depressive withdrawal. While perception is altered in depression, depressives typically do not perceive something that doesn't exist or chronically misperceive something as something else. The incomplete answer to the problem of depressive perception is to say that the changes take place in the depressive's experience of her surroundings. However, I will show that it is not simply the case that the phenomenal

[111] Merleau-Ponty, 1992, 207

character of the depressive's experiences changes. This section will address the depressive's altered perception of her environment in terms of: a) its conceptual relation to and difference from illusion, and b) Wittgenstein's distinction between 'seeing' and 'seeing-as.' This investigation into depressive perception can help to illuminate problems with philosophical conceptualizations of perception by pointing out the heterogeneity in the functioning and functions of perception.

In depression the quality of a thing appears to have changed and the change appears as if it is taking place in the object itself. Let us look at an example that involves the common impression that in depression the world looks cloudy. This example is not merely hypothetical; many depressives describe their surroundings as appearing duller and greyer. Van den Berg had a depressed patient that "went so far as to buy stronger light bulbs because the light in his room had become less bright."[112] If a depressive can look at the sky and see grey when non-depressives look at the sky and see blue, should the depressive's (*mis*)perception be characterized as an illusion? In the case of a visual illusion one sees X when in fact the object or quality is Y. The problem with designating van den Berg's patient or other depressive's perception as illusory is that altered visual perception in depression does not simply involve a visual error. A perceptual illusion in general occurs when certain environmental conditions and/or problems with the perceiver's physiology make an object appear to the viewer other than it is. For example, environmental conditions can cause a straight stick to appear crooked under water and near-sightedness can cause a person to take a stick for a snake. In some cases, a thing can remain illusory even if the person knows it to be otherwise. The discrepancy between

[112] Van den Berg, 1972, 45

depressive and non-depressive perception, however, is not simply a matter of a visual confusion.

Wittgenstein's concepts of 'seeing-as' and 'aspect-seeing' can be helpful in the attempt to articulate the depressive's altered way of seeing, especially in terms of how these concepts differ from depressive visual perception. Wittgenstein writes:

> 'Seeing the figure *as*…' has something occult, something ungraspable about it. One would like to say: "Something has altered, and nothing has altered."[113]

At first glance, this particular description of 'seeing-as' appears congruent with the changes that take place in depressive perception. In a sense, depressive perception also has a hidden and abstruse quality about it. The depressive notices a change in her surroundings, yet she can also recognize the fact that nothing concrete has changed. Consider Faulk's description: "I recognized everything in my room, but at the same time it was foreign to me."[114] Faulk experiences a discrepancy between what he knows to be the case and what he sees. He knows that nothing has changed and yet he perceives a difference. If the room has not changed, then as Wittgenstein asks, "what is different: [his] impression? [his] point of view?"[115] Can Faulk explain what the difference is? What does something look like when it no longer looks familiar? Would Faulk not describe his pet bird, for example, in the same way as before – with the same colors, shape, features, and so forth? Perhaps the difference could only be detected in his tone of voice or the lack of personal anecdotes.

---

[113] RPPI, §966
[114] Falk, 2005, 45
[115] PI, 167

While Faulk did perceive a difference, is it correct to say that Faulk saw his room *as* unfamiliar? Let's consider the differences between Faulk's perception and Wittgenstein's analysis of Jastrow's 'duck-rabbit' picture.[116] In the case of the duck-rabbit picture, one can actually see different images in the same picture – now a duck and now a rabbit. Wittgenstein calls this type of perception 'aspect-seeing.' In contrast, Faulk does not see different images; he takes to the visual field in a different manner. Another difference between Faulk's perception and the duck-rabbit picture is that once someone has seen both the images of a duck and a rabbit, she can then go back-and-forth voluntarily between the two aspects. In contrast, Faulk cannot *see* his room *as* a familiar intimate space at one moment and later *see* it *as* foreign. In fact, one does not *see* Y *as* X; one simply *sees* X. That is, one does not see the familiar room *as* foreign; one simply *sees* the foreign room. 'Seeing as' typically pertains to the subject's realization of veridical perception. For example, if when walking my dog I look down the street and take Pete for Joe, I am not consciously seeing Pete *as* Joe. It is not until I get close enough to Pete to recognize him, or something happens to bring the discrepancy to my attention, that I can realize that I saw Pete *as* Joe. 'Seeing-as' is usually not a phenomenon of immediate visual perception; it requires reflective thought. Though it's reasonable for Van den Berg to *say* that his patient sees his own room *as* less bright, the patient simply *sees* a dim room.

Norman Malcolm maintains that not all seeing is 'seeing-as' and characterizes 'seeing' in terms of prereflective sense-perception.[117] Consider Wittgenstein's example of

[116] PI, 165
[117] Malcolm, Wittgensteinian Themes: Essays 1978-1989, 1995, 109-117

how we take to eating utensils. He comments that it would not make sense to say "Now I am seeing this as a knife and fork." He continues, "One doesn't 'take' what one knows as the cutlery of a meal for cutlery; any more than one ordinarily tries to move one's mouth as one eats, or aims at moving it."[118] In this example Wittgenstein shows that we do not see the thing *as* a fork; rather, we simply see a fork and use it. In contrast to the unreflective act of seeing a fork, 'seeing-as' refers to the ability to see the likeness of at least two things in the same image. Consider Anscombe's example of the man who saw his father's hat as a deer. One would not say during the act of seeing "I am seeing my dad's hat as a deer." In such a case, the person would no longer be referring to sense-perception. "I am seeing my dad's hat as a deer" is an expression based on one's use of one's imagination, not only one's sight. Likewise, if a depressive says "I saw the world *as* grey," she would say this typically after a depressive episode.

The distinction being outlined between 'seeing-as' and 'seeing' in terms of an intellectual and unreflective perception respectively does not mean that all 'seeing' is therefore uninterpreted or that the "recognition of aspects [is] always self-conscious."[119] In fact, some scholars read Wittgenstein as actually blurring the distinction between 'seeing-as' and 'seeing' in order to draw attention to the aspect of visual perception that is conditioned by a way of seeing things *as* they are *habitually* seen, and yet not consciously apprehended as such. The cutlery example need not be interpreted as highlighting a consistent Wittgensteinian theory of the difference between the specific concepts 'seeing' and 'seeing-as;' instead one can take from the example the idea that

[118] PI, 166
[119] Medina, correspondence, 2012

when one looks at a fork one does not first see an object and then see the object as a fork. While the fact that I see a fork depends on a habitual and learned way of seeing and using utensils, there is nevertheless a direct taking up of the fork through one's perception. Regardless, of how one interprets Wittgenstein's intention towards these two specific concepts, it would seem that most visual perception does in fact have mixed qualities of a particular *way of seeing* and an unreflective seeing.

Seeing-through

Returning to depressive visual perception specifically, it could be helpful to introduce a new term that not only speaks to the unreflective, habitual *way of seeing*, but that also speaks to the way that affect can condition and alter what one sees and how one sees it. I refer to this *affective seeing* as '*seeing-through*.' By 'seeing-through,' I mean seeing through a particular lens; I do not mean seeing-*through* in terms of seeing-*into* or seeing-*beyond*. In 1790, the poet Anne Finch speaks to the idea of seeing-through melancholia: "Thro' thy black Jaundice I all Objects see,/ As Dark, and Terrible as Thee."[120] The greyness of the sky, the darkness of objects, and the unfamiliarity of one's surroundings reflect the depressive's *affective seeing.* 'Affective seeing,' or 'seeing-through,' differs from 'aspect-seeing.' The impression of a lack of familiarity is not the same as the dawning of an aspect. Unlike the example of the duck-rabbit picture, Faulk notices that something is missing, but not added.

[120] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 170

In depressive visual perception there is often an absence of color, vibrancy, distinction, and light. The depressive fails to see details and features that give a "warm-blooded sense of belonging."[121] Van den Berg interprets depressive perception as an expression of what it is to be depressed: "The patient is ill; this means that *his world* is ill, literally that his *objects are ill*."[122] Wittgenstein highlights the fact that in grief, a pervasive affective state, "the whole world looks grey" and not just the sky or this or that particular thing.[123] The fact that Faulk's room appears different to him does not mean that change takes place in a single visual image or collection of visual images; the change occurs in his lack of affective connection to the things of his world.

In the essay "Depression, Depth, and the Imagination," Jennifer Church provides a insightful phenomenological account of depression. She argues that a phenomenology of depression should provide an account of the "correspondence between *what* is being felt and *what* is being perceived."[124] While this task is similar to my own, I do take issue with the idea of 'correspondence.' The construction of the relation in terms of two separable spheres, "*what* is being felt and *what* is perceived," gives a misleading picture of the relationship between perception and emotion. Church sets up the problem of affect and perception in terms of the "correspondence" between (the *object(s)* of) feeling and perception. The idea of 'correspondence,' echoed by G. Graham below, leads to a problematic way of understanding the structural and functional relationship of affect and perception. The use of 'correspondence' in this context is problematic for two reasons.

---

[121] Faulk, 2005, 45
[122] Van den Berg, 1972, 46
[123] RRPI, §441
[124] Church, 2003, 175

First, both Church and Graham use it to express the congruency between the quality of emotion and perception, even though there can also be a disjunction between the two. Second, the structural relationship of emotion and perception implied in 'correspondence' presumes a (phenomenological) distinction between the two. Regarding the first concern, Graham uses Church's example of an Ingmar Bergman character in *Scenes from a Marriage* to depict this congruency between emotion and perception:

> [Mrs. Jacobi's] conscious Intentional states of depression, for example, were part of her experience of self and world – a self and world that had particular depressing qualities or objects for her and that, to use Church's apt term, corresponded to her depressed mood or feelings.[125]

While the depressive affect and objects of depressive perception can at times appear to take on the same qualities such as dull affect and the appearance of a dimly lit room, both Graham and Church overlook the disjunction that often occurs between the depressive affective state and her perceived surroundings. For example, pathological sadness does not always present with the appearance of a bleak and grey world. Sally Brampton recounts her experience of going out in public and finding that the features of things were accentuated rather than dulled. She writes, "The people in the supermarket look strange, as if they have been recast into bigger proportions, painted in stronger colours…and noise is overwhelming."[126] She experienced the disjunction between her withdrawn, isolated, and silent way of being with the busyness and liveliness of her surroundings. She

[125] Graham actually writes "Woolf's conscious Intentional states" rather than "Mrs. Jacobi." While Graham does discuss Virginia Woolf earlier in the book, this particular quote appears in the context of his reference to Church's description of the character Mrs. Jacobi. For that reason, I interpret this reference to "Woolf" instead of "Mrs. Jacobi" to be an oversight on the part of Graham and therefore put "Mrs. Jacobi" in brackets within the quote (Graham, The Disordered Mind: An Introduction to Philosophy of Mind and Mental Illness, 2010, 34).

[126] Brampton, 2008, 83

experienced friction between her affective state and her impression of the world around her rather than experiencing a congruency between them. This friction primarily arises from an affective, rather than an intellectual, disjunction for the depressive. The depressive's perception of the world as busy and lively, features at odds with her affective state, is experienced by the depressive as being threatening, invasive, and overwhelming. Due to the negative nature of the affective state, the depressive typically experiences the incongruency between her affective state and the perceived mood of her surroundings as being painful and unwanted. In Brampton's case, the perceived liveliness of her surroundings painfully contrasts with the sadness and emptiness of her depressed state.

The primary problem with the idea of a *correspondence* between affect and perception is the presumption of two distinct and separable acts. Both affect and perception are embodied, belong to the same organism, and operate in interconnected neural circuits. Merleau-Ponty notes that perception is "achieve[d] with our whole body all at once"[127] and that it "brings together our sensory experiences into a single world."[128] In everyday language, words like "feeling" and "sense" point to the blending of affect and perception. 'Feelings' can refer to bodily sensations, emotional states, or attitudes. 'Sense' can be used to indicate both an inclination and sensory perception at the same time (e.g. "I sense a storm is coming"). Concepts like proprioception, egoreception, and exteroception – perception of our bodies, our feelings, and our surroundings respectively – are used to differentiate among perceptions based on the directedness of perception. Nevertheless, these spheres of sensation and perception do not occur in isolation. If a

[127] Merleau-Ponty, 1992, 225
[128] Ibid, 230

branch pokes me in the eye, I immediately feel the sharp pain while at the same time I close and grab my eye, get angry, and think, "Where did that come from and how did I not see it?" Sensory-perception involves the bodily mechanisms through which we access the world and our place in it. Furthermore, how we act and react to stimuli and how we intellectually and physically process phenomena are essentially embedded in affect. Affect not only impacts how one sees something, it also participates in what one perceives and whether one perceives. For the depressive, her perception does not simply *correspond* to an emotional state; rather, she *sees-through* it.

Perception is not monolithic in how it functions for non-depressed as well as depressed individuals. Perception need not be only one kind of mental state. In some cases perception can be mediated by a particular reflective interpretation and in other situations it is pre-reflectively direct. Some perception is heavily weighted by affect, whereas at times special training can help tone down the role of feeling in perception. In addition, the quality and intensity of sensory perception can change in different social contexts and can be experienced differently based on different forms of life. For example, sometimes when I look at the Royal Poinciana tree in my yard I might see it *through* my nostalgia for the first time I visited the Florida Keys. Other times, I look at the tree and simply perceive "tree greenly." Yet frequently when I look at the tree I see it through my responsibility for fertilizing it and cleaning up the fallen twigs. As it is with perception in general, depressive perception is not monolithic and is impacted by feelings, concerns, habits, and so forth. The difference between depressive and non-depressive perception primarily lies with the quality and intensity of the affective dimension.

Attunement

The meaning and meaningfulness of phenomena are always *affected*, or to appeal to Heidegger, they are always *attuned*. Heidegger's conception of 'attunement' and 'mood' provides a way for understanding the phenomenological interconnection of perception and affect. Attunement refers to one's affective situatedness; how one is affectively *tuned in* to her environment. According to Heidegger, moods are not inner conditions that color an objectively given world and attunement does not manipulate what would be an otherwise *pure* perception of one's surroundings. Both understanding and perception are always attuned. Even the "purest *theōria*" is not exempt from affective attunement.[129] Attunement can be understood as an inconspicuous affective connection to our surroundings and the "background sense of belonging to a meaningful world."[130] Attunement is a matter of being *entangled* in the world. It not only provides the background for one's personal connection to her environment, it also provides the background for a social connection. Moods can have a social character and can be shared. Attunement is not solely a matter of *seeing-through*; it also involves *seeing-with* others.

While the idea of meaningfulness is understood in an everyday way as referring to something significant and important – something valued – meaning does not exclusively pertain to phenomena experienced as positive. Both the presence of negative affective states (e.g. grief) and the absence of positive affective states (e.g. happiness) also compose the background for signification. Mood participates in how phenomena are experienced. For instance, Heidegger points to fear as a precursor to encountering things

[129] Heidegger, Being and Time, 1996, 130
[130] Ratcliffe, 2010, 356

in the world as threatening. Alternatively, in grief one might experience things as fleeting and fragile, and in anger one might encounter things as problematic and infuriating. How we treat, respond to, and encounter things is *already* intertwined with mood and affect. On the other hand, sometimes one's encounter with things (as well as situations, people, ideas, etc.) can be an occasion to change one's mood or to become aware of one's mood. Heidegger notes that the ability for moods to "be spoiled and change" points to one's being "always already in a mood."[131] Person *A* can feel energetic and content but when her car fails to start she might become immediately frustrated and overwhelmed by the thought of being late to work. It is also possible that if Person *A* is energetic and content that she will respond to the broken-down car in a measured way rather than feeling upset and worried.

No simple formula such as *circumstances + personal history + temperament + form of life + whom one is with + neurological functioning = perception* can reflect or predict the way that perception, cognition, and affect are interrelated. For example, for some people an even-temper is cultivated through practice, meditation, therapy, etc. For other people an even-temper arises out of a habit of problem-solving and approaching circumstances in a reflective and rational way. Other people may simply have always felt even-tempered and easy going. Others might be even-tempered because of a philosophical and/or religious outlook: Person *B* might practice stoicism, Person *C* might focus on otherworldly and spiritual matters, and Person *D* might live by the motto "*c'est la vie.*" One can attempt to isolate and control certain conditions in order to determine

[131] Heidegger, Being and Time, 1996, 126

how a particular element might affect one's perception. However, one cannot be certain of how Person *A* will experience a broken-down car, not even Person *A.*

Despite the element of unpredictability and the heterogeneity of perception, I maintain that depression does constitute perception in particular ways. I claim that the phenomenal quality of depressives' experiences differs from non-depressives. Also, I assert that depressives experience objects, people, temporality, etc. in *this* way and not in *that* way. What then is the constant in depressive perception that is evidently absent in non-depressive perception? The constants are affective disconnection and affective disordering. Affective disconnection is primarily defined negatively, in terms of loss. The affective character of depressive perception is not homogenous among depressives and is not consistent throughout a depressive episode. For example, a lack of affective connection can present as a loss of interest, passion, focus, and so forth. The second constant in depressive perception, affective disordering, appeals to the abnormal intensity, duration, and directedness of depressive emotions. Affective disordering is defined in terms of a qualification of emotions rather than the particular type of emotions. For instance, depression is primarily experienced as deep and inexplicable grief for some depressives and free-floating and irrepressible anger for others. The common element between these two is not the actual emotion but, possibly among other things, the abnormal intensity and duration of the emotion, an emotion that may or may not have an intentional object.

While one's mood is usually inconspicuous, Ratcliffe points out that in depression mood becomes unavoidable and dominant.[132] Depression, however, is not itself a mood; rather, it is a condition characterized by deep and unassailable changes of mood. One does not simply go in and out of major depression as one can go in and out of a bad mood. A major depressive episode can span many months and even years, and even when a person is in recovery from depression, traces of the symptoms and experience of depression linger. Depression should not be confused with everyday ways of being attuned; it is a pervasive and destructive disruption of everyday attunement. Rather than being the background for signification, the disordered emotions of depression rip apart everyday meaning. Unlike depressed *feelings* which can temporarily alter perception and signification, a depressive *disorder* substantially disrupts one's way of living. In depression, who one is in the world changes and the world itself changes. As Wittgenstein remarks in the *Tractatus*, "The world of the happy man is a different one from that of the unhappy man."[133] For the depressive the world does not cooperate; it pushes back at every point.[134] It pushes back in the form of inertia and the depressive's inability to physically or mentally move about her environment with a sense of ease or familiarity. It pushes back in the form of sensory overload and the depressive's experience of her environment as overwhelming and threatening. Firsthand accounts of depression often describe feelings of drowning, suffocation, heaviness, and slow movement, which invoke the sense that the world is pushing down on the depressive. Suffocation and drowning are not mere metaphors for the depressive; depressives feel

[132] Ratcliffe, 2010, 357
[133] TLP, 6.43
[134] The nature of the intrapsychic conflict of the depressive will be discussed in Chapter 4.

tightness and pain in their chest and are often unable to breathe deeply. In major depression, a person cannot simply feel okay with her condition, because unlike a mood that one knows will eventually pass, the depressive does not have the benefit of seeing a way out of depression.[135]

There are fundamental differences between how the depressive and non-depressive *feel* the world. In fact, it is often the absence of feeling in association with one's environment that stands out to many depressives. As a loss of affective connection, depression is often experienced as fostering a sense of meaninglessness. For the depressive, "Everyday world-meaning is replaced by a radically altered relationship with the world, characterized by irrevocable alienation, despair, futility, guilt, and the like."[136] The things and beings in the depressive's environment can lose their significance and their context. The depressive can experience things, ideas, dreams, and people as meaningless. These elements of the depressive's environment have lost their relevance and signification in relation to her form of life prior to its disruption. While affective disconnection relates to the removal of emotive features, affective disordering often imbues things with a negative signification that was not prevalent prior to the depressive episode. These elements are not completely devoid of meaning, but the meanings are radically altered and sundered from their previous contexts, which leads to a *sense* of meaninglessness for the depressive.

[135] Depression and futurity will be discussed later in this chapter.
[136] Ratcliffe, 2010, 361

Spatiality

Non-depressive and depressive spatialization

Up to this point, I have made reference to the 'surrounding world' of the depressive, which refers to the depressive's sense of the things and beings, including herself, in her perceptible surroundings. 'Surrounding world' largely pertains to the spatialization of the depressive. In general, space is already occupied and defined by *my* body and other people, and our situatedness among objects and places. One's orientation to the spatiality of the surrounding world is in part a matter of one's sense of distance from and nearness to others and objects. Spatialized perception that has the character of distance and nearness reflects a person's pragmatic and affective *place* among the things and beings in the environment. We see, hear, and feel space as open, crowded, ordered, and natural. Spaces can be conquered, cleaned, and occupied. Wars have ignited over spaces. Spaces are divided, possessed, and hidden. Some spaces invoke fear, religious fervor, or hatred. We use spatial indicators to describe interpersonal relationships and the differences among beliefs, familial structures, social positions, and priorities. We talk of "personal spaces" and "comfort zones." "Space" is also used to reference the unknown, infinite, the *out-there* of the sky and unseen galaxies.

Like Merleau-Ponty, my interest is in *lived space* as it is inter-subjectively defined and structured. 'Lived space' refers to the phenomenal space of living sentient beings and is a "setting for co-existence."[137] Ultimately, spatiality is defined in terms of a

[137] Merleau-Ponty, 1992, 221

"double horizon of external and bodily space."[138] A person not only inhabits space, she also takes up space. Space is not simply out there; one is situated in space and space is defined in accordance with the phenomenal and 'virtual body.' Merleau-Ponty uses the idea of a 'virtual body' to denote the body's horizon of possible actions. A person's pre-reflective sense of her body's potential movements and limitations conditions her perception. Perception is a "way of giving form or structure to our environment" in terms of what we can and cannot do.[139] The double horizon – the horizon of one's environment and the horizon of one's body – is unified in the virtual body. It is this unification brought together by the realm of possible actions and interactions that constitutes the spatiality of the body.

While Merleau-Ponty focuses on the limitations and possibilities of the body's situatedness in lived space, the body is not the sole constraint on spatialization. Space is also opened up and closed off by events, social attitudes, and material conditions, to name a few. In addition to sensory perception, health, and illness – on which Merleau-Ponty focuses – the body also incorporates the normative constraints of possible actions and interactions. *My* environment is not only defined by *me*; it is shared. Perception is conditioned by the *virtual other* as well as the virtual body. One's pre-reflective and conscious sense of the possible actions of the people around one also conditions one's perception and spatiality.

Lived space is composed of places. Places are imbued with social meaning and personal value. Places mark the unfolding of events and are understood in terms of where things have happened and will happen. In *Being and Time,* Heidegger presents the idea of

[138] Merleau-Ponty, 1992, 101
[139] Ibid, 115

'having a place' as being interrelated with 'having a use.'[140] Similarly, Merleau-Ponty characterizes a phenomenal 'place' as it is "defined by its task and situation."[141] 'Place' signifies something more than location; it is situatedness within a person's intimate world. 'Having a place' indicates a structure of use that is not merely objective. It is *my* place and *their* place. Placement is a matter of belonging, both 'belonging *to*' and 'belonging *together with*.' According to this view, objects lose their *place* when they lose their utility. However, objects that fall into disrepair may lose their usefulness in their damaged state while still retaining their demand on a person and thus holding onto their *place*. For example, someone might send a television away for repair, but the credenza remains the *place* for the television. People, relationships, languages, ideas, dreams, and so forth can also become damaged, displaced, and be considered irrelevant from the perspective of particular individuals, communities, institutions, and cultural history. Yet places are created to house and protect, or confine and disregard, the un-useful. The culturally *useless* nevertheless make an ethical demand. As philosophers, I, along with many others, contend that we have an ethical imperative to ensure that people seen as un-useful from the perspective of society maintain a *place* in public discourse and policy. Depressives feel the effects of social displacement and feeling useless. Depression is even statistically conceived in terms of the average work and financial loss of depressed *workers*. As I discuss the phenomenal experience of the depressive, it is important to keep in mind the role that social attitudes and material conditions play in limiting the horizon of possibilities for depressives, which I will attend to in the next chapter.

[140] "…useful things are essentially installed, put in their place, set up, and put in order. Useful things have their *place*" (Heidegger, Being and Time, 1996, 95).
[141] Merleau-Ponty, 1992, 250

Depressive spatiality

The depressive's relation to her perceived environment changes in ways that are often devastating and painful. The altered spatialization of the depressive reflects and saturates the disrupted form of life and most closely connects with the depressive's withdrawal from social relations. The force of affective withdrawal and affective disorder overpowers the habits of a form of life and fosters a sense of detachment. When the depressive becomes estranged from intersubjective relations, she finds herself distant from the objects of her environment.[142] For both depressives and non-depressives, a person's relationship with the things around her is complexly infused with meaning, and the relationship between the individual and the things of her world is immersed in social signification. How one relates to objects belongs to how one relates to other people, perceives others to relate to objects, and perceives others relate to her. How the depressive takes to objects is a symptom and expression of her depression. When a patient complains about the strange appearance of objects, van den Berg interprets it to mean that the patient lacks the "right contacts with people."[143] The relationship between depressive withdrawal from other people and depressive estrangement from things should not be seen as a causal relationship. Things do not appear changed to the depressive *because* one's social relationships have changed; both one's perception and social relationships are altered because depression changes the way one thinks, feels, perceives, sees, listens, and participates. For example, while depressed, Martha Manning forced herself to read to her daughter at night, and her feeling of disconnection with reading

[142] The depressive's withdrawal and estrangement from others will be addressed at length in the next chapter.
[143] Van den Berg, 1972, 73

reinforced the feeling of detachment from her daughter. In this case, both Manning's relationship with books and her relationship with her daughter were caught up in a self-perpetuating downward spiral of depressive withdrawal.

The depressive's spatiality vacillates among different patterns of spatial orientation. In particular, the depressive's spatiality has characteristics common to the following patterns: 1. the shrinking of personal space, 2. the weight of space, 3. the unreality of the depressive's surroundings, and 4. the sense of distance from one's environment. These patterns are based on depressives' descriptions of how they experience spatial relations and need not be temporally distinct.

Depressives both describe their personal space as shrinking and seek to be situated in confined spaces. This dual movement of contraction can be seen in John Head's description of his experience in depression: "I had the sense that my personal space in the world was getting smaller, collapsing in on me. I was a sort of black hole. I needed no space."[144] Both the horizon of external space and the horizon of his bodily existence were experienced as disappearing. He makes the stark observation and claim that he "needed no space." Depression has so drastically limited his range of possible actions and interactions that his inert virtual body has rendered his phenomenal body non-existent. He no longer makes demands on the world and his sheer physical presence no longer even demands space. The metaphor he uses of a black hole aptly describes, albeit hyperbolically, the way that depression is experienced as collapsing lived space. The depressive feels life caving in on her and begins to operate in increasingly smaller spaces, both mentally and physically. Merleau-Ponty alludes to Cassirer's description of

[144] Head, 2004, 9

a patient for whom "life is enclosed in narrower limits, and, compared to the normal subject's perceived world, it moves in smaller and more restricted circles."[145] These restricted circles apply to one's body and the physical space that one inhabits, as well as one's cognitive, emotional, social, and behavioral life. Sylvia Plath captures this sense of limited space with the image of a bell jar: "…wherever I sat – on the deck of a ship or at a street café in Paris or Bangkok – I would be sitting under the same glass bell jar, stewing in my own sour air."[146]

The depressive physically recreates the feeling of isolation by limiting her movement and by limiting her contact with the outside world. The depressive not only feels the space around her drawing up, she also seeks out confined physical spaces, consciously or otherwise. Depressives often restrict themselves to their rooms and beds without venturing outside. Also, some curl into fetal positions as if to become physically smaller. Many depressives eat away at the size of their bodies through slumped posture and weight loss. People who are considered to be functional depressives also report stealing away to places such as the back seats of cars in order to cope with the mental pain of forced externalization.

The second pattern of spatialization involves the feeling of heaviness and weight. The pattern of heaviness points to the manner in which the depressive's materiality in space takes on a burdensome quality. Depressives often describe a sense of having a "leaden heaviness" internal to their bodies.[147] For example, Timothie Bright in *A Treatise*

[145] Merleau-Ponty, 1992, 192
[146] Plath, 2006, 185
[147] Fuchs, 2001, 183

of Melancholy (1586) depicts the heart of the melancholy person as being "overcome with inward heaviness."[148] Many depressives speak of feeling a weight bearing down on their limbs and chest from an undefined external pressure. Martha Manning characterizes depression as *tripling the force of gravity*, such that it "takes so much effort just to lift an arm or take a step."[149] Jeffrey Smith quotes Emily Dickinson's reference to this sensation as the 'Hour of Lead':

> But all this lead is not merely imaginary: these metaphors grow straight from the body. The melancholic's limbs feel weighted, blood and bone and muscle alike gone viscid with some invisible burden.[150]

Despite the *invisibility* of the burden, the weight is experienced as quite real and palpable. The horizon of lived space is not only shrinking for the depressive, the depressive also finds that her ability to maintain her place in a shared, lived space has become burdensome. As the depressive's possibilities become limited by depression, the depressive's body becomes more conspicuous to her. She feels the weight of herself. She feels herself taking up space. Simply existing feels heavy.

The third pattern of depressive spatiality involves the depressive's environment taking on an air of unreality. Wittgenstein mentions many people have noticed this sense of unreality emerging before the onset of mental illness. He writes, "Everything seems somehow not *real*; but not as if one *saw* things unclear or blurred; everything looks quite as usual."[151] One can recognize that one's surroundings have not changed and that one's vision is clear; nevertheless, everything appears unreal. The look of the depressive's

[148] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 125
[149] Manning, 1994, 104
[150] Smith, 1999, 72
[151] RPPI, §125

surroundings is dominated by the impression of unreality. While Wittgenstein notes that this impression sometimes precedes the onset of mental illness, depressives also refer to this sense of unreality as lingering throughout a depressive episode. Karen Armstrong describes her surroundings as taking on a "nightmarish unfamiliarity"[152] in her personal account of depression. In the essay "One Cheer for Melancholy," the writer Susanna Kaysen describes depression as a "trip to the country of nothingness." She writes that in this *country* "reality loses its substance and becomes ghostly, transparent, unbelievable…depressed people feel they aren't 'there.'"[153] 'There' refers to the space of shared reality, and the feeling of 'not being there' points to a recognition of one's position outside of it.

Depression erects a veil of unreality that creates a sense of distance, the fourth pattern of depressive spatiality. Unreality is experienced as a feeling of being out of place and being above or outside of oneself. Head explains:

> …there remained a sense of unreality about what was happening to me. Not that I imagined that the things transpiring in that office weren't truly taking place. Rather, I felt I was outside of what was happening, at a vantage point from which I could look down at myself.[154]

For Head it was as if he haunted places "instead of experiencing them."[155] The depressive loses touch with the things and beings in her environment, and lacks the wherewithal to take care of herself and care for the increasingly irrelevant things and beings of her world. Rather than being enveloped in a familiar nearness, the depressive's affective disconnection creates a sense of distance between the depressive and the world.

[152] Armstrong, 2004, 57
[153] Kaysen, 2002, 43
[154] Head, 2004, 43
[155] Ibid, 34

The shrinking of one's personal space, heaviness and unreality of one's surroundings, and distanciation all point to a general sense of being out of place and not fitting. When a person no longer sees an object as her own (whether as a possession and/or responsibility), she no longer takes to it in a caring manner. She no longer *cares* for it, and thus fails to *take care* of it. Because depression attacks one's ability to care, engage, and even need, one's nearness to the objects of one's world disintegrates and objects lose their usefulness. Books sit unread, desks collect dust, and assignments pile up. The structure of the relationships among 'place,' 'utility,' and 'care' do not fundamentally change in depression; what changes is the way the depressive takes to things. The depressed feels that neither the various things of her world, nor her own *being in the world*, have a 'place.'

Utility and a loss of usefulness do not characterize the depressive's dislocation in relation to all things, beings, and situations. Ratcliffe points out that "potential practical utility is not the only kind of significance that things have for us."[156] In particular, we relate to people and experiences as being significant in a variety of ways (e.g. as boring or threatening). Emotions open us up to many forms of signification, including negative ones (fear, grief, etc.). In some cases the depressive wants to be able to care for something or someone but is not able to because she experiences a collapse of the capacity to externalize and reach out. For example, some depressives describe having an abiding sense of duty to a son or daughter, yet depression disabled them emotionally and physically to the point that they neglected their children. Regarding spatiality, it is also not the case that the things in the depressive's environment uniformly lose their use and

[156] Ratcliffe, 2010, 355

place. In fact, depressives are often more drawn to some things during a depressive episode than they were drawn to those things prior to the onset of depression. Things can be suffused with a newfound sense of attachment and can function as instruments for coping with – and in some instances can become instruments for sustaining – the depressive cycle. In many of the memoirs on depression that I consider, writers speak of their dependence on particular items, such as a bed, alcohol, television, a bath tub, and so forth. Even in one's recovery from depression these items are perceived as *places* of depression and depressive *things*. Some of the writers also mention that when they were not in the grasp of a depressive episode, if they noticed an intensification of their desire for these depressive *things*, they would interpret their *turning towards* the *depressive thing* as a signal that they were entering into another depressive episode.

Temporality

Non-depressive and depressive temporalization

In the ordinary Western way of talking about time, we speak of *having* time, *wanting* time, *wasting* time, and *losing* time. We qualify time as *too much*, *not enough*, *long*, and *slow*. In other words, we see time in terms of when things happen and how long they last. Similar to the way that space is structured according to its usefulness and relevance to practices, temporality unfolds in its relation to events and activities. Everyday temporalization is a matter of participating in, planning, and remembering

activities and events in a given environment. Duration is measured in terms of the minutes, days, and years of a particular happening. Merleau-Ponty writes, "Time presupposes a view of time…It arises from *my* relation to things."[157] Merleau-Ponty privileges time as it is lived. He contends that one's experience unfolds as a given unity, not as a series of discreet moments. He explains:

> The synthesis of horizons is essentially a temporal process, which means, not that it is subject to time, nor that it is passive in relation to time, nor that it has to prevail over time, but that it merges with the very movement whereby time passes…all these perspectives together form a single temporal wave…I am present to my present, to all the preceding past and to a future.[158]

For Merleau-Ponty, time is a matter of one's co-existence. Temporality pertains to one's being present and things being present to one's perception. Our perception has this unified character because we inhabit a lived world as it is conditioned by our bodily, affective, social, and practical involvement with it. One's involvement in the world always depends on one's *inter*volvement with a past and a future. Merleau-Ponty claims that what we do and the decisions we make reflect a commitment to the future and a directedness towards our existence in the future. Who *I* am is matter of who *I* am becoming. Merleau-Ponty's focus on lived and embodied time allows for a prereflective *being present to* and within a world. Time is not simply consciously grasped; it is experienced by the body's habitual movements and perceptions. Nevertheless, for Merleau-Ponty the body's relation to what is presently given is always involved in the prereflective, as well as conscious, sense of *possible* actions and interactions; i.e. the *future*.

[157] Merleau-Ponty, 1992, 411-12
[158] Ibid, 330-331

An everyday practical orientation to time encompasses a host of often incongruent value systems, which in spite of their disparities typically have at their core a concern for the temporality of happenings, actions, and events. The measurement of time depends on values as much as it does on the instruments of measurement. Values of temporality can be expressed ethically, politically, and ontologically. An ontological valuation might privilege the unity of time. A political orientation to time might focus on historicity, and an ethical understanding of time might center on futurity. In the *Deconstruction of Time*, David Wood speaks to the interrelation of "temporal valuations" with "ways of thinking of and relating to time."[159] Time can be experienced in many different ways, and Wood points to the multiple pairs of contraries that make up the different kinds of time: "subjective/objective, existential/cosmic, qualitative/quantitative, time as experienced/time as measured, and so on."[160] These different kinds of time operate within different language games and have different rules of engagement.

Ultimately, time is intersubjective. The everyday use of time points to the temporalization of a form of life. How one experiences and understands time is structured according to shared practices. Bourdieu addresses the "social structuring of temporality" as a form of social synchronicity and conformity.[161] Social synchronicity begins, as Thomas Fuchs points out, at infancy and is manifested on a biological level.[162] From the classroom to the church bell, from daylight savings to the eight hour work day, from primetime to tornado sirens, *we* are thoroughly enmeshed in social rhythms. Keeping

[159] Wood, 2001, 141
[160] Ibid, 13
[161] Bourdieu, Structures and the habitus, 1977, 165
[162] Fuchs, 2001, 180

social order is, according to Bourdieu, "fundamentally a question of respecting rhythms, keeping pace, not falling out of line."[163] Nonconformity and social disorder are also characterized by temporal metaphors, such as *marching to the beat of his own drum* and *being out of synch.* However, the disruption of social rhythms is not confined to eccentric individuals; events can also have the effect of destabilizing social synchronicity.

While for the most part people operate in and according to the modes of temporality expressed in and through a form of life, individuals and social groups can encounter various types of jarring experiences that derail the prevailing orientation to time. There are a variety of phenomena that have overlapping features with depressive desynchronization, particularly experiences that take a person out of her everyday participation with her environment. For instance, certain mystical experiences can be categorized by what Fuchs labels an "asynchrony."[164] Mystical asceticism and meditation interrupt normal ways of experiencing, *sharing*, and *using* time. However, the individual's experience of a mystical "asynchrony" differs from depressive desynchronization. Some of the differences between the depressive's experience of time standing still and mystical meditation are that the experience for the depressive is not sought after, and it is painful and cognitively limiting. In a mystical or transcendental experience a person can feel like she is outside of time and tapped into the infinite. In depression, however, the depressive feels trapped in the present. Mystical desynchronization is experienced as liberating, whereas depressive desynchronization is experienced as oppressive. Both experiences lead to a desynchronization of social time,

[163] Bourdieu, Structures and the habitus, 1977, 161
[164] Fuchs, 2001, 181

yet mystical temporality transcends and overcomes one's entanglement in everyday ways of being tied down and affectively engaged in happenings. In contrast, the depressive does not *achieve* a sense of transcendence but *finds herself* confined to the present and unable to engage in lived time.

Depressive temporality

The changes to both temporality and spatiality in depression are interconnected with the depressive's social estrangement and alienation from a form of life.[165] As is the case with the depressive's altered spatial orientation, the depressive's temporalization can be interpreted according to a few dominant patterns. The alteration of the depressive's temporality hinges on two key temporal elements: the passage of time and the directedness of time. This section will demonstrate how the depressed individual's lack of engagement with her environment is echoed in the sense of time standing still and the impression that death is both ever-present and yet beyond one's reach.

Omnipresence of the present

In *Black Sun*, Kristeva blends psychoanalytic theory, therapeutic practice, and poetic self-narrative in her examination of melancholia. She describes depressives as

[165] The relationship between depressive desynchronization and depressive withdrawal is not a causal one and neither one should be understood as grounding the other one.

having a "skewed sense" of time that is warped by a bloated and sorrow-filled present and cut off from the future. In Kristeva's words, time

> …does not pass by, the before/after notion does not rule it, does not direct it from a past toward a goal. Massive, weighty, doubtless traumatic because laden with too much sorrow[166]…a *moment* blocks the horizon of depressive temporality or rather removes any horizon, any perspective.[167]

Kristeva paints a picture of the depressed individual being confined to the moment and not being directed towards a future. According to Kristeva, time does not move through the depressive because the depressive is overwhelmed by sorrow. Jeffrey Smith refers to this experience of constrained time in depression as an "endless loop of now."[168] For the depressive, the present moment can feel heavy and unyielding. The pain of depression repeats itself endlessly throughout the day, such that each moment feels like a repetition of the same. The affective life of the depressive constrains her sense of movement and becoming, and the present becomes affectively omnipresent. Sorrow disrupts the temporal horizons of *having been* and *moving towards*. The depressive moment is a time without change, movement, or relief; that is, a time without a future.

Similar to Kristeva, Merleau-Ponty highlights the feeling of time as an unmovable present in his discussion of a young girl with hysterical symptoms. He writes, "For the patient, nothing further happens, nothing assumes meaning and form in life, or more

---

[166] In addition to describing the moment as "laden with too much sorrow," Kristeva also remarks, "or too much joy." This excessive joy of the moment seems to fit a picture of mania and refers to what Kristeva points out as the nostalgia for "lost time" and the "maternal object." This description is not congruent with the first-person accounts of depressive experience that I survey in this dissertation. It does, however, reflect Kay Redfield Jamison's account of manic-depression. Jamison shows that in mania one becomes obsessed with the present without regard for the future.

[167] Kristeva, 1989, 60

[168] Smith, 1999, 21

precisely there occurs only a recurrent and always identical 'now.'"[169] In this brief description, Merleau-Ponty touches on the collapse of both the past and the future into a present that lacks meaning. The mention of "nothing further happens" is an indication of life coming to a halt. The idea that "nothing assumes meaning and form" represents the disruption of the patient's life as structured by a meaningful past. The depressive disengages from the practices that make spaces and things meaningful and relevant. To be depressed is to be functionally uninvited, never in the *right* place, never in the *right* time, and always *off*. Thomas Fuchs explains melancholia as a form of desynchronization that leads to the "break-down of coherence and resonance with his environment."[170] The depressive is out of synch with the temporality of the social environment and no longer answers to the same clock. Brampton describes losing the meaning of time and trying to "remember what ten in the morning means, how it feels."[171] In "Melancholy Man," Samuel Butler writes, "His Sleeps and his Wakings are so much the same, that he knows not how to distinguish them."[172] Different times of day and days of the week are no longer broken down into activities or plans. There is no *dinner time* or *weekend*. There is no *date night* or *me time*. There is no *time off* or *clocking in*. For the depressive, time primarily becomes something to *use up* and *get through*. Yalom writes that for his patients, "'Passing time' became a conscious and serious proposition" and something to get "over with as painlessly as possible."[173]

[169] Merleau-Ponty, 1992, 164
[170] Fuchs, 2001, 183
[171] Brampton, 2008, 29
[172] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 158-9
[173] Yalom, 1980, 114

The depressive is no longer *directed towards* a horizon that gives meaning to the present moment. The weight of the moment, according to Kristeva removes "any perspective."[174] Blocked from the future, the depressed is cut off from meaningful repetition. While the past might provide the conditions for meaning, the future provides the possibility of relevance. Binswanger explains that when existence "'is cut off from the future,' the world in which it exists sinks into insignificance, loses its character of relevance, and becomes nonreferential."[175] For a person who is not directed towards the future, meaningfulness cannot take hold. While time is a precondition for a meaningful and intelligible world, the desynchronization of the depressive is not the cause of her estrangement from meaning. Depressive temporality unfolds along with and because of affective disordering and affective disconnection.

How one measures and deals with *duration* shifts in a depressive episode. The depressive merely *endures* time, and the experience of depression is often *unendurable*. Fuchs characterizes the slowing down of temporal movement as a "time dilation," and he says that depressives "estimate time intervals to be longer than the actual objectively measured time."[176] This time dilation can be seen in the descriptions that depressives give about how they experience the passage of time. Manning describes her experience of enduring her depressive days: "I never knew the days could stretch out so endlessly. Stretch so far I think they'll break, but they only heave and sag. The weight of them bears down on me mercilessly."[177] In Brampton's words, time moves "like treacle, running

[174] Kristeva, 1989, 60
[175] Binswanger, 1958, 305
[176] Fuchs, 2001, 184
[177] Manning, 1994, 98

thick and heavy through my days."[178] Even though many depressives have the experience of not being able to feel time moving along at a normal speed and cannot conceive of a time outside of the present pain, they nevertheless continue to have a *sense* of time. With the heavy knowledge of *no end in sight*, time becomes the enemy. Recognizing the unendurability of time in depression, Terrie Williams recalls thinking "Tomorrow? Tomorrow was a million years from now. I wasn't going to make it to the next hour, forget about tomorrow!"[179] Days "sag" in depression because time is no longer the staging of activities; rather, it is the unfolding expanse of mental pain and pain keeps one wedded to the present.

In depression time appears to mirror the weariness of the depressive's body. Deceleration of motor functioning commonly accompanies depression. For example, one woman recalled watching her depressed friend crossing a parking lot in such a slow manner that she wondered if her friend would ever make it to the other side. The temporality of the depressive becomes, in Merleau-Ponty's words, "arrested in a bodily symptom."[180] In depression, the bodily symptoms take over one's experience and inhibit one's ability to experience anything other than the symptoms. Consider the feeling of burning your finger on the stove. At that moment nothing else matters. You are neither reflecting on the past nor planning for the future. You are caught in the immediate act of tending to the pain. Pain has the effect of stopping time and it can prevent one from moving around, socializing, and working. It can stifle one's ability to concentrate, sleep, and eat. Pain can inhibit happiness and induce despair. Mental pain in depression also

[178] Brampton, 2008, 26
[179] Williams, 2008, xxiv
[180] Merleau-Ponty, 1992, 164

functions in this way. In addition to being *in* pain, the depressive also lives with the feeling that somehow *she* is the source of her pain. Mental pain is directed at one's self and one's very existence in the world, which qualitatively deepens the inescapable presence of pain.

In one sense, the depressive's lack of futurity originates in an enervated imagination. The depressive appears to be unable to *imagine* a place or time free of debilitating mental pain and isolation. She is unable to think beyond the present moment and to transcend the pain through an ability to conceive of a future different from the present. In severe moments of major depression, the depressive's consciousness and imagination become enslaved by affective disordering and affective disconnection. With affective disordering, negative emotions and mental pain can overwhelm the depressive's ability to intellectually anticipate a future and can constrain the depressive's prereflective and conscious sense of her possibilities. The depressive's affective disconnection leads to resignation and an inability to commit to the future. Being cut off from the future is experienced as an inability to anticipate situations, make plans, and count on things to happen. The depressed individual becomes an unwitting skeptic for whom past empirical conditions are no longer sufficient grounds for securing the expectation of future repetition. While the depressive can remember a past before depression, at times the severity of the moment obstructs the depressive's memory of a time before pain. It is not that the depressive doubts the possibility of a past or a future different from the present, but the severity of the depressive 'now' impedes the cognitive *move towards* a future, the *move outward*, and the *move away from herself*.

A living-death

The depressive is often unable to be *directed-towards-the-future.* While at first glance *not-being-directed-towards-a-future* appears to have the same existential structure as *being-directed-towards-death*, a closer look at the depressive's constrained temporality reveals that the depressive's experience of *not-being-directed-towards-a-future* has a different phenomenal character from the experience of *being-directed-towards-death* for non-depressives. Also, *being-directed-towards-death* for non-depressives has a different relation to meaning than the depressive's lack of futurity. The anticipation of death for a non-depressive typically alters one's sense of significance, relevance, and one's perspective. For instance, the prospect of dying for some people heightens a sense of self and significance, whereas for others it obstructs meaning. Even for the person who is near death, it is not essential to her temporalization that the present moment blocks a sense of being *directed towards*. In the process of dying one can maintain a sense of being *directed towards* - towards others, towards a cause, towards a legacy, towards an afterlife, and even towards one's own demise. Unlike a lack of futurity, death always looms in the future; it has no 'now.' From a psychological standpoint – as opposed to an ontological perspective – the impending loss of life is not necessarily bound up with a loss of futurity. Being directed-towards-a-future is not merely a directedness of one's self towards one's own personal future. Being directed-towards-a-future is a way of being, an attitude, and an expression of one's relatedness to others. People in the process of dying or in anticipation of death make all sorts of plans for a time that will occur after their death. One can even face one's own demise with a sense of hope – a hope based in progeny, legacy, or faith, for example. If it is possible for one to face the end of one's life

with hope, and if *being-near-death* can entail being directed towards a future, what makes depressive temporalization hopeless and what brings about the depressive's loss of futurity?

In part, the hopelessness of depressive temporalization stems from the depressive's premature loss of self.[181] According to Binswanger, in depression the world becomes "nonreferential," and the person "no longer finds anything there from which and by which it could understand itself."[182] Another way to say that the world becomes nonreferential is to say that the world of the depressive loses its reference point. A loss of self is a loss of self-referentiality and a loss of agential vitality. Rollo May speaks to the idea of a lack of futurity as a missing axis for self-understanding: "Personality can be understood only as we see it on a trajectory toward its future; a man can understand himself only as he projects himself forward."[183] One's orientation to one's surroundings is mutually situated with one's understanding of oneself, and a disrupted temporalization feeds the cycle of a disrupted form of life and a loss of self.

The depressive's lack of being-directed-towards-the-future fosters inertia and blocks hope for change. Kierkegaard's melancholy aesthete in *Either/Or* describes the inertia that affects both one's sense of time and one's sense of self. He writes, "Time stands still, and I with it."[184] If time "stands still," then time is nothing and nowhere, in which case *I* too have no place. The stillness and nothingness of the depressive is

[181] A loss of self is not unique to depression, but it is at the heart of depressive temporalization. The first part of Chapter 4 is dedicated to this problem of the depressive's loss of self.
[182] Binswanger, 1958, 305
[183] May, 1958, 69
[184] Kierkegaard, 1959, 25

characterized by Kristeva as a "living death."[185] The depressive *lives* a living-death and experiences life as though she were outside of it, watching her lifeless body moving among the living. A living-death is akin to the experience that Binswanger's patient described as "being like a corpse among people."[186] This idea of a living-death haunts writings on melancholy throughout history. Hildegard of Bingen (ca. 1151-58 C.E.) claims that melancholy "neither completely kills nor fully empowers, just as happens to a prisoner who is neither killed nor set free."[187] Kristeva points out that in the *Inferno* the punishment of the melancholy godless sect is to have "no hope of death."[188] Similarly, Timothie Burton writes that people with melancholy "cannot dye, they will not live."[189] Teresa of Avila describes melancholy as being even worse than death. She writes:

> …in the case of other illnesses it happens that either one is cured or one dies; with this illness, very seldom are the afflicted cured, nor do they die from it but they come to lose their minds completely…They suffer more than death..."[190]

Death sits at the center of the depressive's disrupted form of life, not as an end but as a way of *living*.

A living-death gives the depressive, in Jamison's words, a premature experience of "*how it must be to be old, to be old and sick, to be dying; slow of mind*."[191] Despite her rapid aging, the depressive, unlike the non-depressive, does not experience time as moving quickly. The depressive, unlike the aging non-depressive, does not function in

[185] Kristeva, 1989, 4
[186] Binswanger, 1958, 263
[187] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 82
[188] Kristeva, 1989, 8
[189] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 144
[190] Ibid, 112
[191] Jamison, 1996, 217

terms of how little time she has left. Aging and the prospect of death typically set up time as the enemy. The adversarial role between time and aging plays out in what is perceived to be (by non-depressives) the limited nature of time. Regarding a person who glimpses his own mortality, Camus writes: "He admits that he stands at a certain point on a curve that he acknowledges having to travel to its end. He belongs to time, and by the horror that seizes him, he recognizes his worst enemy."[192] Time is also the enemy of the depressive; however, this antagonism springs from the depressive's sense of time's expanse rather than its scarcity.

The depressive's proximity to death is multidimensional and her experience of death functions in many different ways throughout the course of depression. The depressive *lives* in close relation to death and with an ever-present awareness of her finitude. She also *lives* with the relentless presence of the possibility of suicide. The depressive can *live* with the urgent desire for death, while nevertheless fearing her own longing for it. Galen (ca. 165 C.E.) points out that those afflicted with *black bile* (*melaina chole*) appear "quite bizarre" because they both "dread death and desire to die at the same time."[193] On one level, depressive withdrawal can be seen as the response to a profound fear of death. The depressed individual might withdraw from life in order to escape death (consciously and/or unconsciously). Karl Abraham claims that "Every neurotic state of depression…contains a tendency to deny life,"[194] and to deny life is to deny the possibility of dying. From the perspective of the depressive experience, the consoling thought of death does not stem from a life-denying drive, self-hatred, or hatred of the

[192] Camus, 1991, 13-14
[193] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 68
[194] Abraham, 1985, 31

introjected other. Rather, death is seen as relief from and an end to the living-death of depression.[195] Manning explains: "I don't want to die because I hate myself. I want to die because, on some level, I love myself enough to have compassion for this suffering and to want to see it end."[196] In Manning's case, fear is directed towards life, not death. A living-death is fundamentally a prolonged separation from others and the feeling of *not being at home* in life. Karl Abraham recounted a suicidal manic-depressive patient who would often mumble to himself, "I do not belong to the world."[197] As Abraham noted, the patient "felt non-existent," and the weight of this feeling can be more terrifying than the thought of not existing after death.[198]

Although it might seem counter-intuitive, death can appear to the depressed as a resolution of isolation. Death resolves isolation not simply by *putting an end* to it; it can also be viewed as a form of *being together with* non-being. John Bentley Mays wrote in his journal that death would bring about a "*union of unestranged reality*," whereas his life was dominated by an estrangement from reality.[199] Similarly, Kristeva accounts for melancholy as a longing for non-being – a return to the womb, the chora – and a desire for undifferentiated oneness.[200] Death can appear to the depressive as complete *integration* with the oceanic and a complete stasis.

---

[195] Freud explains depression in terms of an introjected hatred of the other turned to hatred of the self. Similarly, Kristeva describes depression and suicide as a killing of oneself in order to avoid killing one's mother.
[196] Manning, 1994, 99
[197] Abraham, 1985, 34
[198] Ibid
[199] Mays, 1995, 6
[200] The chora is the already existing, the archaic space/non-space not yet touched by the Father, form, or the ego.

The experience of a protracted closeness to and awareness of death is bound up with the depressive's perception of time moving dreadfully slowly. Whether a depressive returns to a normal sense of time depends on the individual's ability to recover from depression or the individual's decision to *put an end to time* through suicide. At some point in a depressive episode, most depressives face the critical question of whether life is worth living. Describing the difference between his awareness of death before and during depression, William Styron writes:

> The difference now was in the sure understanding that tomorrow, when the pain descended once more, or the tomorrow after that – certainly on some not-too-distant tomorrow – I would be forced to judge that life was not worth living and thereby answer, for myself at least, the fundamental question of philosophy.[201]

Styron alludes to the oft-quoted passage from the *Myth of Sisyphus* in which Camus expresses the urgency and significance of the problem of suicide.[202] Although it might be a fundamental question of philosophy, to opt for or against suicide is not necessarily to give an answer to this question. Suicide is a way of making something happen and breaking the stalemate; it is an act against the power of time and an assertion of one's attempt to control it. Yet, suicide is the "definitive act"[203] that makes *nothing* happen for whoever chooses it. When the depressive reaches *bedrock*, so to speak, she faces the choice of how she will ultimately *deal with* time, which is simply another way of saying she faces the choice of how she will deal with life and death. Camus explains: "The mind, when it reaches its limits, must make a judgment and choose its conclusions. This is

[201] Styron, 1992, 28
[202] "There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy…. I therefore conclude that the meaning of life is the most urgent of questions" (Camus, 1991, 3-4).
[203] Ibid, 1991, 3

where suicide and the reply stand."[204] In one sense, suicide is only able to answer the question of whether one *can* live *now*. With suicide the possibility of answering the question of whether life is worth living is foreclosed.

Conclusion

Depressive perception and desynchronization belong to an overall pattern of depressive withdrawal. Disengagement from practices, affective disconnection, and affective disordering are all intricately intertwined with the depressive's experience and perception of her surroundings. The alterations that take place in depression, such as the feeling of the unreality of one's physical space, the unfamiliarity of objects, and the lack of futurity are symptomatic of depressive disengagement. By looking at the expressions of depressed individuals' experience of time, in particular the lack of futurity, one gains insight into the depressive's diminished capacity to communicate and her loss of self. The depressive's inability to be *directed towards* and to be *together with* is experienced and expressed as social, affective, cognitive, and biological withdrawal. Depressive isolation is not, however, an *act* of withdrawal; the depressive does not make a conscious choice to block out the shared reality of the community around her. A prolonged estrangement from the social and natural environment can lead the depressive to commit the ultimate *act* of separating herself entirely from the world by taking her life from it. The depressive can also *fight* depression. She can attempt to resist its grasp by avoiding certain

[204] Camus, 1991, 27

behaviors, ways of thinking, and social situations. Medication and psychotherapy are ways of countering depression.

Depressive temporality centers on the present, but as depression persists the depressive can experience stages of depression. An individual does not experience depression as a consistent whole. One cannot slice open depression, as it were, and find that all of its features are identical through the duration of an episode. The depressive experiences a shift in her sense of self and also her sense of depression. While this chapter briefly touched on the intrapsychic and intersubjective nature of depressive spatialization and temporalization, in the next chapter I will investigate the depressive's altered orientation to herself and other people.

CHAPTER IV

ALTERED SENSE OF SELF AND DISRUPTED RELATIONALITY

Introduction

This chapter focuses on depressive agency, the depressive's sense of self, personal identity, and social relationality.[205] The symptoms of depression lead to a loss of self and social withdrawal, and function as a constraint on agency. In Part I of this chapter, "The Sense of Self and Depression," I introduce the main philosophical concepts and problems that emerge with the ideas of agency and depression, and address the distinctions between non-pathological plurality and the fracturing of personal identity in depression. In this section I also address the intrapsychic perspective of the self in depression and how one's sense of self in relation to depression changes throughout a depressive episode. In Part II, "Depression and Sociality," I transition from the personal to the interpersonal perspective of the relational self in depression. The fact that the first section focuses on intrapsychic phenomena and the second on interpersonal relations does not reflect a metaphysical or psychological priority or division between an *inner* and *outer* 'self.'

[205] While 'identity' and 'sense of self' are overlapping concepts, I use 'identity' to highlight the interconnection of one's social identifications with one's sense of one's personal traits and personality.

Part I, "Sense of Self and Depression," is divided into two sections: "Loss of Self" and "Depressive Identification." In "Loss of Self" I offer a heuristically structured developmental model of the depressive's 'loss of self' and the emergence of an altered self. These stages reflect the depressive's general developmental process of coping with her depressive identity. I contend that the developmental structure of the depressive self challenges prevailing philosophical and folk ideas about the self as unified, and argue that a theory of identity as multifarious can help clarify the relationship between depression and identity. The reader should not interpret the stages of development that I put forth in this chapter as either necessary or uniform in their duration, order of appearance, and experiential content. In addition, I conceive of the stages of depression as often overlapping. The stages that I call "Loss of Self" and "Depressive Identification" are not discrete psychological spheres. The depressive can experience one or more stage concurrently and an individual can stall at any developmental stage. The depressive's ability to move through the various stages largely depends on the social environment in which she lives and whether she knows about and/or has access to therapeutic intervention. A depressed individual can experience many of the developmental stages discussed in this chapter without identifying herself as 'depressed.' However, once the depressive identifies her disordered experience as 'severe depression,' the depressive's experience, as well as how she frames her experience, does change. While identification with the category 'major depression' *necessarily* alters one's experience of depression, one's experience of herself and her disorder can be altered by other means. Depending primarily on one's social support systems, the depressive can come to see her

identification with depression (as ‘depression’) as having a deleterious or therapeutic effect on her ability to cope and recover.

In the first stage, “Loss of Self,” I address the alterations to identity in depression, which begin with the depressive’s recognition that she no longer *feels the same* and develop into the acceptance that she no longer *is the same*. “Loss of Self” is further divided into the following phases: “Loss of *Me*,” “Intrapsychic Conflict,” “Depression Embodied,” and “Disrupted Cognitive Attachments.” “Loss of *Me*” addresses questions about the continuity and multiplicity of personal identity as it develops in and through depression, a process which directly impacts one’s sense of self and engagement in the world. “Intrapsychic Conflict” deals with the tension that emerges from the presence of new feelings, thoughts, and habits, along with the loss of familiar modes of being, acting, and perceiving. “Depression Embodied” concerns the physical alterations that accompany depression and the role of mental and somatic pain in the depressive’s sense of self. Finally, “Disrupted Cognitive Attachments” pertains to the general loss of interest in and connection to one’s values, and addresses the problem of moral motivation and altered cognitive commitments in depression. Bear in mind that the four phases of this stage are divided for heuristic purposes and are not based on temporal priority.

I call the second stage “Depressive Identification.” In this stage, the depressive confronts the identification of her experience as ‘severe depression’ and can come to see depression as an integral part of who she is. “Depressive Identification” has two key patterns: “Identifying ‘Depression’” and “Identification *with* Depression.” While I previously mentioned that the order of the stages is not essential, one could say that the

pattern that I label "Identifying 'Depression'" occurs temporally prior to "Identification *with* Depression." Nevertheless, these two patterns emerge as two sides of the same developmental process in which the identification of depression provides both a name for and an explanation of the depressive's experience. The section "Identifying 'Depression'" specifically addresses the process of identifying one's depressive experience as 'clinical depression' and the ways in which a theory of 'depression' alters one's depressive experience. "Identification *with* Depression" focuses on the individual's assimilation of the depressive position into one's sense of self.

In Part Two, "Depression and Sociality," I explore the relationality of the depressive in terms of withdrawal, and address the social and juridical structures of depression that often marginalize the depressive individual from her social environment. In the final part of this chapter I briefly look at the overlapping categories of race, sex, gender, and class and how they shape the interpretation, recognition, and embodiment of depression. While race, gender, sex, and class do not comprise an exhaustive list of the social identities that shape the experience of depression, they are the most frequently researched in what is a generally underdeveloped field of study – the social determinants of major depression.

Part One: Sense of self and depression

Illness and identity

The depressive condition impresses upon its sufferers questions about personal identity: "What has happened to me?" "Why can't I do *this* anymore?" "Why am I no longer like I used to be?" In *Shoot the Damn Dog*, Sally Brampton asks, "Who are you when you are no longer who you are? What do you do with a self that is no longer your self?"[206] These types of questions contribute to the common characterization of depression as an existential illness. However, depression is not unique in its existential content. David Karp, a professor of sociology at Boston College, describes depression, "like other life altering illnesses," as being "characterized by critical turning points in identity."[207] The uniqueness of depression is not that it gives rise to existential quandaries, but that in depression the trauma is *in* and *to* the 'self' *itself.*[208] Depression attacks what it is to have agency and be a self. It limits one's ability to function and act, understand and perceive, relate and respond to, and connect with oneself and one's environment. Depression profoundly disrupts a person's sense of self, sense of value, and sense of self-control. It can deeply dislodge one's identifications with other people, with one's occupation, with a previously valued skill or talent, and with a passion or drive. Disrupted identifications, along with a conglomerate of depressive symptoms, have the

[206] Brampton, 2008, 93-4
[207] Karp, 1996, 15
[208] I am operating with both an expansive and practical sense of trauma, which spans from personal physical trauma (bodily injuries) to traumatic events (which can include physical trauma). Depression as trauma refers to psychic trauma not (necessarily) induced by exogenous threats.

effect of dismantling one's sense of self. While one might argue that trauma in and to the self is a common feature of all mental illnesses, in depression (as opposed to psychosis, mania, and schizoid disorders) the person typically remains acutely aware of her alteration during the depressive episode and actively feels the loss of self. Similar to the way that a neurotoxin that can paralyze a person's body without disrupting consciousness, in depression the individual usually can see and feel the changes taking place, yet feels impotent to change their course.

Depression gives rise to questions about how depression is experienced at the level of the individual and how it should be conceptualized. Because depression affects the self, the lines between depression as an illness and depression as a form of identity can easily become blurred. In the essay "Prozac Americans: Depression, Identity, and Selfhood," Abigail Cheever asks whether depression should be conceptualized in terms of an 'illness' or 'identity.' This question comes from her reading of William Styron's memoir on depression and his description of depression as a debilitating illness. Cheever focuses on one metaphor that Styron uses after he publicly revealed his struggle with depression. Styron describes feeling as though he "helped unlock a closet from which many souls were eager to come out."[209] Cheever claims that the juxtaposition of the metaphor of "coming out of the closet" and the designation of depression as an 'illness' in Styron's writing points to an ambiguity at the core of cultural ideas about depression. However, she misreads Styron's metaphor as a comparison of depression to homosexuality. Styron does not liken depression to homosexuality itself; rather, he only borrows the metaphor of self-unveiling – *coming out of the closet* – to highlight the

[209] Cheever, 2000, 346

experience of revealing culturally stigmatized and censored aspects of oneself. She then uses this mistakenly framed comparison between depression and homosexuality as a launching pad for claiming that Americans increasingly view depression as a category of identity.[210] While she does correctly identify an uncertainty about the depressive experience, she misdiagnoses it as a contradiction in need of resolution. Cheever writes:

> *Darkness Visible* represents depression as simultaneously an illness and an identity; it is at once a disease – like cancer – foreign to the individual and invasive of the self, and a way of life – like homosexuality – both essential and constitutive of one's being.[211]

Cheever conceives of identity and illness in terms of an *either/or* and claims to diagnose Styron's characterization of illness and identity as a *both/and*. This simplification overlooks the complexity of the interconnectedness of personal identity with depression.

In the context of a conversation about the label "illness" assigned to depression, Andrew Solomon writes, "There is an apparent paradox here that points to existential questions about what constitutes the person and what constitute his afflictions."[212] While one might be able to theoretically distinguish the features that constitute identity from the features that constitute illness and treat these two sets of features separately, the depressive does not necessarily experience these features as distinct. In depression, symptoms change the scope and nature of agency. This illness-constrained agency often merges with one's identity and sense of self. Generally the types of alterations that the body undergoes in illness (especially in severe illnesses) can dislodge certain ways of living. Illnesses, and injures for that matter, often force a person to adapt to new

[210] Cheever, 2000, 364
[211] Ibid, 347
[212] Solomon, 2002, 399

conditions and adopt new habits. Illness can also prompt self-reflection and questioning, which lead to a reevaluation of beliefs, values, habits, and relationships. In this way, illness can be the occasion for reassessing and retooling one's personal identity. Illnesses that specifically impair and alter mental functioning can directly impact features that seem to be at the core of personal identity, in particular personality, humor, taste, spirituality, memory, temperament, and motivation. Mental illnesses can induce immediate alterations of personal identity that are not mediated by personal reflection, choice, and/or pragmatic coping. As van den Berg remarks, "A person whose brain suffers is different *himself*...there is nothing, really, that is not changed."[213] Major depression changes who a person is. It affects how others perceive the depressive and how she views herself. Depression can change behavior, desires, and ways of thinking and it can also change how one relates to others and her environment. Depression can fundamentally alter – and undermine – one's identifications and sense of self.

Depressives typically speak of the alterations of personal identity that take place in depression in terms of a "loss of self" rather than a *transformation* of self. A transformation or alteration implies the emergence of something new; however, in a depressive episode depression is experienced as destruction and disruption – a going under without overcoming. Many depressives speak of their lives before depression as if they belonged to someone else. Writers of depression memoirs sometimes speak of their past selves in the third person, implying a discontinuity of one's self before, during, and after depression. More often than not, however, the depressive maintains the "self" as grammatically continuous but psychically disconnected. The depressive's disrupted sense

[213] Van den Berg, 1972, 49

of self leads to a semantically complicated usage of 'I', 'me', and 'self'. Take for example the claim "I no longer recognize myself." Who is the *I* that becomes reflectively distinct from *myself*? Also if *myself* is no longer recognizable, from what agency does the act of recognition take place? The "*I"* in "I no longer recognize myself" suggests that *I* can both see *myself* now as unrecognizable and remember what *I* now recognize as having been *myself*. *I* am separated from both *myself* as it appears to *me* now and *myself* as *I* have understood *myself* to be in the past; yet there persists this 'I' capable of adjudicating between the recognizable and unfamiliar selves. The 'I' points to the persistence of some degree of agency, however tenuous, amid the experience of psychological discontinuity.

The nature of this tension among the selves in and out of, and before and after depression is primarily a matter of affective disconnection and disordering. The idea that I can no longer recognize myself in depression does not point to a cognitive failure or a disruption of consciousness. In fact, it is in part the persistence of consciousness and memory that makes it possible for the depressive to recognize a loss. The depressive's claim "I no longer recognize myself," is akin to the fact that in depression *I* no longer perceive, feel, think about, and value things the way *I* used to.

The depressive's loss of self is fostered by and fosters desynchronization. Typically, the question "Who am I?" also involves the questions "Who *was* I?" and "Who *can* I be?" The question "Who *can* I be?" mostly depends on the parameters of possibility established in and through a form of life. Depression does not only limit possibilities, it also erects new ones. The depressive horizon is redefined in terms of

death, pain, loss, failure, loneliness, and fatigue. In an in-depth study of fifty people diagnosed with depression, Prof. Karp received a letter from one participant who gave the following description of depression: *"Depression steals away whoever you were, prevents you from seeing who you might someday be, and replaces your life with a black hole."*[214] Confronted with a new life, a different way of seeing, a different body, diminished agency, and a different future, the traditional existential question "Who am I?" can morph into "Is *this* me?" Kay Redfield Jamison asks, "*Which of the me's is me?"*[215] The depressive faces the seemingly impossible task of reconciling the depressive self with both the memory of herself prior to depression and an altered sense of possibility for her future. Due in part to the discontinuity with her past and the absence of a sense of *moving towards* the future, the depressive fails to see herself as being *fully there*.

To overcome the false binarism that juxtaposes illness with identity, we need a theory of the self that allows for alterations, disruptions, loss, and change – a theory that does not pathologize multiplicity, yet one that recognizes that a plurality of selves can in fact be symptomatic of a pathological condition. While fractured identity accompanies major depression, it does not follow that every instance of fractured identity indicates some form of pathology. A plurality of identity can arise in different ways and often reflects a tension and discontinuity with regards to who one is at different points in time and also who one is among different social and natural environments. This inner-conflict is typically rooted in the lives of people who operate within conflicting forms of life

[214] Karp, 1996 24
[215] Jamison, 1996, 68

and/or in ways that conflict with one's form of life. For example, Gloria Anzaldúa points to the *mestiza* as having a "dual or multiple personality" that "is plagued by psychic restlessness."[216] The *mestiza* has to negotiate between at least two different narratives of history, values, style, and self-worth, which can create competing images of who she sees herself to be. She straddles at least two worlds in which she can feel like two different people; meanwhile, she may never fully identify with either one. The general difference between pathological plurality and non-pathological plurality is that pathological plurality either belongs to a condition or is itself the condition that a) substantially interferes with a person's ability to function, b) causes harm to oneself and/or others, and c) cannot be remedied simply through a change of environment alone.[217]

Despite discontinuity and inner-struggle, whether pathological or not, a person typically refers to herself in the first person singular. For instance, *I* maintain the use of "I" and continue to refer to "myself." Conflicting personalities and discontinuous identities are still embodied in *my* body, *my* memory, and belong to *my* agency. The Argentinean philosopher María Lugones affirms the complicated plurality of personal identity as it is constituted differently in different 'worlds' and addresses the persistence of the 'first person.' She writes:

> The experience is one of having memory of oneself as different without any underlying 'I'…I say 'That's *me* in that 'world'' *not* because I recognize myself in that person. Rather that person may be very different from myself in this 'world' and yet I can say *without inference* 'That's me.' I may well recognize that that person has abilities that I do not have and yet the having or not having of the abilities is always an 'I have…' and 'I do not have…,' i.e., it is always

[216] Anzaldúa, 1990, 377

[217] My assessment of the distinction between pathological and non-pathological plurality is neither definitive nor exhaustive. Also how one defines the idea of an 'ability to function,' what one believes should constitute 'harm,' and what comprises a 'change of environment' will vary.

experienced in the first person.[218]

The grammatical persistence of "I" and "myself" need not rely on a substantialist account of the self, but can emerge from a messy continuity made possible in part through memory, practices, and the body. The structure of experience as being in the first person does in fact underlie the disparate ways of being in different 'worlds' and of being more than *one* self.

Even if one's identity prior to depression is characterized by tension, confusion, and multiplicity, depression has a way of collapsing one's identities into a singular loss. Depression does not, however, exclusively emerge in individuals either with or without a fragmented sense of self. For some people, depression disrupts a sense of self characterized by wholeness and continuity, whereas for others, depression disrupts an already fragmented sense of self. Regardless of the continuity of identity or lack thereof felt by a person prior to the onset of depression, neither the diversity nor homogeneity of personal identity can predict or defend against the disruption that a person experiences in depression. The structure of the loss of self and the various components of a disrupted form of life can be experienced potently by both a non-white lesbian immigrant and a middle-class white man living in the United States. Depression is disruptive of personal identity regardless of one's prior identifications.

In this chapter I propose that one can conceptualize a way of coping with a disrupted form of life in depression by looking to a theory of identity that embraces difference, development, and change, such as José Medina's thesis of 'the polyphony of

[218] Lugones, 1990, 396

identity.'[219] Rather than appealing to a model of identity that promotes "a very demanding ideal of unity and harmony," Medina's polyphonic model asserts that "the tensions, conflicts, and division's in one's identity are not necessarily pathological and can be fruitful and healthy aspects of the self."[220] It might at first appear contradictory that I would embrace a model that *de*-pathologizes intrapsychic conflict given that I am appealing to a non-reductive medical model of depression that views major depression as pathological. However, Medina criticizes the idea that intrapsychic conflict is intrinsically pathological, which is not the same as claiming that no psychological pathologies contribute to intrapsychic conflict. A disrupted and disharmonious form of life is not intrinsically psychologically destructive and does not necessarily emerge from or develop into pathological mental states. Inner-conflict and tension can in fact promote psychological well-being, and a fragmented identity can foster a habit of adaptability necessary for thriving in unstable environments. On the other hand, theories of identity that promote unity and harmony can actually threaten one's ability to cope with and understand the losses and changes to one's sense of self and identity. A theory of polyphonic identity provides the hermeneutic space for self-loss and the emergence of a changed sense of self.

Part of the function of this chapter is to show that the problem of depression and identity need not be conceived in terms of an either/or. By showing that the depressive's sense of self in depression has a developmental structure, one can see how illness *and* identity are neither static concepts nor contradictories. Despite my insistence on the

[219] Medina, Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency, 2006
[220] Ibid, 75

dissolution of both the binary of illness and identity and the conceptualization of selfhood as continuous, at times it might be therapeutically advantageous for the depressive to experience depression and identity as an 'either/or.' Likewise, it could be pragmatic for the depressive to ask: "Is this experience an expression of my identity or a symptom of an illness?" However, this is a question that should be asked in terms of therapeutic value, not ontological veracity. In other words, at certain stages of depression it might be therapeutically valuable for the depressive to interpret depression as an illness rather than an integral part of her personal identity. Likewise, an individual might at some point benefit from seeing depression as part of who she has become. However, the value of these approaches should be worked out in a clinical setting.

Loss of Self

In this section I will give an expanded account of the developmental stages of the depressed individual's experience of herself in depression. I begin by looking at the depressive's awareness of a loss of self and how she perceives and understands (or fails to understand) the changes taking place. I propose that a loss of self in depression issues from the loss of an affective connection with a form of life, as well as the emergence of unfamiliar patterns of behavior, thinking, and feeling. That the loss of self is necessarily interconnected with the disrupted form of life does not mean that I conceive of the self and form of life as identical.

It is important to note that not all depressives report this disjunction between a self prior to and in depression. In fact, for some people the realization that they suffer from depression helps explain certain aspects of their childhood, which are consistent with an ongoing depressive behavior rather than discrete depressive episodes. Other people report a combination of these experiences, having both a distinct image of their selves prior to depression and having the ability to still see various characteristics and experiences that occurred prior to an episode of severe depression that appear typical of a depressive disorder. In this section, I focus on depressives who report a loss of self in depression – which anecdotally appears to be the typical experience of depressives.

Loss of 'me'

After a quadruple bypass surgery and subsequent decent into depression, Larry McMurtry, a prolific fiction writer and author of the Pulitzer Prize winning *Lonesome Dove* emerged from surgery in a deep depression. He describes feeling that his *self* actually died on the operating table because of the depression that ensued after the surgery. McMurtry explains:

> From being a living person with a distinct personality I began to feel more or less like an outline of that person – and then even the outline began to fade, erased by what had happened inside. I felt as if I was vanishing – or more accurately, *had* vanished…the self that I had once been had lost its life.[221]

If one retains the problematic view of identity as intrinsically unified, then McMurtry's claim to have outlived his *self* would appear logically impossible. According to this view,

[221] McMurtry, 2002, 69

McMurtry's claim could only be accounted for by an error in judgment. Yet even if we reject substantialist accounts of subjectivity and accept the polyphony thesis, how can we make sense of the experience of self-loss? After all, McMurtry does not speak of self discontinuity, fracturing, or transformation. He does not say that his *old* self died and a *new* self emerged; rather, he asserts "I felt as if I was vanishing." Furthermore, a multiplicity of selves cannot guard against the feeling of self-loss. It is not as if a person accustomed to inner-diversity experiences self-loss in depression as just one lost self among many – all the *me's* get lost in depression. Affective disconnection and affective disordering pervade all modes of being because depression threatens agency, not just a *sense of self*.

One could attempt to circumvent the problematic nature of an assertion of self-loss by denying the fact that the description of self-loss or self-death is in fact assertorial. One could categorize "self-loss" as a metaphorical expression, which necessarily lacks a truth condition. Similarly, one could say that the 'self' of 'self-loss' is a metonym of a conglomerate of discrete disruptions to one's cognitive and affective capabilities. In this case, "self-loss" *stands in* for lost linguistic confidence, lost capabilities, lost relationships, lost convictions, and lost familiarity. In *Silencing the Self: Women and Depression*, Dana Jack Crowley makes the point that a "loss of self becomes a verbal shorthand that conveys a number of things."[222] However, depressives suggest that they have lost more than a collection of particular attributes. Also, the metaphorical style of speaking about a loss of self is an attempt to articulate a fundamental and *real* disjunction between the pre-depressive and depressive selves.

[222] Jack, 1993, 32-3

If we take the depressive's statement of 'loss of self' literally and accept that she does in fact experience an actual loss of self, then how are we to account for this loss? McMurtry provides a possible clue in the connection he makes between "being a living person" with having a "distinct personality." While 'personality' does not have as much metaphysical baggage as 'the self,' the substitution of 'personality' for 'self' does not dissolve the main philosophical problems. The use of 'personality' does give the impression of resolving the question of how one can maintain self-awareness: "*I am aware that I have lost my personality*" seems less problematic than "*I am aware that I have lost my* '*self.*'" 'Personality' appears to circumvent the problems of distinguishing between 'I,' 'me,' 'myself,' 'self,' 'self-consciousness,' and so forth. However, once we proceed to define 'personality,' account for its relation to the 'I,' and how it interconnects with self-consciousness, we discover that we really have not resolved any problems, only postponed them by shuffling them around.

Depression threatens both the *sense of self* – how one experiences herself and her relation to the social and natural environment – and the *sense of being a self* – one's agency in the world. In the first case, 'loss of self' is a statement that belongs to a self-narrative. It is temporally situated in particular narratives through which one views her past and envisions her future. Depressives retain an image of the self that pre-existed depression and speak of missing their old self and longing for its return. One can find examples of this nostalgia for the pre-depressive self in the following accounts: Jeffery Smith writes: "My 'me' was gone, and I wanted it back."[223] In "The Case of Ellen West," Binswanger describes Ellen as feeling "merely 'how low she has sunk'…from that which

[223] Smith, 1999, 2

formerly she really was."[224] In *The Deepest Blue,* Dockett interviews a woman who describes the desire of wanting "to go back" to her life before depression. [225] It is important to understand that the loss of a sense of self in depression is felt as a real loss and that depressives grieve over their lost self. Sally Brampton writes, "I was lost and that loss was catastrophic."[226] Similarly, Kay Redfield Jamison expresses, "In my case, I had a horrible sense of loss for who I had been and where I had been."[227] 'Loss of self' is not simply a description of an inner state; it also pertains to damaged relationships. 'Loss of self' speaks to the depressive's altered relationship with her surroundings.

In the second form of self-loss, the '*I*' itself is called into question. At times depressives describe self-loss as feeling like being in a vacuum, or famously a 'bell jar,'[228] in which one disinterestedly watches one's movements in the world from a distance. As mentioned in Chapter 3, depression in this case is associated with a living-death and nothingness. The 'I' is no longer desiring, hoping, thinking, feeling, and imagining. The 'I' is cognitively and affectively disconnected from itself, other people, and its surroundings. The 'I' is absorbed by physical and mental pain and rendered silent, inert, and withdrawn. Both manifestations of self-loss typically merge into a phase of intra-psychic conflict in which the depressive experiences the loss of self as being accompanied by the appearance of new and undesirable features. Depressives describe experiencing sudden, overwhelming feelings of grief, anger, and anxiety. Also, they recount situations in which they harm themselves or want to harm themselves. In these

[224] Binswanger, 1958, 254
[225] Dockett, 2001, 17
[226] Brampton, 2008, 93-4
[227] Jamison, 1996, 91
[228] Plath, 2006

instances the self is lost and replaced by an unfamiliar, terrifying force. In other words, the lost self is supplanted by an unfamiliar agency that often acts in defiance of one's desires. In the *Noonday Demon* a young depressed woman named Laura speaks about this inner-conflict: "I miss the Laura who would have loved to put on her bathing suit and lie in the sun today…She has been plucked out of me by an evil witch and replaced by a horrid girl!"[229] What these different types of experiences and feelings suggest is that a loss of self can feel like an absence, as well as the presence of a 'foreign invader.'

Intrapsychic Conflict

Depressives often give fluctuating accounts of the origins of depression. At times the depressive describes it as descending from outside of herself and at other times as emerging from an agency within herself. Depressives have described the onset of depression as a 'looming dark cloud in the horizon' and an 'evil welling up within one's mind.' Within a single depressive episode, the depressive can both identify with depression and see depression as an outside force. For example, Kay Jamison Redfield speaks to the ambiguous nature of the source of depression: "However lodged within my mind and soul the darkness became, it almost always seemed an outside force that was at war with my natural self."[230] The image of an "outside force" dwelling in her "mind and soul" reveals the contradiction of depression as both familiar and unfamiliar, and both external and internal to oneself.

[229] Solomon, 2002, 96
[230] Jamison, 1996, 15

In the essay, "My Symptoms, Myself: Reading Mental Illness Memoirs for Identity Assumptions," Jennifer Radden addresses the contradictory ways depressive's symptoms are depicted in depression memoirs. She asserts that some writers describe mental illness "as emanating from alien, sometimes diabolical, sources of agency outside the self, while in others, narrators 'identify with' their symptoms as closely as they do their other experiential states."[231] While she has touched upon an important dichotomy that often exists in the depressives' understanding of the origination of depression, she makes two problematic assumptions about these differences: 1) she presumes, through omission, that they do not occur within a single individual, and 2) excludes the possibility that they can happen both retrospectively and in the episode itself. Radden accounts for the depressives' contradictory explanations of the source of their symptoms by appealing to the changes that take place in retrospection in the depressives' recovery from depression. She claims:

> Retrospectively, the person restored to his earlier personality and agent patterns, or something close to them, often regards the changes wrought in him during a past manic or depressed episode not simply as unsought, unwelcome, and unnatural but as alien.[232]

While Radden explains the apparent narrative conflicts and contradictions by appealing to the passage of time and retrospective framing of one's experiences, it is my view that this conflict emerges as an active tension with the depressive episode. The depressive *lives* the conflict. She is pulled between the poles of identification and disidentification with depression. Depression is both herself and not herself. One way of understanding the

[231] Radden, Moody Minds Distempered: Essays on Melancholy and Depression, 2009, 169
[232] Radden, The Philosophy of Psychiatry, a Companion, 2004, 139

distinction that I am drawing between Radden's view and my own is by appealing to Wood's conceptualization of 'pluridimensionality.'[233] According to Wood, because identity and experience are multidimensional, conflicting terms and conditions can be co-present within a single person. It is not conceptually problematic for the depressive to simultaneously experience depression as both emanating from an "alien" source and emerging from within herself. A view of selfhood as pluridimensional reveals the multiple levels of experience and explanations, which does not, however, relieve the feeling of inner-conflict.

In the discussion on the variations found in first person accounts of depression's origins, it is important to keep in mind the status that these descriptions have for the depressive. Depressives frequently use the rather unclear concept 'sense' to refer to their disposition towards an experience. They speak of a *sense* of loss, a *sense* of a foreign presence, a *sense* of time standing still, etc. This use of 'sense' should not be mistaken with 'explanation' or even 'interpretation.' *Sense* pertains to an affect laden impression that coalesces into an imprecise thought. While *sense* contains cognitive as well as affective elements, it represents something less well-defined than an explanation. That is not to say that interpretation and explanation are not at play in the depressive's use of 'sense,' nevertheless, *sense* is vaguer than the beliefs and opinions operative in an interpretative framework. Despite the vagueness of *sense*, it is experienced as a strong and pervasive hybridization of both feelings and impressions. Depressives describe the sense that unfamiliar emotions and thoughts are arising from nowhere in particular and simply emerging from somewhere out there. It is at this stage that the depressive feels as

[233] See: Wood, 2001

though depression originates from a foreign agent. I emphasize *feeling* and *sense* here because the depressive does not *assert* or even *believe* that her distress comes from an external agent, rather she feels *as though* it does.

Even though contemporary Western theories of depression tend to avoid a spiritualized explanation of depression, depression has historically been linked with demon possession. It appears to be the case that this *sense* of being possessed has outlived its spiritual explanation and persists in present-day accounts of depression. The depressive can still *feel* possessed and yet not have a way to account for the agency (e.g. demonic agency) responsible for the feeling of possession. The depressive's sense of being taken over by an alien presence is a feeling largely related to losing control, which contributes to the overall feeling of self-*dis*possession. This feeling of being invaded or possessed often arises during the depressive's bouts of uncontrollable crying and rage, and can also manifest itself in the sudden appearance of the desire to harm oneself. The depressive feels *as though* these unwelcome and unfamiliar feelings are from an alien source, although the depressive does not ascribe the feelings to the presence of an actual alien. That is not to say that the sense of an unfamiliar agency in depression points to a purely metaphorical dimension. The depressive can actually feel something akin to demon possession and mind control, yet never come to the conclusion that a foreign agent has literally invaded her mind. The loss of control and sense of unfamiliar agency in depression should not be confused with mental disorders involving psychosis and delusional states. For example, 'thought-insertion' in schizophrenia refers to the attribution of thoughts to someone else: "Persons who experience inserted thoughts…believe that *another* person's or agent's thoughts somehow have been inserted

or engendered into their mind or stream of consciousness."[234] The difference here lies in the individual's mental disposition towards the experience; the person suffering from schizophrenia *believes* that the thoughts of a foreign agent are actually lodged in her own thoughts, whereas the depressive *feels as though* an external force has taken control of her mind.[235]

In the essay "Corporealized and Disembodied Minds," Thomas Fuchs contrasts schizophrenia with depression on this point of agential confusion and also contrasts the phenomenal character of the body in schizophrenia and depression. Fuchs argues that schizophrenia takes the pathological form of "disembodiment" while depression is a disorder of "corporealization."[236] The individual with schizophrenia, he contends, experiences a breakdown between the agencies of the self and others, and fails to locate the sources of her own movements, sensations, and thoughts. In contrast, the depressive primarily experiences an oppressive embodiment, in as much as her body becomes an obstacle that interferes with her ability to act and interact with her environment. Fuchs notes that only in "extreme cases" does the depressive experience a detachment from her own body and agency. He argues that depressive disembodiment (what is akin to what I am calling 'depressive *dis*-possession') is the exception to the rule of depressive corporealization and schizoid disembodiment. However, in the sampling of narratives and firsthand accounts of depression that I have used, the disembodied experience of the depressive and sense of an alien agency are actually common among cases of severe

[234] Graham, Self-Ascription: Thought Insertion, 2004, 90
[235] The 'as-though' structure that I use should not be confused with the 'as-if' structure of self-other mimesis articulated in Fuchs' *Corporealized and Disembodied Minds* (2005).
[236] Fuchs, Corporealized and Disembodied Minds: A Phenomenological View of the Body in Melancholia and Schizophrenia, June 2005

depression. While it is not evident in firsthand accounts, the stage of 'depressive *dis*possession' might be shown to be more prevalent when the depressive is being treated with antidepressant medication. One could imagine that antidepressant medication's effective relief of somatic symptoms might also lessen the constraining force of the body on agency, which creates a sense of detachment from one's body.

At this point it is important to distinguish between two forms of depressive *dis*possession, (both of which are distinct from the loss of self discussed in the first part of this section). On one side, the depressive feels the presence of an alien agency, and the other side the depressive feels a detachment from her own agency and body. The first form of *dis*possession is characterized as an active and violent conflict, while the second resembles a passive, detached observation. In the introduction to *Black Sun: Depression and Melancholia*, Kristeva poetically depicts what I refer to as the first form of depressive *dis*possession. She describes the suffering and alienation rife in depression as emerging from an alien agency. In her description of the unknown origins of depression, she rhetorically asks, "Where does this black sun come from? Out of what eerie galaxy do its invisible, lethargic rays reach me, pinning me down to the ground, to my bed, compelling me to silence, to renunciation?"[237] The "black sun" in this passage represents both the darkness and raging fire endemic to depression and illustrates the simultaneity of loss and possession, i.e. *dis*possession. Kristeva characterizes depression as unearthly and emanating from an "eerie galaxy," which suggests an entirely alien origination and an unknown life-form that disrupts one's familiar form of life. While a form of life represents familiarity, order, meaningfulness, collaborative action, and norms of

[237] Kristeva, 1989, 3

sociability, depression incites confusion, anxiety, fear, meaninglessness, loss, alienation, disordered moods, and speechlessness. The depressive does not feel that such alarming unfamiliarity and profound negativity can emerge from within oneself.

As depression progresses, the unidirectionality of self-loss develops into inner-multiplicity and conflict. Despite the fact that depression is clinically characterized as unipolar – in contrast to the bipolarity of manic and depressive states of bipolar disorder – depression is quite conflictual in nature. While depressive people are often depicted as dormant and docile in their sadness, the outward appearance of a tired and haggard recluse conceals the mental torment and struggle the depressive experiences. In contrast to the outward appearance of passivity, depressives frequently use the imagery of war, conflict, and fire to describe their experience. Depressives portray depression as a battle waged in one's mind, in one's body, and even between one's mind and body. For example, Jamison describes her illness as a "war that I waged against myself."[238] This imagery of strife and internal conflict speaks to the depressive's resistance to and fear of depression. Solomon describes the confusing way that both the depressive self and non-depressive self can operate within oneself and struggle against each other:

> Every morning starts off with that breathless uncertainty about who I am…It's as if my self turned around and spit at me and said, don't push it, don't count on me for much…But then who is it who resists the madness or is pained by it? Who is it who is spit at?"[239]

The depressive can come to see the depression as a part of her own agency and yet still see this depressive power as an oppressive and unyielding source of mental pain and

[238] Jamison, 1996, 6
[239] Solomon, 2002, 81

suffering. Karp describes this struggle in terms of his mind being pitted against his body: "As I saw it, my mind made a choice each day about how to torment my body."[240] Even for the people who express having periods of remission and relief from depression continue to characterize the intrapsychic conflict as an unwinnable battle. For example, Brampton writes, "All I know was that I had fought my head for a year, and I had lost."[241]

Many depressives use expressions such as "losing my mind," "going over the edge," and/or "slipping into madness." The verb tense of these expressions indicates a present and ongoing action, unlike the previously addressed 'loss of self,' which speaks to the feeling of self-loss as a completed action. While the substantives "mind," "edge," and "madness" denote a break with normal mental functioning and familiar emotional patterns, the expressions "going over the edge" or "losing one's mind" should not be conceived exclusively or primarily in terms of cognition. An inexplicable and sudden onslaught of emotions such as deep grief or penetrating anger contributes and belongs to the depressive's sense of losing her mind. While some types of depression present with psychotic features according to the DSM-IV, the DSM-IV does not note the fact that even the severely depressed who are not clinically characterized by the presence of psychotic features often experience this *slippage into madness*.

It should come as no surprise that the disruption of a form of life accompanies and contributes to the feeling of 'losing one's mind.' One could say that "to be at odds with one's form of life is to *feel* mad, and to be at odds with other people's form of life is

[240] Karp, 1996, 7
[241] Brampton, 2008, 9

to be *labeled* 'mad.'" Consider the similarity between the orienting function that a parent and a form of life play. The mother (parent or guardian) serves as the primary liaison between the infant and the world. In most scenarios the guardian protects the child from the chaos of a not-yet ordered and not-yet familiar world. A form of life serves a similar function; it guides, familiarizes, and orders the happenings and surroundings of everyday living. If a mother walks down a street holding her child's hand and the child becomes separated from her, within a matter of seconds the child will begin to panic. Similar to the lost child, when the depressive is stripped of the familiarity of a way of living she finds herself out of synch, utterly aware of danger, fearful of her environment, wildly sad, panicky, unable to communicate, and unable to discern meaningful sounds – in other words, *slipping into madness*. A form of life, like the guardian, does not represent bliss and satiation of all desires. Just as an infant frequently screams in the arms of her caregiver, an individual securely operating in a form of life will still experience pain, confusion, doubt, unfulfilled desires, and bad moods. The mother and the form of life are forms of protection and order, but not always successful at preventing or mitigating problems. Regardless of the imperfections inherent in the organic nature of the form of life, a sudden loss or radical disruption of the form of life, especially a disruption that occurs without a discernible cause as it does with endogenous depression, can create the feeling of madness.

Depression does not always present as a raging fire and tumultuous battle. In the second form of depressive *dis*possession, the depressive's experience of herself and her environment is characterized by disconnection and detachment. The conflict at the heart of disconnection is that the depressive can feel separate from herself like a disinterested

observer, *there but not there*. Depressive disconnection is expressed in some depressive's inability to remember events that took place during depression. This experience of separation differs from the feelings associated with self-loss. The sensation of disconnection typically expresses itself in terms of disinterestedness rather than grief. Depressives can even appear to other people as being functional all the while feeling profoundly disconnected from themselves and their world. This affective disconnection can pose a greater danger to the depressive than palpable inner-conflict. In moments of self-separation, the depressive often calmly and quietly engages in self-destructive behaviors. For example, Styron recounts watching himself with "mingled terror and fascination" as he made the necessary plans to commit suicide. [242] He describes this experience in terms of being "accompanied by a second self." This idea of a "second self" should not be confused with Anzaldúa's discussion of multiple personalities or even the idea of a foreign agency that I alluded to earlier. What Styron and others refer to with the image of a "second self" is a feeling of separation between consciousness and agency. The "second self" is phenomenologically closer to what people call "out of body experiences" than multiple personalities. John Head describes this feeling of disconnection in terms of a haunting: "I haunted places I went, instead of experiencing them. I was there, but I wasn't there."[243] The poet Chase Twichell speaks of the experience of being "slightly behind myself, like a shadow, a sensation I used to call 'the eyes behind the eyes.'"[244] Sally Brampton describes feeling like she was part of a scene from a play. She writes, "I could not say that I was even engaged enough to be watching

[242] Styron, 1992, 64-5
[243] Head, 2004, 34
[244] Twichell, 2002, 22

it."[245] The tension at this stage of depression is not expressed in terms of competing desires, goals, comfort levels, personalities, habits, and the like; the friction occurs between the depressive's functioning in the world and how she consciously apprehends it. Despite the disembodied experience of this stage of depression, in the next section I will discuss how depression remains a deeply physical disorder with diverse somatic symptoms

Depression Embodied

Depression not only changes one's sense of self, it also changes the body. More precisely, depression is a change within the body that directly impinges on the self. What might be taken as overtly psychological or overtly physical symptoms and/or causes are far less distinguishable than they might appear. The DSM-IV speaks to the fact that the label "*mental* disorder" can misleadingly imply the absence of a physical dimension to the disorder:

> …the term *mental disorder* unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental disorders' and much 'mental' in 'physical disorders.'[246]

While it remains unclear whether exclusively physiological events can cause severe depression, or whether primarily psychological alterations can trigger the physiological changes endemic to depression – or some combination of the two – it is widely held that depression is both deeply physiological and psychological in both its symptomatology

[245] Brampton, 2008, 66
[246] Gert, 2004, 416

and progression. Writing about depression, Walter Glannon asserts that the "mental and the physical are not independent categories, but two interdependent aspects of one biological system of a human organism interacting with the environment."[247] The neurological changes to the limbic system that occur in depression, for instance, are projected throughout the body and affect emotions, libido, memory, appetite, sensory perception, and motor function, all of which are crucial to self-preservation. Depressives report a wide array of physical symptoms ranging from heart pain to chronic sore throat. Van den Berg's depressed patient "was continually aware of his heart, and he had to keep his hand on his chest to make sure that no abnormalities occurred."[248] Also it is not uncommon for the depressive to experience overtly physical symptoms prior to noticing the psychological ones. People often seek treatment for fatigue, sleep disorders, and digestive disturbances before they become aware of the psychological symptoms. Nevertheless, depression is characterized as a 'mental disorder.'

Many depressives express the desire to have an illness that looks and sounds more like an illness that is understood as and realized in terms of a physical phenomenon (e.g. cancer, heart disease, or a brain tumor) rather than a mental one. The character in Sylvia Plath's *The Bell Jar* exclaims, "if only something were wrong with my body it would be fine, I would rather have anything wrong with my body than something wrong with my head."[249] Andrew Solomon concludes, through his research and his own experience with depression, that the desire for a "more visible illness" was "commonplace among

[247] Glannon, Depression as a Mind-Body Problem, 2002, 246
[248] Van den Berg, 1972, 6
[249] Plath, 2006, 182

depressives."[250] He points out the fact that some depressives go so far as to "engage in forms of self-mutilation to bring the physical state in line with the mental."[251] In depression the body does not always show its illness to other people – no broken bones, skin lesions, or hair loss. Depression usually shows itself in the form of subtle postures, slow movements, and sagging facial features. Unlike someone with a cast or crutches, depressives often find that they have to convince others (including doctors) of the fact that they are in pain. Widespread misdiagnosis and dismissal often take place in the doctor's office, particularly for non-white patients.[252] At times, depressives have to convince employers or loved one's that they really cannot *physically* go to work or get out of bed. Thus, the depressive faces not only mental and somatic pain, but also the pain of social stigma and suspicion.[253]

The primary characteristic of both the so-called 'mental' and 'physical' symptoms of depression is the unyielding presence of pain. Pain is typically seen as an immediate response to damaging stimuli and appears to exemplify a relatively clear-cut cause and

---

[250] Solomon, 2002, 71
[251] Ibid
[252] See: Williams, 2008. I will speak at greater length on the underdiagnosis of depression in African Americans in Part II of this chapter.
[253] The characterization of an illness as 'mental' for some people can increase a sense of personal blame, failure, and weakness. The marginalizing and moralization of mental illnesses – due in part to the skepticism surrounding the claim that depression is a medical condition, cultural stigma about mental illnesses, and philosophical and religious beliefs about the role of personal responsibility in controlling one's emotions – largely play into the painfulness of the diagnosis of depression that some people experience. There tends to be widespread agreement among medical professionals and lay people that an illness such as cancer is in fact a medical condition with visible medical signs. However, no medical test can show definitively that a person has severe depression. In addition, books on popular psychology, various celebrities and public figures, life-style magazines, and the like, attack the medicalization of depression and deride people for using antidepressant medication. Cultural stigma also surrounds the label 'mentally ill' and this designation conjures up negative images of insane asylums and deranged and disruptive eccentrics. In Part II: *Depression and Sociality*, I will speak in greater detail about diagnosis as interpellation and social the structuring of depression.

effect process. It can be said of most people that they: a) experience pain (with the exception of those with neurological disorders), b) have relatively similar pain-behaviors (within a particular social-environment), and c) are able to verbally communicate the experience with others (who share a common language). Also it is generally the case that one can rely on the observation of another person's behavior to determine whether she is experiencing pain. Folk psychology need not consult systematic clinical trials to determine the fact that people tend to respond to stubbing their toes by yelling, gasping, whimpering, or cursing. Pain typically appears to be non-reducible and experienced as a simple; *it is what it is*. If I ask someone if she is in pain, I would expect her to be able to answer "yes" or "no." If she responds by saying "I am not sure" or "It is possible," then I would rightly surmise that she does not grasp the question (or that she had an overly nuanced understanding of what it is to be in pain). Despite the seeming straightforward nature of pain and pain behavior, 'pain' does not refer to a uniformly experienced or uniformly generated state.

In the mid-twentieth century a group of surgeons performing prefrontal lobotomies appeared to relieve the symptoms of individuals suffering from intractable pain. The surgeons operated with the assumption that severing the axons connecting higher order cortical areas with pain receptors could inhibit an individual's ability to experience pain. After the surgery, patients appeared calm, relaxed, and pain-free. However, it came to be known that the patients did in fact continue to feel pain, but they simply, in one patient's words, "didn't care."[254] If something like the ability for a person to care about pain can affect the experience of pain, then how should we account for the

[254] Norden, 2007, 69

relationship between one's cognitive and affective states with the experience of pain? In addition, given the depressive's affective disconnection, what function(s) does pain have in depression? Pain has an affective and cognitive value for humans, aside from the sheer pain-sensation. It is plausible that depressives experience the cognitive and affective features of pain without necessarily experiencing the sensation of pain issuing from a nociceptive response to harmful (internal or external) stimuli. Although depressives do experience locatable somatic symptoms throughout the body – such as lower back pain, headaches, digestive problems, and a tight chest – the depressive's experience of pain does not always refer to a locatable pain-sensation. For the most part, depressives tend to feel pain diffusely throughout their body and primarily speak of having pain in their *mind*. Familiar qualities associated with physical pain, such as being dull or sharp, throbbing or unyielding, and relatively locatable,[255] tend not to apply to mental pain. Mental pain in part indicates painful affective states, such as grief and despair. However, mental pain is not quite *just* grief, *just* hopelessness, or *just* sadness; it is more than each of these and yet it is not simply all of these combined. Psychic pain not only expresses itself in terms of emotion, it also refers to cognitive distress. With thoughts of suicide and self-destruction, for example, the thoughts themselves can *feel* painful and exhausting. Yet how do we *feel* a thought? This question is wrongly stated, for the depressive does not feel her thoughts, she feels pain accompanying her thoughts. Ultimately, 'mental pain' signifies the diffuse intermingling of amorphous, negative, and painful affective and cognitive states.

[255] For example, one may not know which organ a pain belongs to but nevertheless knows that it is in her right side and not her left.

The label "clinical depression" gives cohesion to otherwise disparate symptoms, but the diffuseness of depression can often make it unrecognizable as such. In one sense, somatic symptoms lose their self-evidentiary status in depression: lower back pain, stomach ache, fatigue, sore throat, stiff joints, etc. can all be an *expression* of depression. On one level, when the depressive complains of lower back pain, we have indeed hit explanatory bedrock. Whether the pain is a somatosensory percept constructed in the parietal lobe is irrelevant to the reality of the pain being located and experienced in the lower back. In other words, the fact of the matter is that she *really* does feel pain in her lower back. However, if we want to know what function the lower back pain has for the depressive, then it does not suffice to say that the pain "is what it is," because the pain is in fact both something that it does not appear to be (an expression of psychological distress) and also what it is (i.e. pain in the lower back). Given that neural pathways in the brain appear to have a countless number of possible connections, we face the problem of attempting to explain one mental function by way of another, as well as the 'chicken and egg' problem if we attempt to identify an initiating neural event that set off a process resulting in the depressive symptom, e.g. lower back pain. Suffice it to say that even if the 'how' and 'why' of the neurochemical processes were discovered – down to the first emission of a neurotransmitter by a particular axon of a single cell body in a particular nuclei in a specific stratum of a particular region of a particular lobe, signaling to a specific receptor on a particular neuron, under the particular set of conditions controlled in the most minute detail and so forth (bearing in mind there are around 100 billion neurons in the brain) – still we would not know how depressives experience pain. We also need to inquire into: how pain influences the depressive's behavior, how pain factors

into the depressive's relationships with the social and natural environment, what pain makes the depressive do and what it inhibits her from doing, how pain affects beliefs, values, temperament, interests, and so forth. The meaning and function of pain belongs to a form of life and the presence of mental pain in depression often contributes to the dismantling of a form of life.

Disrupted Cognitive Attachments

As mentioned in previous chapters, the disruption of a form of life in depression occurs as a loss of familiarity and affective disconnection. This loss of familiarity and affective disconnection also takes place with one's cognitive commitments. Often in depression a person's convictions and value systems undergo changes. However, depression does not necessarily alter the *content of beliefs*; instead, it typically affects the *nature of believing*. If someone has a jarring experience that runs contrary to her system of beliefs, one can reasonably expect that she might question the veracity of the content of those beliefs. In contrast, depression does not primarily incite a reevaluation of beliefs; in depression one simply finds that her convictions are absent (at least during the depressive episode). For example, Karen Armstrong, a writer and former member of a convent, speaks of her loss of belief: "I found only a question mark where the old conviction should have been."[256] She continues, "Beliefs and principles that I had taken so completely for granted that they seemed a part of my very being now appeared

[256] Armstrong, 2004, 16

strangely abstract and remote."[257] Depression affects values indirectly, in as much as the individual's desires and beliefs at first do not tend to change into something else; rather, the affective quality of believing and desiring is substantially diminished. Instead of one's beliefs no longer *making sense* in light of new evidence, the depressive often no longer *has a sense* of her convictions. Over time the diminished affective connection with previously held beliefs and values can alter the status of the cognitive commitments for the depressive, which may or may not return when and if she recovers from depression. While all beliefs, values, and desires are not uniformly affected in severe depression, it appears that the intentional objects that evoke the greatest emotions (in terms of depth and duration) prior to depression are the ones that appear to be most glaringly absent during depression.

This diminished affective connection with one's beliefs and values is often expressed in terms of the depressive's inability to act in accordance with her values. While the content of some propositional attitudes might go unaltered, the motivational pull that these beliefs and values have appears to weaken in a depressive episode. A depressed individual may actually have the desire to do *x*, yet lack the ability or motivation to act in a way that would make *x* come about. In the article "Mental Illness, Motivation and Moral Commitment," John Russell Roberts addresses the motivational role of desire and values in depression. Roberts operates with the premise that depressives "have all their usual normative beliefs, yet they do not act on them," and that their suffering increases from their inability to pursue their values.[258] While this premise

[257] Armstrong, 2004, 16
[258] Roberts, 2001, 45

is true for some depressives some of the time, it does not correctly characterize the variety of changes to values, actions, and desires that the depressive experiences during a depressive episode. Regarding Roberts' assumption that depressives retain "*all* their usual normative beliefs,"[259] first person accounts portray a more diverse picture of the retention, alteration, and loss of values in depression. The assumption that the identity of normative beliefs remains the same simply based on the continuity of the content of those beliefs is problematic. Take for instance a person's religious belief. Depression does not necessarily make someone no longer believe in God or continue to believe in God; depression can however make the belief in God *feel* empty. While some depressives might report having the same propositional attitudes in depression as she did prior to and after depression, what those beliefs and values mean for the depressive and how she incorporates them into her life can be fundamentally different in a depressive episode. In the skepticism of depression, unlike philosophical skepticism, the depressed individual neither doubts nor believes. Her skepticism is not conceptual; it is lived and felt. Kristeva describes the depressed as a "radical, sullen atheist,"[260] and just as depressive skepticism is not grounded in doubt, depression's form of atheism is not directed towards God, belief, or proofs. The depressive is a "sullen atheist" because she is not *directed towards*.

In the second part of his thesis Roberts claims that depressives fail to act on their values and that values appear to lose their intrinsic motivational pull in depression. Given the common belief that depressives suffer from a lack of desire, Roberts seeks to understand how this dearth of desire can co-exist with a continued identification with

[259] Roberts, 2001, 45, emphasis added
[260] Kristeva, 1989, 5

values and the values' apparent lack of motivational pull. He claims to resolve this dilemma by asserting that depression does not actually attenuate desire itself but interferes with the capacity to achieve the satisfaction of desire. He then concludes that the lack of satisfaction of desires explains why values are not self-motivating for depressives. According to this view, the interconnection of desires with the lack of motivation to act in depression takes place as a type of trial-and-error process: The depressive has a desire (which Roberts uses interchangeably with a value), acts on the desire, does not feel the satisfaction associated with acting on desire, thus no longer acts on the desire, and therefore the value is no longer self-motivational. The problem with what I am calling a trial-and-error process is that Roberts assumes that the action is first performed and then met with negative feelings, which thereby prevents the repetition of said action. However, affective interference in depression typically takes place before this trial-and-error process is even initiated. Even though Roberts recognizes the "sheer preponderance of continuous, free-floating negative affect" that "wreaks havoc with motivation and action,"[261] the way he formulates the problem of depressive inaction is that a specific action is accompanied by specific negative emotional response. Roberts refers to Andrew Solomon's example of the difficulty of engaging in the simple task of taking a shower, which Solomon compares to the "Stations of the Cross,"[262] to demonstrate the incongruity of action and desire. However, it is not as if Solomon's reflection on a previous negative experience of taking a shower recreates the sense of pain and strife. For the severely depressed, it is not merely a matter of not being able to

[261] Roberts, 2001, 54
[262] Ibid, 43

experience the satisfaction of acting on one's desires; depressives claim not to be able to act at all.

While it might be true that in depression one lacks the capacity to feel or achieve the satisfaction of various desires, this lack of satisfaction alone does not fully account for the apparent disjunction between valuation, action, and motivation. In the article, "Depression and Motivation," Benedict Smith points to Iain Law's account of the lack of motivation and inaction in depression as resulting from the presence of an "aspect of impossibility."[263] The 'aspect of impossibility' refers to the depressive's perception of an act as insurmountable or unduly difficult. According to Law, while the depressive may still have the motivation to do *x*, a counter and more persuasive motivation prevents the person from doing *x.* Consistent with this explanation, "the failure to act is not accounted for by citing a *loss* of relevant propositional attitudes;" rather, it is "the content of particular mental states" that impedes action.[264] However, a lack of motivation and inaction does not exclusively emerge from cognitive changes. A theory of cognitive attachments and motivation in depression cannot be complete without recognizing the driving force of the depressive's attempts to avoid, abate, and live with pain, as well as recognizing the role that affective disordering and disconnection plays. The depressive lacks the affective connection that opens up the world as meaningful. The world itself appears to lose its motivational pull and no longer holds the same value that it did prior to depression. Over time, embodied affective disconnection and disordering can alter one's evaluative commitments and propositional attitudes. Depressives experience an

[263] Smith B., 2012
[264] Ibid

interruption of cognitive and affective fidelity with their mind and world. Given the variability of emotions and thoughts, the depressive loses self-trust. Likewise, the depressive does not find the world to be reliable and predictable.

B. Smith points out that both Roberts and Law focus on a psychological explanation of inaction and fail to take into account the role of the body. For the most part, the adult body is habitualized to perform tasks and respond to situations in an unnoticeable and unremarkable way. However, these habitual movements become effortful and painful in depression. In a malaise one might not get out of bed because one feels that "there is no point," whereas in depression, one can feel physically incapable of getting out of bed. Due to the alterations of depressive perception and depressive desynchronization, regardless of belief and desire, the world is no longer accessible in the same way. The body retreats from health-sustaining acts. It is repulsed by food, threatened by social contact, and resistant to physical activity. Depressives describe having heavy, tired limbs, and severe fatigue to the point of near paralysis. The mere thought of getting out of bed can even be terrifying for some depressives. In *Black Pain*, Terrie Williams describes her experience with depressive immobility, which she suffered while she was the head of a successful marketing and public relation firm: "It was less like I didn't want to wake up, and more like I couldn't…I had the sensation of a huge weight, invisible but gigantic, pressing down on me, almost crushing me into the bed and pinning me there."[265] This description of the weight and immobility of Williams' body hearkens to Fuchs characterization of depression as process in which the materiality of

[265] Williams, 2008, xxii

the body comes to the fore. [266] He explains that in depressed individuals, "drive, impulse, appetite, and libido are reduced or lost," which results in the depressive's "sense of the possible" failing to "generate future goals and plans, leaving the self confined to the present state of pure bodily restrictions."[267] In depression, the body becomes a limitation on the world, rather than its access point.

An explanation of depressive inaction and loss of motivation needs to address some of the key points of all three views: the roles of countervailing desires and emotions (Law), the inability to find satisfaction of desires (Roberts), and the body's interference in action (Smith and Fuchs). The depressive's inability to act in accordance with her most pressing desires and values, as well as the intermingling of competing desires and the attenuation of values, belong to the overall loss of agential vitality that results from affective disconnection and disordering. Furthermore, the depressive's alienation from a meaningful and compelling form of life can cause the depressive's cognitive and emotional attachments to become murky, weak, and remote, which contributes to her overall sense of self-loss and self-*dis*possession.

[266] Fuchs, Corporealized and Disembodied Minds: A Phenomenological View of the Body in Melancholia and Schizophrenia, June 2005
[267] Ibid, 99

Depressive Identification

Identifying 'Depression'

All of the first-person accounts used in this chapter appeal to a basic medical model of severe depression. However, each of the authors speaks of a period of time in which he or she experienced the symptoms of depression without understanding the symptoms in terms of a 'depressive disorder.' Even in contemporary Western cultures dominated by psychiatric models of depression and the commercialization of antidepressants, people still often report experiencing a delay between the advent of symptoms and a diagnosis of depression. [268] Karp describes his experience of depression as "the beginning of a long pilgrimage" to "figure out what was wrong with me, what to name it, what to do about it, and how to live with it."[269] Similarly, John Head writes that his experience of depression was a part of his life for "more than twenty tortured years" before he had a name or an explanation for it.[270] The identification of one's experience as 'depression' is often experienced as a defining moment, whether one chooses to accept, ignore, or reject such an identification.

In the essay "Saying It," David Pugmire discusses the impact of giving verbal articulation to apparently "indescribable" emotions. Pugmire endeavors to identify the changes to personal level thinking and feeling of an individual in relation to the articulation of an emotional experience. While depression is an affective disorder and not a single intentional affect, Pugmire's analysis of the subjective effect of articulation as a

[268] One can discover the idea of clinical depression without a professional diagnosis or consultation. While many of the authors of the memoirs did in fact receive a diagnosis from a psychiatrist, one can learn about clinical depression from various sources.
[269] Karp, 1996, 4
[270] Head, 2004, 74

form of affirmation can still shed light on the way in which the depressive's awareness of her experience *as* 'depression' shapes her experience of depression and of herself. Pugmire points to five forms of articulation, which he categorizes as types of affirmation: 'identification,' 'consolidation,' 'reorientation,' 'initiation,' and 'transfiguration.'[271] Pugmire understands 'identification' as the verbal avowal of a previously unnamed or unarticulated emotion and conceptualizes articulation as bridging the lacuna between the person and her alleged "indescribable" emotion. According to this picture of verbal affirmation, one can become more connected to an experience through naming it and identifying it *as* something. For the depressive, this identification means seeing one's ill-health and disordered mood *as* depression rather than as a mysterious deterioration of one's mind. Many depressives find it relieving to be able to give an explanation to their mental distress and to be able to attribute it to a known disorder. For example, while working in the office of psychologists, Glenn Townes began to understand his own experience in terms of 'depression':

> It was only through [the patients] that I learned that insomnia, irritability, crying spells and mood swings were symptoms of depression. It seemed odd, but in getting to know some of the patients, I began to understand myself. It was like looking into a mirror or listening to a tape recording of my own thoughts.[272]

Sally Brampton also felt relief when she was diagnosed with depression. She recalls her psychiatrist insisting to her, "You are ill…You are very, very ill," which to her "felt like the nicest thing anybody had ever said."[273] While people generally tend to associate the diagnosis of a severe illness with terrifying news, Sekyiwa ("Set") Shakur, like Townes

[271] Pugmire, 2010, 381-2
[272] Williams, 2008, 88
[273] Brampton, 2008, 9

and Brampton, felt a profound sense of relief when first diagnosed with severe depression. She writes, "…it was such a relief when I was finally diagnosed. I wasn't just a 'bitch' or 'crazy,' there was a reason for all these painful feelings."[274] For many depressives, the identification of 'depression' provides clarity and order, moderates self-blame, lessens the sense of isolation, helps the depressive to feel less alone, and gives the hope of treatment.

Recognizing one's experience as 'depression' can be a drawn out process for many individuals and not everyone responds to the idea of 'clinical depression' with relief and acceptance. Some people deny that they are depressed and others become even more deeply symptomatic when they realize they are suffering from 'clinical depression.' Especially given 'depression's' status as a mental disorder, no matter how disordered one might already feel, admitting to mental illness poses personal and social challenges. Also, in the early stages of depression, characterized by frequent crying, mild dysphoria, and sometimes even exclusively by severe somatic symptoms, a person's identification of her ill-health with 'depression' can propel her from feeling generally unwell to experiencing full-blown severe depression. In the latter case, identification with 'depression' brings about a realization that unleashes psychological pain previously experienced as somatic symptoms.

For many depressives, the identification of one's experience as 'depression' serves to erect a theoretical schism between the individual and the disorder. A dualism of illness and self provides a way of explaining and coping with intrapsychic conflict. For

[274] Williams, 2008, 6

example, Solomon recalls, "At the worst stage of major depression, I had moods that I knew were not my moods: they belonged to the depression."[275] Alternatively the individual's identification with 'clinical depression' can have a paradoxical effect in which the individual gives in to the control that depression already has over her. In another sense, identification can affirm integration rather than sustain a dualism between identity and illness. Rather than asserting that the individual is a separate, distinct agent who is threatened by a discrete disease entity, according to a model of integration the depressive can affirm the fact that depression has emerged within *her* brain, developed out of *her* experiences, and has altered *her* 'self.' In this sense, identification is an affirmation of depression *being a part of me.*

The second form of affirmation that Pugmire addresses is 'consolidation.' Consolidation through verbal affirmation helps one "to settle on a state" and thereby "to suspend openness to change and to ambivalence."[276] For the most part, when the depressive identifies with 'clinical depression' it might clarify and consolidate her understanding of her depressive experience, yet the verbal avowal does not function as a *hermeneutic* seal. To "settle" on one's experience as being that of depression leaves many questions unanswered and raises new ambiguities. As Karp points out, the struggle is not only to find a name for one's disorder; one must also figure out *what to do about it* and *how to live with it*.

Pugmire conceptualizes the third form of affirmation as 'reorientation.' According to the process of reorientation, "I see myself as related to the world in the appropriate

[275] Solomon, 2002, 18
[276] Pugmire, 2010, 381-2

way…Suddenly things fall into place in a new way."[277] This idea of *things falling into place* relates to the sense of relief that many depressives claim to have when they understand their mental distress as belonging to depression. However, the relief can be fleeting. When a person first states "I am depressed," it can be a meaningful avowal and can even have some immediate affective changes, but the significance, particularly the ongoing significance, primarily depends on what one does with the identification and with whom one shares it. Also, the 'reorientation' that accompanies naming one's disorder and finding an explanation for it is not an embodied and full reorientation if the depressive is still deep in the mire of a depressive episode. Because affective changes often lag behind cognitive changes, an intellectual understanding of one's experience as 'depression' cannot undo the grip of affective disconnection and affective disordering. Take the simple hypothetical example of someone misunderstanding another person: Asher thinks that Sophie insulted his work behind his back and then becomes enraged. Even though Asher comes to realize that Sophie actually praised his work instead of insulting it, Asher continues to feel a tinge of resentment whenever he sees Sophie. Contrarily, if Asher finds incontrovertible evidence that Carrie, for whom he has romantic feelings, actually insulted his work to colleagues, this information might not change his attraction to Carrie. He can even interpret Carrie's insult as an endearing act rather than an occasion for anger. It is difficult to instantaneously reform and/or form emotional attachments to ideas, people, and experiences. Emotions belong to patterns of behaviors and neural networks that require time and repetition to rewire. Considering a mental state as affectively pervasive as severe depression, both on a personal and

[277] Pugmire, 2010, 381-2

neurochemical level, 'reorientation' is unlikely to immediately unfold along with 'identification.'

The first three forms of affirmation highlighted by Pugmire refer to cognitive changes that take place in naming, but for the depressive, the cognitive changes alone are not transformational. Due to the destructive effect that depression has on one's form of life and sense of self, the transformational potential of identifying 'depression' primarily depends on how one acts on this new form of identification. Finding a new vocabulary cannot on its own bring about substantial changes; one must also discover and adopt new practices and new ways of relating to others. While the explanatory role that a diagnosis has can be relieving or frightening, therapeutically advantageous or harmful, confounding or penetrating, the effect of the psychiatric framing of one's symptoms primarily depends on the course of action the depressive chooses to take and what she does with the medical explanation. This need for more than knowledge and 'identification' brings us to Pugmire's last two types of affirmation: 'initiation' and 'transfiguration.' With 'initiation,' Pugmire explains, "I may join myself to a larger cultural system (which, in my avowing, I endorse);"[278] and 'transfiguration' is a matter of affirming the experience poetically.[279]

Despite the variety of changes that the depressive can experience by identifying her mental distress with 'depression,' the depressive can nevertheless undergo all the developmental alterations previously mentioned in this chapter regardless of whether she

[278] Pugmire, 2010, 381-2

[279] I will address the idea of 'initiation' in Part II of this chapter. While I do not specifically reference Pugmire or his concept 'transfiguration' in the next chapter, I do address the idea of transforming one's experience through writing.

identifies her experience with 'depression.' In other words, no matter what she calls her experience or how she explains it to herself, she still feels a loss of self, an alienation from others, an alteration of values and beliefs, a loss of control, and a sense of an external agency at war with her mind. For the individuals that do identify their experience as 'depression,' many of them, especially those who experience chronic depression, move beyond the identification *of* depression to an identification *with* depression. Particularly in a long-lasting, non-reactive depressive episode and/or recurring depressive episodes, the depressive cannot simply affirm a binary model of personal identity and illness. The binary opposition can wear down, both in terms of the depressive's cognitive assessment of her depressive experience as binary and her feeling towards *it* as foreign. Depression itself becomes too familiar. The alterations that depression wreaks on one's personality become too enduring. The old self remains distant and depression becomes a part of one's sense of self and identity.

Identifying with *depression*

Just as one's sense of self in depression has a developmental structure, so too does one's identification *with* depression. The early stages of the depressive's identification *with* depression *as* 'depression' often involve the recognition that the 'I' itself is implicated in mental illness. The meaning of one's identification *with* depression is that "*I* am depressed." While the truth of this realization might appear to be self-evident, its simplicity hides the painful awareness that undergirds this admission. The fact that '*I'* am depressed means that depression is not simply done to me; rather, it belongs to me and is

a part of who *I* am. To identify with depression and to recognize that "*I* am depressed" assumes some degree of acceptance of one's condition *as* depressed. The recognition that *I* am depressed involves the admission that *I* have changed and that *I* am in fact different from how *I* used to be. This acceptance should not be mistaken as an alleviation of tension and inner-conflict. Likewise, the identification *with* depression does not establish a unified depressive self. The acceptance that *I* am depressed is phenomenologically similar to the process of mourning. For some depressives the proper response to the loss of the pre-depressive self is to let it go. For others the past self never quite disappears but only goes into hibernation and comes out older, weaker, and thinner. Larry McMurtry came to the conclusion that he must grieve rather than strive to regain his lost self. He writes:

> I wasn't quite myself, but I hadn't started grieving either, for the self or the personality that had been lost during the process…I did not feel like my old self at all, and had no idea where the old self had gone. But I did know that it, he, me was gone, and that I missed him…I mourned its loss but soon concluded that gone is gone – I was never really going to recover that sense of wholeness, of the integrity of the self.[280]

In some cases it might be possible for the loss of an essentialist understanding of the self – what in McMurty's case was a self that had "a sense of wholeness," a self whose loss felt like the "integrity of the self" had slipped away – to be experienced as liberating. However, due to the negative and painful conditions intrinsic to depression, the depressive's loss of self is typically experienced as quite devastating. It is only after the depressive recovers from major depression that she can greet the changes with a sense of freedom and starting anew (although this response is neither essential to depression, nor

[280] McMurtry, 2002, 70

typical). For McMurtry and other depressives, the identification with depression is a painful identification and a farewell to a former way of living.

Unlike McMurtry, Solomon's experience with depression led him to insist on the persistence of some aspects of his personality, which he claims depression cannot fully undo. Even though Solomon affirms the continuation of various features of one's self throughout depression, he also affirms a "multifarious identity"[281] and eventually comes to regard depression as an essential aspect of who he has become. He writes, "To regret my depression now would be to regret the most fundamental part of myself."[282] Solomon embraces depression as a part of his self and not as an alien agency. Not only has he incorporated it into his sense of self, but for Solomon it is the most "fundamental" part. Whether the recovering depressive interprets the depressive self as being continuous with the pre-depressive self like Solomon, or discontinuous like McMurtry, the recovering depressive emerges from depression with an altered sense of self and a disrupted form of life. Depression is not in itself a form of life (see chapter 2); it runs *counter* to a form of life and is in many ways counter to *life* itself. The ability of the recovering depressive to (re)constitute a vital personal identity largely depends on her ability to reconcile herself to the form of life that depression has disrupted. 'Ability' in this context does not exclusively or primarily apply to personal capacities; it also refers to the conditions of possibility given with a form of life. One's *ability* to reconcile her new sense of self with the disrupted form of life depends as much on the social practices and discursive opportunities available within a form of life – however disrupted it has become – as it

[281] Solomon, 2002, 21
[282] Ibid., 440

does on the depressed individual's desires and skills. Alternatively, the recovering depressive can help to resist and/or expand the practices of her form of life or seek out alternative forms of life that are more accepting of a *depressive identity.*

Some of the aspects of a form of life that depression disrupts, such as the synchronicity of the depressive's temporalization with her social environment and the familiarity of her surroundings, can be salvaged in recovery from depression. A recovery from depression in part involves the restoration of one's affective connection to her environment. However, the reestablishment of affective connectivity does not mean that the recovering depressive relates to herself, others, and her social and natural environment in the same way she did prior to depression. Who she is during, prior to, and recovering from depression are different persons; therefore, how she interacts with a form of life also changes. While depression does not quite fit into Lugones' characterization of 'world' mentioned earlier in this chapter, it is nevertheless helpful to apply Lugones' ideas about the multifariousness of identities and worlds to an understanding of depression. Like Medina's theory of polyphonic identity, Lugones provides a non-pathological view of the plurality of personal identity that can potentially help the depressive to reconcile the pathological (depressive) self with her other selves. Without the intellectual mandate to see the self as unified and harmonious, it seems theoretically plausible that the depressive would have a better chance of recovery.

The depressive's response to self-loss and identification with depression are not final acts or decisions; they are only part of the ongoing negotiation of personal identity and depression. Ultimately, personal identity in depression cannot be explained

exclusively in psychological terms. While alienation from other people and estrangement from meaning dominate the depressive experience, in a sense the depressive is never alone in depression. Depression is socially structured and the depressive can never fully withdraw from a form of life. Although the affective connection to one's form of life is disrupted, a form of life can continue to set limits on the ways the depressive can understand depression and influence whether she understands it as such. In addition, a form of life is bound up with all the social complexities that constitute personal identity. Social categories of identity, such as race, ethnicity, gender, and class, can affect an individual's understanding and treatment of depression. Also, how the developmental stages of depression unfold in part depends on the depressive's social environment and the individual's ability to recover from depression largely depends on her social support systems. In Part II of this chapter, in which I address the sociality of the depressive and the social structuring of 'depression,' I plan to further develop an understanding of personal identity in depression as multifarious and interconnected with a form of life.

Part Two: Depression and sociality

Too often traditional philosophical discourse allows one to appeal to the idea of 'the social' and even to the idea of 'the particularity of social contexts' without ever invoking actual social phenomena. Referring primarily to Austin and Wittgenstein, Shusterman remarks that "it seems reasonable that philosophies which explicitly affirm the crucial role of 'the social' should themselves take the actual study of society far more

seriously."[283] So how should one go about an investigation into the social structures of depression? I plan to start with the following basic premises about the social structuring of depression: a) a host of cultural values are implicated in depression; b) a depressive identification has social ramifications; c) social categories of identity are at play in the diagnostic act and impact the nature and availability of treatment; d) social structures and systems factor into the complex causal mechanisms at play in each episode of depression for each individual. These four aspects of the social structuring of depression require an in-depth analysis; however, I will only briefly touch on each one. Also, I aim to briefly identify some of the types of ideologies, social structures, and vocabularies that perpetuate the marginalization of depression and the ones that can best create the space for dialogue. The main picture that I want to provide is that the social elements involved in depression are as diverse, complex, numerous, and deep as the elements at play in agency itself.

Depressive Identity

In the last section I introduced the ideas of depressive identification and the integration of 'depression' within personal identity. This idea of a 'depressive identity' is conceptually and phenomenally problematic on various fronts and shares many pragmatic and conceptual problems common to social categories of identity: problems such as essentialism, separatism, group solidarity, the voluntariness of membership, definition, and whether the social group is erected by oppressors for the purpose of subjugation or

[283] Shusterman, 2000, 21

reclaimed and redescribed by the group members. However, depressive identity does have a few unique problems. First, how can one's sense of self merge with the very thing that destroys a sense of self? Furthermore, how can group identification be forged when depression leads to social withdraw? In this section I will address how depression interacts with social categories of identity and the problems associated with the social formation of a depressive identity.

Depressive Withdrawal

When one identifies with a particular explanation of identity and behavior, one becomes integrated with a community and a larger narrative. To identify and to be identified involves active and passive forms of identification with others, regardless of how precarious and reluctant the association might be. That is not to say that each person labeled *A* necessarily identifies with all other *A*'s; however, who is identified as *A* is not always up to the person labeled *A.* Given that social interaction grounds both personal and group identities, the formation of a depressive identity proves difficult in the midst of a depressive episode. The affective disconnection and disordering of depression that leads to the disruption of a form of life and the attenuation of agency – exemplified by desynchronization, loss of futurity, shrinking of personal space, disrupted cognitive attachments, etc. – contribute to the deterioration of the depressive's capacity to be with others. The depressive not only physically withdraws from social relations and public spaces, she also becomes cognitively and affectively isolated from a meaningful world. Withdrawal from other people characterizes the primary loss of affective connection for

most depressives, and withdrawal from social practices contributes to the depressive's withering sense of self. Karp explains depressive withdrawal in terms of a "vicious feedback loop," in which the elements of depression – "hopelessness, withdrawal, and the erosion of the self" – deepens the severity of each other.[284] Karp writes: "…when the pain of human association leads to withdrawal and isolation, the self loses its social foundation, begins to wither, and in that process the social world comes to appear even more alien."[285] While Karp speaks to the idea that personal identity both develops and is sustained through social relations, his reference to a "social foundation" of identity paints a misleading picture of the social as the ground floor on top of which the self is constructed. While identity can be said to be *grounded* in the social, the social is not a homogenous, solid, and stable structure. Personal identity has an organic and osmotic relationship with the various elements of social structures and interpersonal relations. Depression is one among many illnesses, traumas, and events that can disturb seemingly impervious social bonds and structures. Depression can also push through the cracks of already vulnerable identities and social connections. The loss of self, described in the first part of this chapter, both feeds and feeds off of the depressive's decaying social connectivity.

Karp highlights the fact that the "pain of human association" in depression results in withdrawal. The presence of somatic symptoms, the unpredictability of mood, the dizzying pace of public life, the persistence of mental confusion, the difficulty of communication, and the feeling of extreme alienation all contribute to the pain of social

[284] Karp, 1996, 27-8
[285] Ibid

interaction. While non-depressives frequently prescribe "going out and being around people" to alleviate depressive symptoms, for people experiencing major depression, both the thought and the act of socializing can intensify the symptoms of depression. Faulk recalls that being "alone was somehow just better than being around people."[286] Often a depressive's attempt to remedy isolation through socialization does not combat the inwardness of the pain but can actually deepen it. Karp notes that "Much of depression's pain arises out of the recognition that what might make one feel better – human connection – seems impossible in the midst of a paralyzing episode of depression."[287] The disparity between the depressive's disrupted life and what appears to her as the seamless activity and movement around her has a way of heightening the depressive's sense of separation from others. At the level of the depressive's experience, the avoidance of others does not emerge from a combination of particular symptoms. The depressive feels the pain as a whole, as all-encompassing.

The pain of social interaction often takes the form of an intense fear of social contact. For instance, Brampton writes, "I would like to leave this room, but I can't. I feel safe in here. Or, as safe as I feel anywhere, which is not very."[288] The comparative safety of self-confinement raises questions about the nature of the threat and painfulness of social interaction. One might be tempted to explain away depressive withdrawal as a fear of uncertainty and a fear of losing control. Brampton's description of her fear seems to point to those two factors. She writes: "The thought of going to a shop or making a decision about what to buy terrified me. Crowds frightened me, going on the Tube

[286] Falk, 2005, 50
[287] Karp, 1996, 16
[288] Brampton, 2008, 344

frightened me. Being outside frightened me."[289] However, for Brampton and other depressives, the fear of socialization is often not a fear of what they do not know; instead, it is a fear of what they know will happen. Once they step out into the world they will be forced to respond to and interact with it. John Bentley Mays accounts for depressive withdrawal in terms of a "strategy of coping with the confusions of the world."[290] However, it is typically not the case that the confusions of the world *cause* a sense of not having control; the world is confusing because the depressive has already lost control. She does not have the agential vitality that allows her to count on herself to be able to function. Her loss of agency is experienced as a loss of the ability to act and react. Relatively simple acts like navigating a sidewalk and ordering food can be paralyzing. Social situations force the depressive to do things that she no longer feels capable of doing, and they force her to be a certain way that she no longer feels capable of being. It's like being thrown into a river without being able to swim.

Similar to the way that the depressive's sense of self has developmental stages, what withdrawal is and how it functions can change throughout the course of a depressive episode. Withdrawal can expressed in terms of an actual physical isolation from other people, an emotional and experiential distancing from others, and/or a compartmentalization of the depressive self, to name a few. Depressive withdrawal can develop in relation to various emotions associated with mental pain, such as fear, grief, guilt, and anger. These emotions can then trigger certain forms of withdrawal. For example, guilt can lead to withdrawal in the form of compartmentalization, and fear can

[289] Brampton, 2008, 95
[290] Mays, 200, 109

lead to physical withdrawal. As we will see later in this chapter, for some people – particularly male depressives – depressive distancing can even take the form of externalization. Violence and reckless behaviors can be symptomatic of the life-denying tendencies of depression. Rather than physically withdrawing from one's surroundings, the depressive can sustain his social isolation by forcing others to retreat. Because a major depressive episode, characterized by affective disconnection and disordering, fosters a deep and paralyzing estrangement from other people, depressive identity cannot develop until the severity of depression is allayed to some degree. The identification *with* 'depression' can be an initiating component of an eventual recovery and can provide a way of understanding and dealing with social isolation.

Interpellation and depression

'Clinical depression' is not a label that spontaneously evolved among melancholic individuals. 'Depression' is a category developed and influenced by medical, pharmaceutical, juridical, market, and other cultural forces. While the American Psychiatric Association (APA) has the responsibility of codifying 'severe depression' in the Diagnostic Statistical Manual (DSM), its members take their cues from a variety of sources – clinicians, therapeutic practices, neuroscience, pharmaceutical trials, and academic research, to name a few – none of which is immune to the pressures of politics and the market. In particular, pharmaceutical companies have influence on the funding for clinical trials, grants for academic research, the organization of support groups, legislative oversight for insurance payment regulations, treatment and diagnosis at the level of the doctor, and commercial backing for news and entertainment multi-media.

Critics of the pharmacological approach to mental illness argue that the market drives diagnosis and is thereby implicated in the creation of depression and interpellation of depressive identities.

David Healy, a psychiatrist and outspoken critic of the pharmaceutical companies' role in American healthcare and the marketing of psychotropic drugs, notes in his article "Good Science or Good Business" that only fifty people for every one million people were considered depressed in the 1950's, whereas now it is one hundred thousand people per million.[291] He argues that the emergence of 'depression' coincided with the development of antidepressant medication, in particular selective serotonin reuptake inhibitors (SSRI's).[292] Similarly, the contemporary philosopher Carl Elliot points out that "Medical treatments do not simply cure or control medical conditions; they also create them."[293] However, both Healy and Elliot do not outright deny the existence of 'depression' or even deny that it has a physiological basis that may benefit from medical treatment. They speak of 'depression' as a condition different from and prior to the psychopharmacological model of depression. Healy, for example, refers to 'classic depression,' which he distinguishes from many of the conditions being treated with antidepressant medication, including contemporary 'depression.' He claims that the pharmaceutical industry "has educated prescribers and the public to recognize many other kinds of cases as depression."[294] He holds a view of depression (classic depression) as a non-pharmaceutically produced category, yet does not in this article explain the

[291] Healy, 2000, 20
[292] Ibid
[293] Elliot, 2004, 429
[294] Healy, 2000, 21

difference between the two and whether psychotropic medication can benefit the symptoms of "classic depression."[295]

The various critiques of depression primarily fall into three categories based on questions about 1) the existence of depression as an illness, 2) the adequate diagnosis of depression, and 3) the treatment of depression with psychotropic medication. Most critiques of a medical model of depression primarily focus on how depression is treated. The main concern seems to be less about definition than about the roles and effects of antidepressant medication, which Healy argues is a category of medications that "Modulate lifestyles rather than cure diseases."[296] However, Healy recognizes that many moral arguments against contemporary depression often unfairly target the use of antidepressants, while ignoring various forms of self-medication. Referencing Peter Kramer's book *Listening to Prozac*, which makes the argument that antidepressants are being used to treat states such as alienation, Healy asks: "Would we be talking about alienation if it were over-the-counter tonics rather than prescription-only antidepressants that were involved…?"[297] He accuses philosophers of willingly overlooking the relationship between mental health, alienation, and self-medicating, while criticizing the treatment of conditions such as alienation with the likes of Prozac.

While the market plays a key role in the rising rates of the diagnosis and pharmacological treatment of depression, the fear and criticism over the medicalization of mental illness actually preceded the emergence of pharmaceutical companies. Similar to

[295] Healy, 2000, 21
[296] Ibid
[297] Ibid, 22

belief that the medicalization of depression actually increases the frequency of depression, Foucault notes that in the 18th century, "Already Raulin had observed that 'since the birth of medicine…these [mental] illnesses have multiplied, have become more dangerous, more complicated, more problematical and difficult to cure.'"[298] One aspect of the resistance to the medicalization of mental illness derives from the concern over the pathologization of identities and personalities. There are two main categories of argumentation against the pathologization of identities and behaviors: on one side, the concern is that deviant behavior will be legitimized and thus spread, and on the other side, the fear is that abnormal behavior will be suppressed and controlled. Some critics argue that the medicalization of depression creates and rapidly reproduces the number of cases of depression, thereby diminishing the role of individual moral responsibility. On the other hand, some people contend that the medicalization of depression leads to the pathologization and treatment of normal human grief and/or the suppression of spiritual and artistic depth. The primary concern in the latter critique is that the label "mental illness" will undermine the uniqueness of the individual and undervalue the generative potential of negative mood states. According to this view depressive moods are affirmed as idiosyncratic personality traits, which are constitutive of personal development. Often this position corresponds to the belief that depression (melancholy) is a gift of the artist and intellectual. Some critics even go so far as to argue that the medical treatment of depression not only deprives the individual of artistic and spiritual achievement, but deprives the entire culture as well.

[298] Foucault, 1988, 211

Other critics of the medical model of depression are less concerned with the label itself than the appropriateness of its application. They argue that 'severe depression' is too readily applied to people for whom other, more appropriate explanations would suffice. In some cases this type of concern comes from people who have suffered from debilitating depression and fear that the seriousness of the illness will become watered down if applied to too many people. In fact, they argue that the sheer number of diagnoses of depression devalues the uniqueness of their suffering. Others, less concerned with the number of cases, argue that hasty diagnosis, especially by under-qualified medical personnel, will change the perception of depression as being less severe than it really is.

Another variation of the concern over the application of 'depression' is based on the belief that depression is a part of an adaptive biological development. These critics argue that the physiological symptoms of depression are the body's natural protection against environmental stress. According to this view, the interference in the biological processes taking place in depression, especially neurochemical interference, hinders the body's ability to fully heal.[299] Similarly, some people contend that the label will be over-applied to people undergoing justifiable, psychological processes, such as mourning, grief, spiritual emptiness, and humiliation, which are a natural part of the healthy psychological development.[300] Both the fear of the creation of depressive identities and the fear of the suppression of depressive identities are based in a moralization of depression. The moralization of depression is rooted in a teleological assessment of

[299] For an account of depression as adaptive see: Martin, On the Evolution of Depression, 2002
[300] See: Elliott, Pursued by Happiness and Beaten Senseless: Prozac and the American Dream, 2000

human development, which in many cases affirms a view of the self in terms of authenticity and inauthenticity.

Disorders of mood, cognition, and behavior provoke questions about the legitimacy and verifiability of diagnostic classifications. Often questions about legitimacy and verifiability of depression are vehicles for evaluative questions such as: Is the identification with depression a type of false consciousness and/or a way of taking on the perspective of the oppressor? Is the acceptance that *I am depressed* simply an attempt to be reintegrated into the community? Does the identification with and treatment of depression as an illness entail a willing complicity with cultural norms about good behavior and sound mental health? Is the identification with 'clinical depression' a form of bad faith and does it reflect an escape from "all that I am"?[301] These types of normative approaches primarily fall into three lines of questioning: Does the identification with depression result from a) the cultural oppression of deviance, b) the normativity of happiness and well-being, and c) a flight from authenticity? Perhaps the most revealing question is what Elliot takes to be a Wittgensteinian line of questioning about the existence and application of 'depression': "In whose interests is it to pose such a question?"[302] Rather than addressing these critiques from the standpoint of a supposedly disinterested observer, it is from the standpoint of the depressives that I aim to address these three main categories of critique.

[301] Sartre, 1956, 99

[302] Elliott, Does Your Patient Have a Beetle in His Box? Language-Games and the Spread of Psychopathology, 2003, 196.

Cultural oppression of deviance and the normativity of mental health

Given the fact that 'depression' has become pragmatically and conceptually interconnected with antidepressants, the concerns over antidepressant medications tend to fuel critiques of the veracity of depression as an illness. One's imagination does not need much prompting to draw a connection between the mass production and consumption of antidepressants with the mollifying opiates of *Brave New World* and the laced water supply of *Thanatos Syndrome*. Critics, or prophets (depending on one's perspective), easily slip down this road of fear and conspiracy; however, these fears of conspiring powers waging a large scale assault on how we think and behave can detract from the actual complexity of the problems associated with the identification and treatment of depression. While I am critical of many of the critics of a medical model of depression, I do indeed find that many of the social elements that factor into the identification and treatment of depression are ethically problematic.

A dilemma that I perceive to be at the heart of contemporary assessments and treatments of depression is the fact that the power of creating diagnostic categories is limited to the American Psychiatric Association, despite the fact that the DSM has widespread impact on non-medical related practices. The DSM is subject to and helps create policies that affect legal, economic, judicial, and social structures that have bearing on individuals, families, communities, and governments. While its aim is to guide clinicians in the diagnosis and treatment of patients, it also has immense political ramifications. In regards to the classification of depression in particular, Solomon points out that the "problem is not so much the politics of depression as our failure to recognize

that there *is* a politics of depression."[303] He explains that politics are involved in "Who researches depression; what is done about it; who is treated; who is not; who is blamed; who is coddled; what is paid for; what is ignored."[304] It is not merely the more formal structures of classification that are impacted by psychiatric categorization; the DSM also affects social and personal perception. The authority to bestow the name *depressed* upon an individual rests in the hands of doctors, the "professionals of representation."[305] A medical diagnosis assigns the individual to a place and position in relation to others. Schizophrenic, bi-polar, psychotic, chronically depressed – these are not adjectives one merely adds to a list of attributes. The naming of one's *problem* as *illness* and the designation of one's status as a patient both limit and produce certain types of agency.

John Sadler, a professor of medical ethics and psychiatry, addresses the view that psychiatric diagnosis has widespread influence and impacts the very way we think about ourselves. He writes:

> …psychiatric power, embraces more than mere economic or political power; it takes on metaphysical power as well, influencing how we understand ourselves, how we think, and what the 'nature of things' is.[306]

This view echoes Bourdieu's assessment of classificatory systems, which he argues have the "symbolic power to make people see and believe."[307] As mentioned earlier, the depressed individual can come not only to identify her experience *as* depression, she also integrates depression within her very sense of self. The identification *with* depression alters the way one sees the world and one's place in it. It is an acknowledgment of

[303] Solomon, 2002, 393
[304] Ibid, 361
[305] Bourdieu, Language and Symbolic Power, 2001, 243
[306] Sadler, 2004, 174
[307] Bourdieu, Distinction: A Social Critique of the Judgment of Taste, 2002, 480

difference and disability. It is an admission about the limits of one's ability to *heal thyself*. It is a recognition of the interdependence of the self and the body, the mind and the brain. One can see why people resist such a designation and protest the psychiatric classificatory system as oppressive.

Another criticism of a medical model of depression is based on the assertion that psychiatry presumes that health is a matter of happiness and balance. The concern is that psychiatric conditions are interpreted as pathological based on a normative view of well-being. Dana Crawley Jack argues that mental health "coincides with the dominant values of the culture: autonomy, independence, power, wealth."[308] In Jack's assessment, falling short of these values can be interpreted as pathological. Similarly, Elliott expresses the concern that Americans (U.S.) rely on antidepressants to heal normal human difficulty such as existential and social alienation. He points to the mass consumption of antidepressant medications as the American response to *spiritual emptiness* and *restlessness*. He suggests that "psychic well-being isn't everything" and argues against the "therapeutic world view" that "sees every human predicament as a problem to be fixed."[309] Ultimately, most criticisms of 'depression' derive from the fear of limitations that mental health care places on human freedom.

Because mental health care has a direct impact on views of the self and agency and lacks consistent tools for determining etiology, measuring severity, and identifying symptoms, it is vulnerable to criticism and skepticism. However, health and well-being in general are also evaluative constructs. Each act of diagnosis and treatment of any type of

[308] Jack, 1993, 18
[309] Ibid, 11

ailment is rooted in a complex and vast matrix of value judgments that have led up to the moment in which such an act can be performed. The goal should not be to eliminate normativity from medical science and mental health care, which cannot be accomplished, but to make it more transparent and self-conscious of its valuations.

Given the amount of pharmaceutical advertisements that claim to cure and treat depression, coupled with the large quantities of antidepressants prescribed in the U.S., it is easy to come to the conclusion that people are overexposed to depression and thereby over-diagnosed and over-medicated. The discrepancy between what mental health advocates call "underexposure" and critics call "overexposure" lies in the nature of the information given and the populations targeted to receive the information. One could make the argument that a population overmedicated with antidepressants could lead to spiritual emptiness, artistic triteness, pain intolerance, and perhaps even moral weakness in the culture – of course, perhaps the same could be, and has been, said about television, alcohol, air conditioning, and so forth. On the other hand, a population of individuals without adequate treatment for major depression can and has lead to higher rates of suicide, homicide, drug addiction, and work loss. Also, unlike depressive feelings, or even a melancholy temperament, which have long been associated with artistic, spiritual and intellectual growth and productivity, a depressive disorder impairs one's ability to function on the most basic levels. The consequences of underexposure far outweigh the possible downside of overexposure.

Flight from authenticity

The ideal of a unified self has prevailed throughout the history of Western philosophy and has shaped the interpretation of melancholy and similar deviant mental states. The view of the self as unified has lead to positions that tend to either demonize or romanticize melancholy. On one side we see sweet melancholy genius overflowing with nostalgia for simplicity, a yearning for nature, desire for truth, and an urge to create. On the other side we see demonic facial contortions showing weariness of life, hastened signs of old age, and an uncanny absence of vitality. While a negative depiction of melancholy resembles most contemporary perceptions of melancholy's heir-apparent – depression – many cultural critics and academics have retained the romanticized view of melancholy and hold depression up to the same ideal. According to this view, depression and depressives, like the melancholy philosopher-genius, have a special relationship to truth, meaning, and/or contribute to a richer and more authentic life.

The philosopher Jennifer Hansen argues that depression could be "an important means to self-fulfillment and self-actualization."[310] Similarly, Jennifer Radden contends that depression narratives emphasize a "depth of appreciation and feeling that come with depression" and insists that there is "great personal meaning and value" in depression.[311] The narratives that Radden cites as having an appreciative character are Styron's *Darkness Visible*, Danquah's *Willow Weep for Me*, and Jamison's *Unquiet Mind.* However, these authors depict a much more complex and graver picture of depression than Radden reports. They describe their depressive episodes as periods of desperation

[310] Hansen, Affectivity: Depression and Mania, 2004, 40
[311] Radden, Moody Minds Distempered: Essays on Melancholy and Depression, 2009, 175

and deep pain, dominated by unrelenting thoughts of suicide. These particular authors, as well as many others, report that depression erodes their ability to act, communicate, and connect, while diminishing their desire to live. From the perspective of the depressed individual, the primary affective, cognitive, and social effects of depression do not lead to existential authenticity or special psychological insight. In convalescence, depending on the depressive's social environment and personal skills and desires, the recovering depressive can work through the depressive experience to (*re*)create meaning and meaningfulness. However, this response is neither intrinsic to the depressive experience, nor does it redeem it. For example, Jamison states that her illness, manic-depressive disorder, contributes to a deeper experience of life and allows her to see the "limitless corners" of her mind. However, she also describes depression as "awful beyond words."[312] She continues,

> *There is nothing good to be said for it except that it gives you the experience of how it must be to be old, to be old and sick, to be dying; slow of mind; to be lacking in grace, polish, and coordination; to be ugly; to have no belief in the possibilities of life, the pleasures of sex, the exquisiteness of music, or the ability to make yourself and others laugh.*[313]

During a depressive episode the depressive is concerned with surviving, not thriving. Depression itself is a destructive force and Jamison was fortunate not only to survive it, but to be able to find meaning in the experience.

It is important to distinguish the meaning that depressives have gained through the process of recovery and their experience of depression during a depressive episode. In a

[312] Jamison, 1996, 217
[313] Ibid

depressive episode, one is exhausted, estranged, lonely, grieving, and scared of one's own mind. While it is possible for the depressive to develop an appreciation of depression after her recovery from it, it takes a great amount of work, self-knowledge, supportive relationships, and creative outlets to give meaning to the very experience that destroys meaning and meaningfulness. Martha Manning expresses her sentiment regarding the idea that depression reveals existential truth:

> All the romantic nonsense about depression somehow making one into a creature of unique sensibilities is easy to agree with when I feel good...All of this stands up to the light, but it's bullshit in the shadows. I don't care about unique sensibilities. All I care about is surviving. My goal in life is just to get through the days.[314]

Manning draws the distinction between the value that depression has for her when she feels well and when she is "in the shadows." Often memoirs and first-person accounts are themselves an attempt to give meaning to depression. Whether one strives for spiritual redemption or simply wants to bear witness to the horrors of depression, the meaningfulness of depression cannot be generated during the depressive episode itself and is certainly not intrinsic to depression. Depression does not have a direct causal connection to the production of meaning, philosophical insight, and/or something akin to an authentic self-actualization. Mike W. Martin, who attempts to provide a philosophical basis for promoting the moral and creative benefits that arise from depression, does not even go so far as to claim that these benefits make chronic depression intrinsically valuable. He explains, "…that is like arguing that a heart attack is not pathological if it motivates a person to adopt a healthier way of living."[315] He goes on to say, "Fortunately,

[314] Manning, 1994, 173
[315] Martin, Depression: Illness, Insight, and Identity, 1999, 274

much sickness, including life-threatening depression, has positive results, beyond its mere cessation."[316] Regardless of whether it might be true that *in order to overcome one must first go under*,[317] the problem is that in going under, not everyone even comes out. The high rate of suicide attempts among depressives alone should point to the lack of intrinsic creative and truth-bearing properties of depression.

A view of identity as multifaceted and multifarious gives us a way of understanding the experience of depression (whether acknowledged as 'depression') outside of the normative schema of authenticity. Struggling with questions of authenticity and identity, Solomon writes, "Who is the real me?...The ailing me is not a more or less authentic self; the therapized me is not a more or less authentic self."[318] He explains:

> Chemistry and biology are not matters that impinge on the 'real' self; depression cannot be separated from the person it affects. Treatment does not alleviate a disruption of identity, bringing you back to some kind of normality; it readjusts a multifarious identity, changing in some small degree who you are.[319]

Based on the many similar testimonies of depressives, it seems that one should conclude that depression neither negates nor promotes authentic being. In other words, depression is not an existential condition or a constitutive mode of human life, even though it prompts existential and evaluative questions and quandaries. Depressive disengagement does not free oneself for a more authentic existence; rather, it draws one nearer to death – actual death, not theorized.

---

[316] Martin, Depression: Illness, Insight, and Identity, 1999, 274
[317] Nietzsche, 1961
[318] Solomon, 2002, 431
[319] Ibid, 21

Depression reveals that identity is not primarily or exclusively a matter of consciousness and unity; it shows that identity is embodied, social, and malleable. Even if depression does have a special relationship to *truth*, *authenticity*, and a *deeper* life – which I claim is neither intrinsic nor even typical – it certainly seems ethically problematic to promote such a view, knowing full well the suffering that accompanies depression. Ethically speaking, if someone promotes the existential benefit of life-negating states like depression, then I believe that they better have good evidence and reason for doing so. If one focuses on the possible life-enhancing aspects of depression (though neither common nor intrinsic), then one forgets the primary negating tendency of depression: the negation of life itself.

Social Structuring of Depression

Not only do depressives withdraw from others, but other people recoil from depressives. Because the symptoms of depression are, according Coyne, "both incomprehensible and aversive to members of the social environment," people find depressives often tiring and intolerable.[320] Foucault highlights the fact that initially the political outrage over the imprisonment of the insane was based on the belief that sane prisoners should not have to be confined with the insane population. In other words, the imprisonment of *the mad* was not considered an injustice for the mentally ill, "but *for others*."[321] Unfortunately for the depressed individual, depression does not deaden a

[320] Coyne, 1985, 231
[321] Foucault, 1988, 228

person's awareness of the burden she imposes on those around her. As Danquah notes, "Depression is a very "*me*" disease…Most depressives find themselves – as much to their own disgust as to everybody else's – annoyingly and negatively self-obsessed."[322] Some depressives who are fortunate enough to have a few close friends and/or family members prior to the onset of depression have found that these relationships serve as a life-sustaining force. However, depression can test even the tightest social bonds, and casual acquaintances tend to dissociate easily. People's repulsion from depressives is not necessarily due to a lack of empathy or the stigma associated with mental illness, but because they lack the stamina to withstand the constant onslaught of frustrations caused by the depressive. People cannot count on the severely depressed to do or show up for work. People cannot even rely on the depressive to return a phone call or respond to messages. On a more personal level, people also cannot expect the depressive to be able to carry on a conversation or take part in other people's sorrows and joys.

Diversification of the *depressive experience*

Depression, from the perspective of the depressive as well as culture, is not a privileged marginality. I once heard depression described as "every family's secret." T. Williams assures her readers that "there is not one among us who has not been touched by this," yet depressives remain marginalized and seeking mental health care is often viewed as shameful.[323] The topic of 'depression' is shunned in workplaces, rarely

[322] Danquah, 1998, 31
[323] Williams, 2008, 3

discussed openly within most families, and typically goes unmentioned in social gatherings. When people do talk about depression, it often has the feel of a clandestine and derisive whisper. In depression one becomes *de facto* marginalized regardless of one's social identity prior to the onset of depression. The depressive is not merely subject to the cultural views of mental illness; she also embodies and reproduces the views of her form of life. While discrimination might be a trigger for depression, depression itself seems not to discriminate among its hosts. Timothie Bright, the 16th century author of *A Treatise of Melancholy,* contends that melancholy is indiscriminate: "the cause respecteth not time nor place, nor circumstance of person, nor condition, seeketh no opportunity of corporal imbecillity, but breaketh through all such considerations, & beareth down all resistaunce."[324] Centuries later, Sally Brampton makes a similar observation after staying in three psychiatric units: "Nobody there looked like the sort of person who suffers from depression. It is no respecter of type. Or gender. Or class. Or money. Or success."[325] While depression crosses social categories of identity, the treatment, diagnosis, and acceptability of depression do tend to differ based along the intersecting lines of race, gender, and class.

It is inordinately difficult to provide an adequate assessment of identity structures in general, much less how they interact with, inform, and affect the experience, treatment, and perception of depression. How social groupings function in the life of an individual and in the life of a social group can change over time, and what these identity markers mean differs among different social groups and among individuals within the same social

[324] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 127-128
[325] Brampton, 2008, 16

group. In addition, these categories have moving boundaries. At the level of both the individual and society, new social factors can emerge and others dissipate, which affect the nature of the social identity. Furthermore, the development of these social identities does not occur congruently among individuals or social groups. Race, gender, sexual orientation, and socioeconomic status do not all intersect at the same points with regard to depression. Each category of social identity impacts all the other categories and no single category can be considered a consistent determining factor for depression. Likewise, no single theory can adequately account for the interaction of social variables and how they function in depression. Given such a high level of indeterminacy, one might argue that the philosophical assessment of identity structures serves no purpose. However, despite the irregularities, social categories of identity do have real implications on a person's experience of depression. For instance, depending on class, religion, race, gender, sex, education, and geographic region, a person's possibility of recovering from depression varies greatly. The main factors involved in race, gender, class and sex, that have bearing on the diagnoses and treatment of depression center around: the availability of medical professionals, the medical and social background of health care providers, the financial ability of the depressive to access medical treatment, and the social acceptability of medical treatment for depression. Simply promoting awareness of the various social conditions affecting mental health can help promote better policies and more effective individual treatment.

Gender and sex

If one was pressed to make a generalization about who gets depressed, the answer would likely be that depression is a white person's problem. The stereotypical depressive is a wealthy Anglo-American woman popping Prozac like bon bons. However, this image actually contradicts facts about the types of social conditions that are most likely to contribute to depression. Several studies have shown that stress is one of the best predictors of depression, and chronic stressors such as poverty, discrimination, unemployment, and disability often lead to depression. In addition to chronic social pressure, acute stressors such as trauma, illness, and bereavement are also triggers for a depressive episode. Studies confirm that women are almost twice as likely to experience depression as men, regardless of ethnicity or nationality.[326] After thirty years of research scholars have not been able to identify and agree on one variable that can explain the cause of gender disparity in depression.[327] It has been posited that women are more likely to report depressive symptoms to doctors than men, which might account for some of the gender disparity of depression. Others point to cross-cultural trends that increase a woman's vulnerability to depression. Discrimination, increased susceptibility to violence and abuse, elevated levels of poverty, and the burden of child rearing all contribute to high levels of acute and chronic stress among women.[328] Nolen-Hoeksema posits that

---

[326] "Diagnosable depressive disorders are extraordinarily common in women, who have a lifetime prevalence for major depressive disorder of 21.3%, compared with 12.7% in men (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993)." (Nolen-Hoeksema, 2001, 173)

[327] Ibid

[328] While I have referenced cross-cultural trends about depression in women, there is no agreement about the universality of depression. For instance, Richard Shweder, a psychological anthropologist, argues that depression is a psychological universal transformed into culture-dependent emotion (Kleinman, 1985, 178), whereas Beeman, an anthropological linguist, contends that "the assumption of universality of depression

both "stress experiences and stress reactivity" associated with some of the aforementioned gender differences lead to higher rates of depression in women compared with men.[329]

Given the fact that women represent the majority of reported cases of depression, the common picture of depressive symptomatology reflects how depression is conveyed and experienced by women. Cultural patterns not only contribute to the triggering of depression, they also affect the experience of it. For instance, women are generally less encouraged than men to exhibit signs of aggression. Translated into depression, men who are depressed are more likely than women to express depression in terms of hostility, anger, and aggression. Terrence Real recognizes that while "many men are depressed in ways that are similar to women, there are even more men who express depression in less well-recognized ways."[330] He argues that the "less-well recognized" signs of depression belong to a "cultural cover-up about depression in men." Real notes that undiagnosed depression "drives several of the problems we think of as typically male: physical illness, alcohol and drug abuse, domestic violence, failures in intimacy, self-sabotage in careers."[331] Because these patterns of behaviors do not fit the traditional model of depression, they are less likely to be interpreted by the primary care physician (and people in general) as symptomatic of an underlying depressive disorder.

---

seems ill-founded" (Beeman, 1985, 217). The psychological symptoms of depression, as opposed to physical symptoms, are the most variant cross-culturally.

[329] Nolen-Hoeksema, 2001, 176

[330] Real, 1997, 23

[331] Ibid, 22

Research on the relationship of sexual orientation and depression has a complicated background. Sexual orientation has historically and mistakenly been seen as a cause of poor mental health. Prior to 1973, the DSM categorized non-normative sexual behaviors and preferences as pathologies in-and-of themselves.[332] Homosexuals have unfortunately been subject to various forms of pseudo-therapy aimed at correcting non-normative sexual orientation and sexual behaviors. Another complicating factor is that there is a lack of agreement on how to conceptualize sexual orientation. Also, people's sexual behavior and self-identification might change over time.[333] Horowitz and associates note that while the "literature on depression and mental health suggests that differences between SORB [sexual orientation behavior] groups do exist," the "evidence is equivocal."[334] He points to one study that showed that homosexuals report higher rates of depression and more suicide attempts than heterosexuals (Bradford et al., 1994),[335] whereas two other studies showed no notable differences between these two groups (Gonsiorek, 1991 and Zinik, 1985).[336] With regard to the third study, Horowitz noted that it revealed "significantly greater depression" among bisexuals than either homosexuals or heterosexuals.[337] In recent years the suicide rates among bullied gay teenagers is garnering national attention and outrage, along with the suicides of teenagers bullied for reasons other than sexual orientation.

[332] Nurius, May, 1983, 120
[333] Horowitz, Weis, & Laflin, August, 2001, see pages 205-207
[334] Ibid, 208
[335] Ibid
[336] Ibid
[337] Ibid

Class

Socioeconomic status certainly plays a role in the development, diagnosis, and treatment of depression; however, not every dimension of socioeconomic status – education, income, home ownership, etc. – has the same type of impact on depression. Home ownership, for example, is linked with lower rates of depression than household income.[338] In addition, research shows that "not all resources have the same influence on the health of all actors."[339] For instance, while rates of depression are highest among black women, black women with high socioeconomic resources have the lowest levels of depression among black and white men and women.[340] Roxburgh mentions that despite the fact that research shows that black men with low levels of economic resources are less depressed than white and black men and women, African American men are disproportionately engaged in "externalizing behavior" and "consequently pay an almost incalculable price for low resources in the form of higher rates of incarceration, higher mortality, and more substance abuse than other groups (Western, 2006)."[341]

Interestingly, even though the first-person accounts surveyed in this dissertation spanned various social categories of identity, they all portrayed a similar experience of depression. The factor that most likely accounts for the convergences among the narratives is the high education levels among the authors. Miech and Shanahan point out that "poor coping resources such as an external sense of control and low social support

[338] Roxburgh, 2009, 370
[339] Ibid, 376
[340] Ibid, 371
[341] Ibid, 375

are more prevalent among respondents with less education"[342] The ability to avoid or delay stress exposure primarily corresponds to education levels, which is often a key indicator of socioeconomic status. In a study evaluating the rates of depression and education levels, it was noted that "individuals with higher education have more health resources – such as a better ability to avoid chronic stressors and healthier lifestyles."[343] Furthermore, this same study found that physical health was the leading indicator in accounting for the gap between education levels and rates of depressive symptoms.[344]

Race

African Americans have also been subject to oppressive categorization in terms of mental health. Terrie Williams points out that at "one time in this country, it was a accepted belief that Black people who wanted to be free were, by definition, out of their minds… a disease with an actual name: *drapetomania*."[345] Head remarks that, "blacks as slaves weren't perceived as having a psyche susceptible to mental illness."[346] In addition to historic and ongoing prejudice, African Americans face numerous obstacles to receiving a correct diagnosis and adequate treatment of depression such as the stigma of mental illness in Black communities, the prevalence of misdiagnosis and underdiagnosis, distrust of the psychiatric and medical communities, and a lack of access to mental health care.

[342] Miech & Shanahan, June, 2000, 167
[343] Ibid, 164
[344] Ibid, 170
[345] Williams, 2008, 246
[346] Head, 2004, 16-18

In a study evaluating the acceptability of treatment for depression among African Americans, Hispanics, and whites, it was discovered that African Americans were more prone to believe that antidepressant medications were ineffective and addictive, and believe that prayer could help heal depression. Both Hispanics and blacks were more resistant to counseling and medication than white people.[347] Consider the following conclusions drawn about the acceptability of treatments among these three racially differentiated groups:

> African Americans are less likely than white persons to find antidepressant medication acceptable. Hispanics are less likely to find antidepressant medication acceptable, and more likely to find counseling acceptable than white persons…Overall, 70% of patients (n = 579) found anti-depressant medications to be an acceptable treatment for depression (74% of white persons, 51% of African Americans, 59% of Hispanics)."[348]

If the combination of counseling and antidepressant medication is indeed the most effective treatment for depression, the above study shows that whites are far more likely to recover from severe depression than both African Americans and Hispanics. Head attributes the resistance to treatment among blacks as stemming from historical bias, the church's stance that God is the only healer of a troubled mind, as well as "mistrust of 'experimental' medicine," a view stemming from the use and/or withholding of medicine in medical research in which blacks were used as "human guinea pigs."[349] In the study mentioned above, the results also showed that African Americans preferred to be treated

[347] Cooper, et al., 2003, 486
[348] Ibid, 479 & 483
[349] Head, 2004, 18

by a medical professional of the same race, more than white or Hispanic individuals.[350] Terrie Williams suggests that "Black men are even more suspicious than Black women of the primarily white professionals who might help them. They see these experts as being in part responsible for the social problems that contribute to their feelings of depression."[351] Ellin LaVar writes that the stigma is that "the white man messing up your mind."[352]

This mistrust of the medical establishment, particularly mistrust over the treatment of one's mental functioning, speaks to perceived and actual racial homogeneity in the medical community that spans the spectrum from individuals used in research to the primary care physician in the clinic. Even with all the obstacles that prevent individuals from seeking mental health treatment in black communities, when an African American does make it to the doctor's office she then faces the systematic misrecognition of depressive symptoms that are common among non-white people. Williams explains this process:

> The amazing thing is that even when we bring ourselves to ask medical professionals for help, there's a risk that we won't get it. Maybe it's their bias, or maybe it's poor research (which has been done almost exclusively on whites), maybe it's human error…whatever the reason, professionals often don't recognize that the signs and symptoms for depression may be different for African American patients than for white patients. These doctors don't see our distress because they aren't looking through the right lens. They see the *effects* of depression – broken homes, addiction, violence, anger – but not the depression itself.[353]

[350] Cooper, et al., 2003, 486
[351] Williams, 2008, 78
[352] Ibid, 66
[353] Ibid, 240

Head also comments on the behavioral effects of depression that are often viewed as pathologies of African American communities. Rather than addressing the root causes of systemic problems, Head points out that the so-called 'treatment' of what are perceived to be social ills is to "quarantine us" in prisons.[354] He calls attention to the fact that "many African American men receive their first and only treatment for mental illness behind bars."[355] Unfortunately, as the United State's most populated centers for the treatment of mental illness, in prisons and jails the "treatment is apt to be directed at keeping them under control rather than alleviating the effects of their illness."[356]

As evidenced anecdotally and in studies, the stigma around mental illness is higher among African Americans than among whites. For the most part, depression simply is not a part of the vocabulary of many black families and communities. Meri Nana-Ama Danquah writes: "Clinical depression simply did not exist within the realm of my possibilities; or, for that matter, within the realm of possibilities for any of the black women in my world."[357] She also writes about the negative association of people of color with mental illness, which she contrasts to the impression of white men and mental illness about whom there is often a glorified view of the relationship between mental illness and creativity. Similarly, Yvette Hyater-Adams's succinctly notes, "Depression is what white folks do."[358]

Given the fact that labels like "insane" and "hysterical" have been used to dismiss and pathologize difference, politically marginalized groups are often quick to counter-

[354] Head, 2004, 24
[355] Ibid, 4
[356] Ibid
[357] Danquah, 1998, 19
[358] Williams, 2008, 40-41

identify with the mentally ill. There seems to be a profoundly common fear of appearing "crazy" in communities of color. Although mental institutions began dissolving in the 1970's and are scarce today, for decades eccentrics and marginalized people legitimately feared institutionalization. Social difference, whether in the form of gender or race or sexual orientation or any other non-mainstream group, has a history of punishment and exile. African Americans have had the legal standing of being less than human, and homosexuals have been associated with criminal perversion and mental illness. Today, prison is the institution that houses a disproportionate number of blacks and the mentally ill. Williams acknowledges that African Americans are "scared to death of being labeled mentally ill."[359] She also points to the "long legacy of secrets and lies in the Black family" as creating the social condition of silence about pain.[360] In line with this view, bell hooks recounts the adult voices of her childhood warning her about institutionalization: "'Little girl,' I would be told, 'if you don't stop all this crazy talk and crazy acting you are going to end up right out there at Western State [mental institution]'."[361] Unfortunately, this counteridentification, even if understandable, reifies the insidious stereotypes about mental illness and creates a culture of exclusion and silence about mental illness in general.

[359] Williams, 2008, 22
[360] Ibid, 10
[361] hooks, 1990, 209

Silence and Disclosure

While meanings, practices, and identities are primarily formed in relation to a way of living, a form of life does not dictate the limits of life's possibilities. Various conditions that arise within a form of life can serve as challenges to what is understood as the *given.* Challenges to a form of life can come about accidentally, through events, or through deliberate scientific inquiry. Questioning the definiteness of one's form of life can even arise from one's body and emotions. For example, a form of life can be contested by the intangible sense that something is not quite right. People who have bodies, ideas, and/or feelings that do not accord with their form of life are, whether directly or indirectly, challengers to a form of life. For better or for worse, depression is another condition that necessarily resists a form of life. It also has the unfortunate effect of resisting life itself. This dissertation has thus far given an account of disrupted agency in terms of a disrupted form of life, as exemplified by depressive temporalization, spatialization, and loss of self; however, depression must also be considered in the way it is disruptive *to* a form of life. The idea of a depressive identity, which is not a contrary to depressive illness, can perhaps provide a way for rebuilding agency and also renegotiating one's relationship with a form of life. The depressive can look to other deliberate and/or unwitting challengers to a form of life to shed light on what it means to embrace a multifarious agency.

Many people, both before and after a depressive episode, are considered to be highly successful entrepreneurs, intellectuals, artists, politicians, physicians, and so forth, so it might seem that their cultural authority and success undermine the idea that they that

they have a disrupted form of life. The fact that some depressives can function in some settings some of the time, speaks to the fact that depression has developmental stages and that depressives experience a multiplicity of identities. In some stages of depression, the individual is able to repress depressive symptoms for a certain period of time. Williams characterizes this functional depressive self as "passing for normal." This idea of "passing for normal" hearkens to the idea of "passing for white." The act of *passing* suggests that one hides the truth of her identity in order to fit the norms of a particular community. The projected appearance of normalcy is not necessarily a betrayal of one's true feelings. *Passing for normal* can be a means of coping with depressive symptoms and is often a feeble attempt to hold on and survive.

Often the ability of depressives to function in one role, usually work related, belies the crippling effect of pain in depression. Brampton speaks about the fact that she and other depressives are "capable of smiling and talking cheerfully while at the same time planning our own deaths."[362] For some depressives, the attempt to pass for normal is experienced as an active and exhausting holding back. *Passing* can take on the normative tone of trying to pass for someone else and attempting to hide one's identity. Williams repeatedly refers to the "mask" that she and other people wear in depression. She writes, "I had reduced myself to two modes: my game face, the soul-destroying mask I wore to work, and the numbed-out shell of a woman who sat alone in her apartment eating and sleeping."[363] In the essay "Moving to New Boroughs," Peg O'Connor describes the posture of hiding one's difference as having an active rather than a passive quality.

[362] Brampton, 2008, 18
[363] Williams, 2008, xxiv

Secretiveness, she argues, is an attempt to control other people's access to oneself.[364] The "active" quality of what O'Connor labels 'secretiveness' does not necessarily originate from the person who is consciously withholding something. Also, secretiveness can be the necessary stance of the person who is in an environment that is hostile to the thing that is hidden. In other words, secretiveness is *re*active. The depressive's silence about her illness is often an unreflective defensive stance. On the other hand, for some depressives, an active and conscious withholding of information regarding depression does take place. Jamison notes that when she reaches a certain level of intimacy with someone she faces the discomfort of whether to mention her illness. She says that not talking about her depression with someone "generally consigns a friendship to a certain inevitable level of superficiality."[365]

The secretiveness about depression is in part a reaction to the perception that nobody else feels the same way. Head writes: "You don't seek out others who are living the same kind of life; you're convinced that there *are* no others who suffer the way you do."[366] However, as Williams came to find, "The more I took off my mask, the more I shared my story, the more folks shared back with me."[367] She speaks of "coming out" for the first time about her struggle with depression and the liberating effect of telling the truth.[368] The acts of *passing* and *coming out* can be used as examples for the depressive's attempts to respectively hide and disclose her depression. They provide models for how

[364] O'Connor, 2002, 435
[365] Jamison, 1996, 200
[366] Head, 2004, 124
[367] Williams, 2008, xxvi
[368] Ibid, 1

to express and make sense of the shame and isolation of depression and the struggle for recognition and acceptance.

Depressives could benefit from having their own form of what has become the empowering – though for many people a dangerous - cultural ritual of 'coming out.' However, one reason that the expression "coming out" inappropriately applies to the experience of revealing one's experiences with depression is that *coming out depressed* is not connected with a larger ritualistic and subversive movement. Coming out about one's sexuality is not simply an individual moment of disclosure; it is a performative utterance that celebrates one's identity and joins one to a larger community. That is not to say that everyone who discloses his or her non-normative sexual orientation wants to do so or even that he or she is comfortable with his or her own sexuality. On an individual basis, coming out may not originate from feelings of pride, and some people are 'outed' against their wishes; nevertheless, from a cultural standpoint, "coming out" has become a ritualistic expression and assertion of one's agency. While disclosing one's experience with depression may not have the same cultural significance as 'coming out' and lacks the quality of pride and celebration, it is nevertheless a form of self-affirmation. Self-affirmation of one's depressive identity might seem like a misnomer, given that it is depression that erodes one's sense of self. Disclosing one's struggle with depression is a form of self-affirmation in as much as it reasserts the 'I' – "*I* suffer from depression" – and it gives voice to one's experience with depression.

A more appropriate, although less recognized, ritual of disclosure is a type of language game that O'Connor addresses, 'breaking the silence.'[369] "Breaking the silence" refers to the charge of unveiling the actions and actors involved in abuse, oppression, and violence. Unlike "coming out," which implies that the person coming out is in fact coming out about herself, "breaking the silence" can be a collective or individual act, often by of a social welfare group, a bystander, a victim or group of victims, a governing body, and in rare cases, the perpetrator(s) of violence. Like violence, depression is unequivocally a form of mental and physical suffering, and the disclosure of one's experience with depression is not an act that celebrates this experience. Depressives, like victims of violence, can celebrate surviving and overcoming, but they do not celebrate the pain itself. Ultimately, the act of breaking the silence about depression can be empowering and liberating; it is both an assertion and forging of agency. Brampton writes: "I have discovered that when I break the treaty of silence, I am amazed to find how many people will join me."[370] Unveiling one's struggle with depression can be a way of rebuilding one's connections with other people and a form of life.

Conclusion

A philosophical reflection on the depressive's experience of self-loss, agential conflict, and attenuated cognitive attachments demands a critical engagement with

[369] O'Connor, 2002
[370] Brampton, 2008, 102

theories of identity. In my view, a theory of identity as multiplicitous can account for the alterations to identity and one's sense of self in depression without reinforcing normative ideals of authenticity or unity. A philosophical investigation of the depressive's social identity also raises pragmatic questions about the social structuring of depression as an illness and the roles that social categories of identity play in the assessment, diagnosis, and treatment of depression. While depression disrupts one's agency and sense of self, the identification with 'depression' can function as an intellectually and pragmatically productive means for understanding one's experience of depression, as well as establish a foundation for one's recovery from it. In the next chapter I will address the disruption of form of life in terms of the depressive's disrupted discursive agency. I will show how the symptoms related to 'language-loss' in depression are emblematic of the depressive's sense of a loss of meaning and loss of voice.

CHAPTER V

DISCURSIVE DISRUPTION AND THE ESTRANGEMENT FROM AFFECTIVE MEANING

Introduction

Thus far I have proposed that we understand depression within the broader context of its relation to a form of life. A form of life infuses temporality, spatiality, interpersonal relations, and one's sense of self. Language and meaning are also defined by and function within a form of life. How one experiences the passage of time, one's surroundings, one's body, and other people, and how one uses language and lives in language, only has meaning, expression, and purpose within the wider context of a form of life. When a person experiences a mental illness, it alters her relation to and experience within a form of life. Severe depression does not simply interfere with discreet elements of existence; it interferes with and alters the functions, meanings, and experiential aspects of an entire way of living. It is not simply that a person's *life* gets disrupted in depression; depression disrupts her *form of life*. Depression erodes the vitality and pull of the multifarious intersubjective structures that undergird meaningful action, meaningful orientation, and meaningful experience.

In this chapter I will show how the various elements of depressive disruption are interconnected with the depressive's estrangement from language. Also, I will show that language-loss does not result from an apparent inadequacy of language or the indescribability of depression. Multiple social, physiological, and psychological structures and systems are implicated in the depressive's loss of language. The depressive's experience of language-loss is interconnected with a breakdown of meaning structures, a withdrawal from interpersonal relations, an alteration in how the depressive perceives and judges the world, desynchronization, a lack of emotional resonance, and social silencing. I contend that a disruption of language and meaning in depression is not principally a failure of representation and cannot be reduced to an intellectual dysfunction. Ultimately, the depressive's loss of language is tied to a broader estrangement from meaning and meaning-making. This estrangement from meaning is grounded in the depressive's affective disconnection and disordering. The alterations to the forms, expressions, and meanings of one's affective life in depression spread throughout the depressive's entire existence and disrupt the depressive's form of life. The disturbance of language and linguistic abilities constitute a surface problem – the depressive symptom – while the underlying problem of language-loss is the diminished felt-meaning of linguistic expressions. What is experienced by the depressive as discursive disruption belongs to a more widespread disruption of the role of affect in meaning-making and meaning-processing. The breakdown of the depressive's discursive agency occurs as a disruption of meaning and voice. The depressive's estrangement from language does not exclusively pertain to the depressive's loss of speech. Her estrangement from language consists of a thoroughgoing rupture of the various linguistic

and non-linguistic structures that participate in meaningful communication, perception, feeling, thought, behavior, and interaction.

Language-loss is relational and the breakdown of relations in depression can occur at the level of concepts, names, meanings, and grammar, as well as at the level of social relations. This disintegration of linguistic agency and structures of meaning does not emerge exclusively as a problem of and for the depressive. In this chapter I will also confront the roles that the interlocutor and the social environment play in the depressive's deterioration of communication. This chapter concludes with an account of the elements at play in the depressive's recovery of meaning and revitalization of voice. As is attested to in many of the narratives, it is through writing to and talking with an *understanding* and receptive interlocutor that depressed individuals have been able to rebuild themselves and recover a voice. Due to the physicality of depression, loss of futurity, proximity of death, and estrangement from oneself and others, depression appears to create its own rules, its own way of behaving and speaking – its own language-game predicated on the breakdown of language. A constructive language-game of depression established through the shared experiences of depressives potentially opens up a space for the depressive's recovery of language.

Part One: The Estrangement from Meaning and Language

'Language' and 'language-loss'

Throughout the dissertation I have used 'language' to refer to the coalescence of

various types of communicative exchanges that take place in and through linguistic expression. My use of 'language' always refers to particular living languages spoken in particular social, historical, and geographical contexts, which are always reproduced by particular speakers guided by particular grammatical and semantic regularities, metacommunicative styles, normative attitudes, economic conditions, etc. I contend that language only has meaning in a form of life; it is essentially bound up with practices, attitudes, habits, and styles. One's life within language involves ways of perceiving, understanding, acting, and feeling. Language is not a unified structure and does not have a unified or homogenous grammar, use, form, medium, or presentation. While language is a social practice, it also functions at the level of one's thoughts, emotions, subconscious states, and even in one's physical movements. Language operates at the intersection of the body and mind, thought and act, understanding and feeling, and the self and other.

One can gain insight into the elements and functions of language by looking at how language breaks down as well as how it works. Just as language is heterogeneous, language-loss is also multiplicitous in its sources, forms, elements, and functions. Historically, philosophical propositions about 'language' have focused on linguistic and semantic elements assumed to be common to most forms of language and to most speakers. Philosophers of language have focused on the problems associated with meaning, intention, sign, reference, speech acts, etc. The consideration of linguistic errors, such as slips of the tongue, elisions, and miscommunication are evaluated as self-contained, linguistic anomalies. Linguistic phenomena that do not apply to "most people" are either relegated to the margins or dismissed altogether. Most philosophical accounts

that consider the contexts, embodiment, and politicization of speakers presume the framework of mental health. The use and disruption of language in depression bring to the fore philosophical problems concerning the relationships among language, meaning, identity, and the body. In particular, the disruption of language in depression reveals the often overlooked and undervalued role that affect plays in constituting meaning and discursive agency.

Cesare Ripa's 1603 engraving titled "*Melancholicus*" depicts the figure of a melancholy scholar with his mouth covered by a scarf and a man throwing himself into a river.[371] In *The Interior Castle*, Teresa of Avilla attests to the damage done to the melancholy person's ability to comprehend words:

> …if a person in this state who knows how to read well takes up a book in the vernacular, he will find that he understands no more of it than if he didn't know how to read even one of the letters, for the intellect is incapable of understanding.[372]

What is it about melancholy that can silence a scholar and drive a man to suicide? What does a malady such as depression teach us about the relationships among language, thought, affect, and agency? Does it speak to the content of our words, the arbitrariness of the signifier, or the tenuous connection between name and referent? Is it a referendum on the presumed primacy of language in thought? Does it reveal the power of the semiotic over the symbolic? Is it a protest against the symbolic or does it signal the impotency of the symbolic in the face of despair? Is the depressive's estrangement from language an exclusively linguistic phenomenon? In the above passage, Teresa of Avilla locates the

[371] Radden, The Nature of Melancholy: From Aristotle to Kristeva, 2000, 11
[372] Ibid, 114

melancholy person's diminished capacity to read in the intellect. However, the depressive's inability to process language accompanies an overall disengagement from one's social and natural environment, which infuses every aspect of one's way of living with a profound estrangement from meaning, sense, and familiarity.

My use of 'language-loss' refers to the various discursive practices disrupted in depression, such as the disrupted capacities to read, write, speak, converse, listen, and communicate with oneself in thought. For the depressive, the words of a familiar book can appear to be written in a foreign script. The words often look empty and hollow. The depressive also frequently hears the speech of other people as remote and hard to follow, similar to what it is like to listen to someone speaking underwater. Depression has the effect of defamiliarizing the sights, sounds, and meanings of words and phrases. Jeffrey Smith recounts that depression kept him from speaking and inhibited his ability to understand other people's speech. He remarks, "I could not speak; and I could not listen...I saw his lips moving, but his words were lost on me."[373] Even when the depressive is able to speak, her phrasing is typically monotone, monosyllabic, and full of elisions. Robert Burton describes melancholics as being "of few words, and oftentimes wholly silent."[374] In "On the Signs of Melancholy's Appearance," Avicenna refers to the "abandonment of conversation" as one of the first signs of melancholy.[375] Often the depressive finds herself paralyzed as she struggles to speak. The words feel somehow trapped inside her. However, words are not stuck like a whole piece of candy lodged in one's throat. The words are not formed, not complete; they feel wedged somewhere in the

[373] Smith, 1999, 4
[374] Radden, 2000, 148
[375] Ibid, 77

neural sphere. The depressive knows they exist, has used them countless times, yet they swirl around in a dark cloud of non-grammatically structured thought.[376]

The disruption of speech and the disruption of linguistic confidence are the most prevalent and noticeable feature of the depressive's estrangement from language. When depressives do speak, they tend to speak slowly and with a flat tone. They frequently limit expressions to single syllable words and taper off at the end of sentences. Styron described his attempt to speak as sounding like a "hoarse murmur."[377] Depressives' verbal utterances also lack the facial expressions and bodily gestures that commonly accompany the speech of non-depressives. Eye contact, tonal emphasis, hand gestures, and the various elements that factor in to the musicality and expressive dimension of speech are typically missing when the depressive attempts to talk. Depressives describe the act of speaking as being effortful and demanding excessive energy. The energy to initiate and sustain communication evades the depressive, and like her body, words can feel heavy and hard to move. Even the act of vocalizing the initial sound of a word can seem to require an unfeasible surge of strength. Andrew Solomon describes the communication of simple linguistic expressions as feeling like a complex, intricate intellectual feat.[378] Martha Manning differentiates between the difficulty of giving a verbal response and the inability of initiating speech. She writes, "It's enough just to speak when spoken to, to give some minimal reaction to a stimulus. But to actually be the stimulus doesn't even occur."[379] The generative force of one's own discursive agency is severely diminished in depression. Meaning no longer feels as if it is self-generating, and

[376] I will address the relationship between thought and language later in the chapter.
[377] Styron, 1992, 19
[378] Solomon, 2002, 52
[379] Manning, 1994, 93

the depressive lacks the discursive agency from which she could play an active role in *making* sense.

While the depressive's experience of language-loss is powerful and real, depressive 'language-loss' nevertheless has the '*as if*' structure that distinguishes depressive symptoms from other disorders. The effects of depression on language resemble the symptoms of other conditions that accompany brain lesions and brain injuries that occur in neural regions of the brain, regions that impact the motor and cognitive functions necessary for speech and language comprehension. Take for example Solomon's claim that once "you cross over [into depression], the rules all change. Everything that had been written in English is now in Chinese…"[380] This experience resembles *alexia*, a condition caused by brain injury or disease that impairs one's ability to comprehend written and spoken language. In Solomon's case, though depression does not actually cause English print to look like Chinese script, the words on a page *might as well be written in a foreign script*. The depressive can look at a word and recognize it, but the word holds no meaning. It is *as if* it is foreign because the depressive can no more read in her mother tongue than she can in the foreign language. Similarly, while the depressive's speech might be confused and lumbering, it is not the case that the depressive's arrangement of words is utterly incoherent as is the case for a patient with *aphasia*. If it is eventually shown to be the case that depressives do in fact undergo an alteration of the neural networks involved in the comprehension, processing, and articulation of language, the impairment does not appear to be permanent.[381] In addition,

[380] Solomon, 2002, 49
[381] Lesions caused by depression have yet to be detected by autopsy or brain scans.

the appearance of the symptoms of depressive language-loss is not static, and the intensity and form of language-loss can change over time.

Language-loss can occur in the deepest throes of depression, yet the depressive does not undergo a single, permanent, and uniform alteration of her use of and relationship to language throughout the duration of a depressive episode. Like depression, the estrangement from language and meaning in depression is non-teleologically developmental. In other words, depression and its corresponding disrupted phenomenological domains have a developmental structure, a structure that does not have an intrinsic path or resolution. Language-loss in depression can be broken down into four main forms of loss: being at a loss to find the right words, a loss *of* one's ability/desire to speak, a loss of content (not having anything to say), and a loss of sense. The first form of loss is bound to the inadequacy of language to express and represent the depressive experience. This form of loss pertains to the apparent failure of one's language to adequately represent depression and the impotency of language to console or make sense of the pain. The second form of loss – the lack of interest in talking and an inability to speak – is the most commonly described, but perhaps hardest to explain. The third form of loss, loss of content, is a response to the void and emptiness that engulfs the depressed, rendering her silent, with nothing to say. The fourth form of loss occurs when the familiarity of language is lost to the depressed and the meanings of words slip away.

From the look of a word to the performative meaning of an utterance, language can break down at many points. Merleau-Ponty addresses some of the complex ways that

language can be disrupted and avers that "linguistic deficiencies cannot be reduced to a unity."[382] He claims that linguistic disturbances can affect

> …the body of the word, the material instrument of verbal expression – sometimes the word's physiognomy, the verbal intention…sometimes the immediate meaning of the word…and sometimes the structure of the whole experience, not merely the linguistic experience.[383]

Language-loss is a pervasive disruption of a meaningfully and linguistically structured way of living. The sound of the depressive's voice, which is thin, weak, quiet, broken, and monotone, attests to the disruption of the depressive's discursive agency. Both the material voice and the concept 'voice' capture the interconnectedness of meaning, identity, and language. One can have no clearer picture of the depressive's loss of meaning, identity, and language than one can by considering the depressive's disruption and loss of voice.

Meaning

Language-loss involves a breakdown of verbal and non-verbal meanings, meanings that are interconnected with an embodied form of life. This disintegration of meaning can take place at any level of signification, in any instance of meaningful movement, in any aspect of linguistic communication, for any symbolically structured perception, and with any identifiable affect. The term "meaning" can be used to refer to the sense of a linguistic expression; it can also be used in reference to an existential

[382] Merleau-Ponty, 1992, 194
[383] Ibid

and/or spiritual significance of an experience, belief, feeling, etc. 'Meaning' can also be understood in terms of 'sense,' 'purpose,' and 'significance.' These three types of meaning – sense, purpose, and significance – can themselves be used in different ways. They can refer to the meanings of the particular elements that make up a linguistic expression, the overall meaning of an expression, and a range of experiences that are not explicitly linguistic. For instance, meaning as *sense* can refer to the definition, connotation, denotation, and intelligibility of an expression, experience, feeling, and practice. Meaning as *purpose* can be understood as the function and/or aim of an expression, experience, feeling, and practice. Meaning as *significance* can indicate the implication, value, and importance of an expression, experience, feeling, and practice. These different uses of 'meaning' are not exhaustive, and the differences among them are often indistinguishable in our everyday way of talking about them. For example, "sense" is often used interchangeably to refer to meaning as *purpose*. A person can say that something does not make sense, in which case the person means that it has no *meaning (purpose)* in a given context. The attempt to understand language-loss in depression can benefit from an investigation into the different ways that depressives are estranged from meanings, even if these differences are often overlapping.

For the most part, meanings come to us ready-made. As children we are taught the meanings of words and how and when to use them. People tend to passively and unreflectively iterate and apprehend the meanings of verbal expressions. Similar to the way that familiar movements like brushing one's teeth or waving one's hand become habitualized and automatic, linguistic comprehension and speech often take place as if they occur on their own. We say things like "Pass the salt" and "Good morning" and

"The other day I saw the strangest thing" without effort or deliberation. While meanings seem to be passively handed down and repeated, each iteration of a word functions as its revivification. Linguistic meaning is continually reenacted. This active quality of sense-*making*, while typically overlooked in our everyday practices, most often comes to the fore when something goes awry. Mistakes, misunderstandings, forgotten words, and uncomfortable verbal exchanges serve as reminders that we are not simply passive vehicles for speech to flow through us, but we are active participants in sense-making.

The verb "to make" in the expression "makes sense" reflects an act of creation. Of course when asked "What are you making?" a person would not respond, "I am making sense." Yet there can be an active construction taking place in the process of understanding the meaning of something. Let's say a person reads the truism, "If you hoot with the owls at night, you can't soar with the eagles in the morning." If asked what it means she might say, "I cannot make sense of this expression" or "I am still trying to make sense of this expression." The grammatical structure of these particular responses shows that the burden of sense-making is on the person reflecting on the expression (e.g. "*I cannot make sense…*"). Alternatively one can respond by saying "This expression does not make sense," in which case the sense-making appears to be the task of the expression itself. On the one hand, the meaning of this expression appears to be the property of the expression. The statement is equivalent to "This expression *is* nonsensical." On the other hand, the statement could be interpreted as if the expression is its own source of agency (e.g. "The expression *conveys* nothing"). It can appear to be the case that the sense-making implied in the comment "This expression does not make sense" falls somewhere in-between being the attribute of the expression and an act of the expression. With this

way of looking at meaning, it seems that the expression does not quite actively make the meaning, yet it does not simply passively possess it.

In addition to placing the burden of sense-making on the expression and on the receiver of the expression, sense-making can also be attributed to the speaker or the author of an expression. Let's say that two people are in a conversation and one speaker says to the other, "If you hoot with the owls at night, you cannot soar with the eagles in the morning." The other person can respond, "That expression does not make sense." In such a case, the sense of the expression is still not related to the first speaker's ability to speak meaningfully. However, if the second person remarks "*You* are not making any sense," then the burden of sense-making is placed on the first speaker. Alternatively, semantic responsibility can be distributed between the two people if the second speaker adds "to me" to the end of the claim: "You are not making any sense *to me*." This addition of "to me" places blame on both speakers for the unsuccessful communicative exchange.

The truism can also be considered to be intelligible but nonsensical. For example, the second speaker might respond, "I understand the idea, but not why you said it now." The expression is nonsensical to the second speaker because of the context in which it was said. For instance, the first speaker might have said, "If you hoot with the owls at night, you cannot soar with the eagles in the morning" in response to a question about where she was born. An expression can be said to be intelligible but not sensible if the expression does not resonate with one's life. While the expression is still meaningful on one level, it does make sense on another level. In this case, one might say, "That used to

make sense to me, but now that I've seen eagles soaring during the day on several occasions, it no longer seems relevant." Here 'sense' pertains to the relevance of the expression and how the expression matches up with one's experience.

If semantic responsibility can be attributed to multiple elements within a single utterance, how should one go about understanding where meaning breaks down for the depressive? For the most part, the depressive attributes the lack of meaningfulness of an utterance to the expression itself ("*It* no longer makes sense") or to a failure on both the part of the expression and herself ("*It* no longer makes sense *to me*"). The depressive rarely seems to place the blame for a communicative failure (i.e. when sense is not successfully conveyed) on another person. The depressive recognizes that language is working fine for the people around her. The depressive reads sentences and knows they should make sense or listens to a friend and knows that she should understand what her friend is saying. Likewise, the depressive can remember when language seemed to work fine for her. The depressive's claim of the unintelligibility of language is not a judgment on the status or legitimacy of the speaker, but a judgment on the depressive's own linguistic competence. If the depressive attributes the lack of meaningfulness to herself and/or to the expressions she encounters, what does this say about the breakdown of meaning in depression?

Even though the depressive might place the blame on herself or on language itself, throughout the chapter I will show ways in which both the interlocutor and the context play important roles in the breakdown of meaning in depression. Ultimately I locate the cause of the depressive's semantic disruption on her diminished capacity for

affective connection. The depressive's linguistic estrangement is symptomatic of an estrangement from what the contemporary philosopher Eugene Gendlin calls the "felt meaning" of word.[384] Similar to the way that the depressive can perceive the features of her surroundings as bearers of depressive properties (the sky as grey, the light as dim, etc.), meaning can also appear to the depressive as the missing property of words. Depressives describe written words as appearing empty and spoken words as sounding distant. Often when a verbal expression no longer makes sense to the depressive, the depressive can nevertheless recognize the words. The depressive can *know the sense* of a word and yet *feel* that it *no longer makes sense*. In this case, the depressive does not fail to recognize words; nevertheless, she gets lost in the meaning of the verbal expression. Imagine what it would be like to see a house that has a fully intact exterior, but no floor or foundation. One would say that it is a house, but not a house. It looks like a house, but cannot function as one because it is suspended in air.[385] Similarly, for the depressive, words can appear and sound intact and recognizable, yet simultaneously *feel* hollow and flimsy. It is as if the sense and familiarity drops out from under the word; it is in Merleau-Ponty's characterization "modified down to its sensible aspect, *it is emptied*…"[386]

Familiarity and meaning often seem to be intangible qualities of words themselves. Both Wittgenstein and Merleau-Ponty refer to words as having a particular "physiognomy." Wittgenstein remarks that words can have a "familiar physiognomy,"

[384] Gendlin argues that "symbols are 'associated with' felt meanings, and …these associated felt meanings constitute our experience of meaning" (Gendlin, 1997, 67).
[385] This metaphor is neither an allusion to Heidegger's claim that *language is the house of being*, nor is a reference to language as the ground of existence.
[386] Merleau-Ponty, 1992, 193

which he describes as the feeling that a word "has taken up its meaning into itself, that it is an actual likeness of its meaning."[387] Features of words, like the curve of an "S" or the rhythm of "tit for tat," can feel as familiar as the smell of coffee or the sound of seagulls. Words like "slithering" and "rainbow" somehow acquire "an actual likeness of [their] meaning."[388] "Slithering" moves through one's mind as if it itself is creepy and wet. "Rainbow" feels full of color and light. Yet familiarity is not an actual attribute of any particular thing. Familiarity first and foremost qualifies a relation. How we live in and with language imbues words with feeling, memories, familiarity, and ultimately with meaning. Merleau-Ponty describes this familiarity as the "near-presence of words."[389] Merleau-Ponty understands the familiarity of language as an *existential* nearness. 'Existential' does not refer to depth of meaning, spiritual meaning, or universal meaning; it is the living, social, and experiential meaning. For Merleau-Ponty, the "existential meaning" of a word refers to the way in which language is lived out.[390] The *near-presence* of language points to a pragmatic proximity between the word and the speaker. It speaks to the *existential* and *felt meanings* of words and the ways in which words have a place in one's form of life.

Just as meanings are created in action and interaction, the depressive's loss of lived meaning is connected to her withdrawal and inaction. Objects and words lose their meaning in as much as they lose their *pull*. The depressive is no longer drawn to the things and beings of her world; they lose their utility, their place, their purpose, and

[387] PI, 186
[388] Ibid.
[389] Merleau-Ponty, 1992, 180
[390] "We find here, beneath the conceptual meaning of words, an existential meaning which is not only rendered by them, but which inhabits them, and is inseparable from them" (Ibid, 182).

eventually fail to make sense. To borrow Merleau-Ponty's words, the depressive "is not caught up in" her environment.[391] She "no longer asks" of her environment and she no longer expects it to respond.[392] It is not simply the case that the depressive has nothing to say in withdrawal; it is as if the world also has "nothing more to 'say'" [393] to the depressive. As long as the depressive fails to interact with her natural and social environment, she remains decontextualized and meanings remain remote.

It could be helpful to look at other ways that language can lose its familiarity in order to better understand what takes place in depression. Artistic expression, whether in the form of poetry, visual art, theater, music, and so forth, can be a means for dislodging the felt-meanings of words and expressions through odd juxtapositions, misuse, or the atypical emphasis of words. Art can draw attention to the materiality of the sign – to its sound or visual form – whereas in our everyday use of language it typically goes unnoticed. The artistic *de*-contextualization of language from its ordinary usage is also a form of *re*-contextualization. Art repositions language within a new context and creates different ways of experiencing language. Meanings can slip away and change when they are removed from their usual context. Similarly, the depressive's estrangement from meaning can be accounted for in terms of her decontextualization. However, unlike aesthetic forms of decontextualization, which tend to be situation/event/form specific, the depressive loses a familiarity with language and meanings in general. It is not the case that the context has simply shifted for the depressive. The depressed individual does not

[391] Merleau-Ponty, 1992, 156
[392] Ibid
[393] Heidegger, 1996, 343

move out of one context and into another one; she loses the sense of being involved in any particular context.

Take for example Gregor's sense of decontextualization in Kafka's *Metamorphosis*. In many ways Kafka's story of Gregor's extreme alteration of identity mirrors the depressive's descent into an unrecognizable world and self. [394] Kafka's *Metamorphosis* captures the interconnection of loss of existential-nearness with the experience of a disrupted form of life. In the *Metamorphosis*, the protagonist Gregor undergoes a drastic existential alteration as he suddenly awakens to his lost human form and encounters his new identity as a human-sized insect. Gregor unexpectedly finds himself with a new voice, a new body, and eventually a new sense of self.[395] The many conversions of Gregor's life all take place within the familiar setting of his room and his family's flat. How Gregor perceives his surroundings and how others perceive him fundamentally change even though he never actually leaves his home or his family. Items as common and comforting as furniture no longer have use or purchase for his newly changed self. With an increasing sense of alienation, Gregor becomes indifferent to his situation and begins to lose sight of his humanity.[396] Gregor no longer participates in the form of life of his family and his past.

In a severe episode of depression, the depressive can even lack the perspective and situatedness from which something can appear to be relevant or irrelevant. The experience of relevancy only functions in a context and against an existing background of

[394] I am not asserting that Kafka intended to use the *Metamorphosis* as a metaphor for the depressive experience or even that it is the proper interpretation of Kafka.
[395] Joshua Shenk also notices the likeness of Gregor's altered life to depression and points out that "the first rupture is one of language" (Shenk, 2002, 243).
[396] Gregor feared that he was "totally forgetting his human past" (Kafka, 2004, 32).

other significant things (practices, acts, meanings, etc.). Depression disrupts one's ability to judge or feel relevance. The difference between the depressive's experience and other experiences in which language is defamiliarized (such as aesthetic experiences) is that the depressive's facility for linguistic practices does not return when she ventures into the world. One has to live in and with language in order for it to feel familiar and full. The depressive's affective capacity for familiarization is damaged and when the feelings associated with language dissipate, the meaning itself changes or appears to be lacking. The sense of being in a foreign environment stays with the depressive even when she is among friends and situated in a once-familiar environment. While it is true that when a person is removed from a certain context she is more likely to lose touch with the verbal and non-verbal practices of that context, simply being in a familiar place and among familiar people cannot resituate the depressive. A once-familiar context cannot secure the familiarity and roundedness of language. For meaning to take hold, a person must be a participant in her world and affectively engaged with it.

Language and its inadequacies

In this section I will address a few philosophical approaches to the problem of depressive language-loss. One can understand the source of depressive language-loss as being attributable to the failure of language itself, a failure of sociality, and/or a failure of the body.[397] Regarding the first dimension, I will address the idea of language-loss

[397] None of these three main dimensions of language-loss – language, the social, and the body – represents a unified field of inquiry.

emerging from the inadequacy of language and the inadequacy of particular language-games. Secondly, I will focus on the social dimension of language-loss by looking at the depressive's alienation from the symbolic order, interpersonal relationships, and social practices. Thirdly, I will examine a few accounts of how the body can get in the way of speech. While the effects and sources of language-loss cannot be adequately explained in terms of any one of these dimensions, it is my contention that elements from each of these approaches factor into the disruption of discursive agency in depression. Even though these approaches help contribute to an understanding of language-loss in depression, it is my contention that the loss of language in depression indicates a problematic relation with language that is not necessarily a problem intrinsic to language.

Language is sometimes used as the scapegoat for the linguistic failures in depression, and it is often deemed to be an inadequate medium for capturing the experience of depression. Language can be said to lack the agility, precision, depth, and/or emotive aptitude for something as deep and disordering as depression. For Jeffrey Smith, it is not that language lacks precision but that language is too concrete to describe the experience of depression. He describes the depressive as being a resident in "some parallel universe, a place inclined to resist the concrete nouns, verbs, and adjectives..."[398] Similarly, Karen Armstrong describes language as being too "neat" and orderly to depict the confusion and distress wrought by depression. She views language as being essentially antithetical to the experience of depression and depicts depression as an "experience that has nothing whatever to do with words or ideas and is not amenable to the logic of grammar and neat sentences that put things into an order that makes

[398] Smith J., 1999, 61

sense."[399] Both Armstrong and Smith fault language for its orderliness and concreteness. It is as if language is too good for depression rather than inadequate.

Depressives also characterize depression as being so life-negating, dark, and full of despair that language cannot seem to reach it. One of Kristeva's patients would often say, "*I speak…as if at the edge of words…but the bottom of my sorrow remains unreachable.*"[400] For the patient, depression feels too cavernous to be illuminated by the type of clarity that language can provide. However, the most troubling problem for the depressive is not that language is too weak, flimsy, and distant from the reality of depression to be able to adequately give voice to her sorrow; the problem is that language feels remote and absent. The familiarity and ease of language-use is a reality no longer realized for the depressive. To say that language does not reach the bottom of depression is a statement about the profound isolation, terror, and confusion of depression. It is not, however, a claim about the ontological status of language. Depression does not exist *outside of language* or at the *limits of language.* It is not a realm of experience or of being that *exceeds* language. First and foremost, language is not contained within a defined realm of *knowability* and *sayability.* That is not to say that language is thereby *everywhere*; rather, it is to say that language is not a bounded entity or limited by internal properties. Words are real and concrete for the depressive; it is depression that touches on unreality.

What one claims that language can and cannot express is largely a matter of what a form of life sanctions as being unintelligible and undescribable. Social groups passively

[399] Armstrong, 2004, 55
[400] Kristeva, 1989, 56

and actively set limits on permissible discursive practices. Encouragement, disapproval, punishment, and overt censorship are just a few ways of propagating discursive attitudes. These attitudes in turn become the embodied habits of individuals. Bourdieu points out that social conditions not only mold ways of thinking and speaking, they also shape what is designated as unthinkable and unspeakable.[401] Because of the normative limitations inculcated by individuals within a social group, a person may not have access to a vocabulary that could actually aid the communication and understanding of the depressive experience. Often, subtle and nuanced notions of class, gender, sex, and race influence our judgments concerning who is susceptible to depression. It also impacts who gets to talk about depression and who has knowledge of 'depression.' Given the prevalence of stigma associated with mental illness, it is a plausible assumption that social structures lead to the depressive's loss of speech. The implicit and explicit views of depression as a personal weakness can become incorporated modes of self-silencing.

Stigma presumes some degree of awareness and knowledge of that which is stigmatized. However, not every form of social silencing is associated with stigma. If a person lives in a social environment that does not give voice to the depressive experience, whether as 'depression' or as something else, then it is plausible that the absence of a suitable discursive framework for understanding one's experience with depression could lead to a general discursive disorientation. Brampton recalls a fellow suicidal patient in the psychiatric hospital who could not tell people how he felt and would only utter "I don't understand."[402] The inability to adequately conceptualize one's suffering can create

[401] Bourdieu, Structures and the habitus, 1977
[402] Brampton, 2008, 49

a sense of powerlessness and lead to mental confusion and unease. In contrast, the act of acquiring a psychiatric vocabulary and framework often helps people regain a sense of control.

In *Epistemic Injustice: Power and the Ethics of Knowing,* Miranda Fricker argues that the absence of a suitable hermeneutic framework for understanding one's situation constitutes, in many cases, what she calls an 'epistemic injustice.' The specific form of epistemic injustice that she refers to as 'hermeneutic injustice' occurs when a group's "social situation is such that a collective hermeneutical gap prevents them in particular from making sense of an experience which it is strongly in their interests to render intelligible."[403] She appeals to the tradition within feminism that brings attention to the "way in which relations of power can constrain women's ability to understand their own experience."[404] Fricker points to forums such as 'speak outs' in the 1960's as means for raising consciousness of women's issues and experiences. In these events the ability for women to share "half-formed understandings" with each other gave rise to "social meaning that brought clarity, cognitive confidence, and increased communicate facility."[405] She uses a story from Susan Brownmiller's writings on the women's liberation movement in the United States to exemplify this experience of hermeneutical clarity. Brownmiller refers to a young mother, Wendy Sanford, who discovered at one of these meetings that she, like so many others, suffered from post-partum depression. Sanford explains, "In that one forty-five-minute period I realized that what I'd been blaming myself for, and what my husband had blamed me for, wasn't my personal

[403] Brampton, 2008, 7
[404] Ibid, 147
[405] Ibid, 148

deficiency."[406] Fricker describes the increased awareness of a condition like post-partum depression as a form of overcoming epistemic injustice.

Fricker does differentiate between hermeneutical injustice and "hermeneutical disadvantages." She claims that an example of a hermeneutical disadvantage, which should not be confused with an epistemic injustice, is the case in which a person suffers from a "condition affecting their social behavior at a historical moment at which that condition is still misunderstood and largely undiagnosed."[407] Rather than being a case of injustice, she refers to it as a case of "circumstantial epistemic bad luck."[408] However, if a group of people are systematically denied the economic and social resources through which one can attain knowledge of a condition, or on the other hand if a viable explanation of behavior is intentionally repressed because it contradicts another epistemic practice (e.g. the presumption of free will), then one could say that it does constitute a hermeneutical injustice. For Fricker, the difference between hermeneutical injustice and hermeneutical disadvantage is a difference between the wrongful withholding of knowledge and the mere absence of knowledge. However, it is difficult to determine what is a historical fact – for instance, the fact that how we currently understand severe depression was not available to people in the early 20th century – from what could have been a historical possibility. In other words, during many of the historical periods in which a condition is "misunderstood and largely undiagnosed," the condition was misunderstood due to a deliberate prevention of the expansion of scientific knowledge and the repression of situations that would foster free-communicative exchanges. The

[406] Brampton, 2008, 149
[407] Ibid, 152
[408] Ibid, 152

oppression and punishment of the act of congregating by people deemed to be a threat to a form of life is a historical constant. If, for instance, women had greater access to places that promote hermeneutic freedom and critical reflection on accepted interpretive structures sooner than the mid-twentieth century, issues of mental health might have come to light and become socially acceptable sooner. Nevertheless, it does make practical sense, as Fricker avers, to distinguish between what can be reasonably known to be a deliberate and wrongful withholding of knowledge by a particular group, from the manifold ways that material and social conditions contribute to the slow development of knowledge. Currently, many communities in the United States already subject to systemic poverty and unemployment, such as Native American Reservations and inner-cities, are subject to what Fricker would likely claim as the hermeneutic injustice of a lack of access to mental health care. Furthermore, people in these situations often face stigma internal to their communities that silence open conversations about severe depression in the home, workplace, and houses of worship.

While many social and material structures factor into the silence around depression, a lack of understanding about one's depressive condition does not actually *cause* the depressive's language-loss. It would be incorrect to conclude that one's primary symptoms are the result of not understanding one's primary symptoms. Furthermore, just because someone does not have a conceptual framework for understanding a particular experience does not mean that she has no means for talking about it. As Pugmire points out, "Unconceptualizable does not mean opaque or even

mute…"[409] If one only has a foggy impression of her emotional state she can still be able to say something about it. Also, one can have a clear impression of what one is experiencing – sadness, grief, fatigue, hopelessness – and yet lack an explanation for it. On the other hand, if a person does have the conceptual framework in place for understanding depression, she can nevertheless experience language-loss. Take Manning for instance, a clinical psychologist who deals with depressed patients on a regular basis. Despite working in an environment that focuses on understanding mental illness and encouraging people to openly talk about mental illness, her personal struggle with depression severely interfered with her ability to communicate. Having both the means for understanding her experience and access to people who would listen to her did not prevent Manning from becoming estranged from language.

That one can identify with a psychiatric model of depression does not mean that the psychiatric vocabulary perfectly suits the depressive experience. Many people complain that the very word 'depression' gives a dull and sterile impression of what is actually a deeply disturbing condition. Styron remarks:

> …for over seventy-five years the word has slithered innocuously through the language like a slug, leaving little trace of its intrinsic malevolence and preventing, by its very insipidity, a general awareness of the horrible intensity of the disease when out of control...[410]

While some people focus on the indescribability of mental pain, others actually blame the word "depression" for its inability to represent the psychic pain they suffer. Resigned to the use of "imperfect words" such as "depression" and "melancholy," the writer Joshua

[409] Pugmire, 2010, 384
[410] Styron, 1992, 37

Wolf Shenk reminds himself that despite their inadequacy, "an imperfect word is sometimes better than silence…"[411] 'Depression' serves as the depressive's token for explaining to herself and to other people what she is experiencing. To have a name for one's condition is to have a means for sharing. To have a name for one's condition is to have a type of linguistic currency. Yet one can accumulate linguistic currency and nevertheless lack the discursive vitality or social conditions to use it.

While depression is difficult to understand and difficult to describe, language-loss in depression is not solely a matter of the indescribability and unintelligibility of the depressive experience. The depressed individual experiences a failure of language in general. Nell Casey points out that to be in depression "is not to have words at all, but to live in the gray world of the inarticulate, where nothing takes shape, nothing has edges or clarity."[412] The depressive's alienation from language points to something that is more far-reaching than unintelligibility and prior to social silencing. Language-loss in depression points to a problematic relation with language that is not essentially a problem inherent in language itself.

Language as co-existence

While it might appear to be the case that in depressive speech-loss "all that is lacking is the requisite nomenclature,"[413] not having the *right* words cannot account for the extent of the depressive's linguistic disruption. Because the burden of successful

[411] Shenk, 2002, 250
[412] Casey, 2002, 284
[413] Wittgenstein, Zettel, 1970, §482

communication also lies with the other, we must take into account the issue of the other to whom the depressive attempts to speak. According to Mead, the speaker takes up "the attitude of the other toward one's self."[414] One's ability to speak, how and when one speaks, and what one says largely depends on whom the speaker understands the listener to be. In particular, speech is affected by what the speaker expects the interlocutor to know, what she thinks her response might be, what she knows of her sense of humor, taste, politics, and so forth. These assessments are typically based on affective attitudes grounded in a repository of deliberative and hasty judgments. The felt safety, comfort level, and the repertoire one has with another person have an emotional and intellectual bearing on one's discursive agency. Various kinds of meanings are communicated and assessed even prior to the verbal exchange. For instance, if the speaker anticipates that she will be misunderstood or that she is speaking to an unresponsive person, this expectation of a poor reception can short circuit communication before it begins.

A certain level of discursive trust must exist before a speaker utters a sentence. In addition to impinging on one's decision to speak and how one speaks, the attitude of the other also impacts how one *thinks*. The internalization of other people's attitudes can effectively keep a person from speaking and can even silence one's *inner* voice. Social silencing can take place in advance of and after speaking. Fricker argues that some forms of testimonial injustice are pre-emptive. In these cases "the speaker is silenced by the identity prejudice that undermines her credibility in advance."[415] This wrongful act of silencing can take the form of passing over someone in a conversation based on the belief

[414] Mead, 1967, 48
[415] Fricker, 2009, 130

that she has nothing of value to contribute, and systematically excluding groups from particular epistemic practices. We typically only speak when we feel that we have the right to speak, and this assumed right is often determined in advance by habitually reinforced ideas of credibility. In some cases credibility is duly earned and other times wrongfully denied. Fricker refers to Hornsby and Langton's argument that a person can be silenced even when she speaks if her illocution is not taken up by the other.[416] In this case, one can be silenced by being ignored or dismissed.

On the other hand, a responsive conversation partner can bring forth a voice that might otherwise be silent and even non-existent around other people. When a person is among people with whom she feels at home, the expectation of connection is itself a catalyst to speech. Van den Berg writes, "That is why I am speaking so easily; that is why I am seeing so much, because my friend is hearing me."[417] With a responsive conversation partner a person finds that she can not only share what she has been thinking, she can even talk about something that she had never quite thought of before. In other words, a sympathetic discursive partner is not merely a responsive force; she is also a generative force.

Social environments and individual people shape and disrupt one's discursive agency in innumerable ways. Meanings are not only made, they are also shared. From the sense of a word to the purpose and significance of one's life, we inherit, embody, regenerate, and pass along the meanings shared within our form of life. While the depressive is susceptible to social silencing, even depressives who benefit from social

[416] Fricker, 2009, 140-141
[417] Van den Berg, 1972, 73

receptivity lose the "at homeness" that facilitates meaningful linguistic exchanges. Communication demands agreement in the way people judge the world, yet the depressive no longer inhabits the same form of life as non-depressives. Manning highlights the separation she felt from the language she had always shared with the people around her. She writes, "I have lost *their* language, *their* facility with words that convey feelings."[418] She felt as though *her* language no longer belonged to her. It was no longer her default setting. Part of the reason that the depressive loses the sense of *at-homeness* with other people is because she lives in a disrupted and altered form of life. In Kristeva's words, depressives are "absent from other people's meaning."[419] The depressive is out of synch with other people's possibilities, with the time of other people, with the expectations and plans of other people. While the cultivation of voice requires someone else to *see-with,* the depressive's ability to engage and *see-with-others* is obstructed by *seeing-through* depression. The nature of the depressive's estrangement from language is a matter of the depressive's diminished capacity to see-with-others and her damaged ability to "think *according others*."[420] Language no longer functions as a means of connection because the depressive's affective separation is too pervasive, and by not serving the function of connecting the depressive with other people, language can appear as if it is broken.

Despite the role that social structures and interlocutors play in contributing to the silence about 'depression' and the depressive's silence, the burden of linguistic disruption in depression does not primarily rest on the interlocutor. That does not mean, however,

[418] Van den Berg, 1972, emphasis added
[419] Kristeva, 1989, 181
[420] Merleau-Ponty, 1992, 179

that sociality is not implicated in the depressive's loss of language. Depressive language-loss is deeply interconnected with the depressive's withdrawal from other people. According to Merleau-Ponty, the connection between social withdrawal and language-loss is not an arbitrary one. Language-loss, for Merleau-Ponty, is a "refusal of co-existence."[421] He points to a case study of Binswanger to demonstrate that the loss of language is a rejection of communal existence. Binswanger's young female patient exhibited neurotic and hysterical symptoms of language-loss after her mother forbade her to see her intimate friend. Earlier in life she also experienced speech-loss after an earthquake. In explaining the young woman's emotional response, Merleau-Ponty states that her "emotion elects its expression in loss of speech."[422] He conceptualizes speech-loss as the patient's way of dealing with overwhelming social demands. This expression of emotion through language-loss does "not merely represent a refusal of speech"; he contends that it is also a "refusal of others or refusal of the future."[423] The refusal of speech, others, and the future are expressions of a more general withdrawal from life itself.

In the case of Binswanger's patient, both of the instances that preceded her loss of voice are themselves events that cut the girl off from others. The earthquake and the forbidden relationship were significant disturbances of communal existence that instigated her further withdrawal from co-existence. Relatedly, in depression, an individual's capacity for social connection is damaged. Depression can, however, emerge where no apparent disruption of one's communal existence takes place. In other words,

[421] Merleau-Ponty, 1992, 160
[422] Ibid, 160
[423] Ibid, 164

the loss of voice in depression need not be a direct response to a social trigger. Language-loss in depression is an expression of social withdrawal in so far as the depressive's language-loss and social withdrawal are both features of the depressive's affective disconnection and affective disordering. The depressive's ability to verbally engage is subject to the distortion and inertia that afflicts the depressive's ability to engage generally.

The body and speech

While language primarily has a communicative function, how the individual lives in language expands beyond language's use as a tool for social connection. The breakdown of meanings and the disruption of language in depression does not simply take place in the depressive's speech or in the depressive's receptivity to written and spoken words. In depression, meanings are disrupted prior to any linguistic act.

While language is based on shared social practices, meaning attribution is not exclusively bound by one's form of life. Meanings are also created and limited by our physical and psychological conditions. Consider conditions such as autism and Asperger syndrome (a higher functioning form of autism). Individuals with these conditions live in a severely modified form of life. They do not attend to most of the same types of features and elements of the world that people without these conditions do. They do not read emotions from facial features. As infants they may not mimic the gestures and sounds of the people around them. What they pick out as significant and interesting is not

customarily shared or promoted by their social environments. They often see patterns and details that others fail to notice. For those autistic individuals who understand the shared linguistic meanings of words, these meanings rarely function in the same way as they do for most people. People who fall somewhere along the autism spectrum typically interpret language more literally and perceive the metaphorical, poetic, and ironic dimensions of language as confusing, nonsensical, or false. Their physiological condition radically alters meanings that are shared by their social environment. It is not only the case that they *lack* certain ways of assessing shared meanings, they also perceive and interpret phenomena as meaningful differently from how most people do.

The epistemological and semantic deviations of individuals with conditions like autism and Asperger syndrome are typically more evident than they are with depressives. These differences are also more commonly interpreted as different ways of seeing and understanding, whereas depressives are not typically assessed in this way. Take for example the way people talk about autistic individuals. A mother might say of her autistic child, "He does not see things the way we see them." On the other hand, the depressive way of seeing is usually assessed through a more normative lens. That is not to say that individuals with autism do not suffer from other's negative judgments of them. In fact, they are often subjected to forceful attempts to curb their behavior and perception. They are also systematically misunderstood and often victims of abuse and ridicule. Nevertheless, their perceived deviation from normal mental functioning is often assessed in an everyday way as a difference in how they *see* the world. One of the reasons that depressives are not typically understood as "seeing things differently than we do" is because prior to depression the individual might have fluently participated in the

meanings embedded in her form of life. However, the depressive does in fact undergo a shift in the way that she sees and understands the world. Her body changes how she assesses and attributes meaning. The depressive's affective disconnection leads to a loss of meanings and affective disordering often leads to the emergence of new meanings, albeit typically negatively structured meanings.

The estrangement from meaning that arises from affective disconnection pertains to the estrangement from past meanings. While the depressive and theoretician often fail to see the ways in which new meanings develop in depression, Ratcliffe observes that depressives do not experience a "complete absence of all forms of significance" and that the depressive experiences the emergence of new meanings. He shows how meaning changes in relation to the depressive's altered way of relating to the world:

> They still relate to the world in some way, but in a way that is quite different from what most of us take for granted most of the time. Everyday world-meaning is replaced by a radically altered relationship with the world, characterized by irrevocable alienation, despair, futility, guilt, and the like, with no hope of reprieve.[424]

The emergence of altered meanings ensues from the depressive's altered emotional states. In depression, semantic changes are usually initiated by affective changes rather than intellectual developments. The depressive typically feels the emotions and bodily feelings of despair and futility before she understands them as such. Rather than having a clear reason for or intentional object of these emotional states, the depressive's emotional state is directed at life itself. Emotional states like guilt and grief become generalized conditions in depression.

[424] Ratcliffe, 2010, 361

Ratcliffe's claim that meaning is "replaced" would be better if it reflected the fact that new meanings in depression do not function as simple *replacements* of old ones. The new meanings that come about through affective disordering are typically negatively structured. These meanings are structured such that the negative space, the absence of past meaning, is evident. They are not mere replacements because they do not take up psychological and social space in the way that past meanings do. To experience something with a newfound sense of pain and terror that previously was associated with pleasure is not to simply interpret a practice differently. The depressive both loses the reach of certain emotional connections, and she experiences the onslaught of overwhelmingly negative emotions and feelings. Both of these types of changes impact language-loss in different ways. For example, a lack of emotional connection can create a sense of emptiness, confusion, and foreignness. On the other hand, a surge of grief can render the depressive unable to externalize and verbally communicate.

Depression exemplifies how our bodies and emotional conditions participate in meaning and produce meaning. In addition to being related to a horizon of a given social environment, we are also related to a sphere of possibilities established by our bodies. As mentioned in Chapter 3, Merleau-Ponty refers to this dual situatedness as a "double horizon of external and bodily space."[425] How one perceives the horizon of bodily space affects one's perception of the external horizon, and conversely our social and natural environment impacts our perception of our bodily horizon. Depression changes one's bodily horizon and limits one's ability to access and interact with the world. The depressive's body limits the practical field. Merleau-Ponty explains that the body has

[425] Merleau-Ponty, 1992, 101

become "the place where life hides away."[426] How the depressive experiences herself and the world around her, how she perceives and feels time, and what she sees as being possible and meaningful have become "arrested in a bodily symptom."[427] Without the orienting role of moving-towards-a-future and without the grounding anchor of being "caught up" in one's environment, the horizon of the depressive contracts.

Affective disconnection and disordering profoundly alter how the depressive intellectually processes meaning and language. Not only does the depressive experience linguistic disturbances on the level of overt forms of communication; she also experiences linguistic disturbances on the level of linguistically structured thought. The omnipresent *now* of depressive corporealization generates neither meaningful inner speech nor meaningful dialogue. In a severe episode of depression the rules and regulations of verbal and non-verbal practices no longer guide the depressive; they no longer apply. Grammatical structures require a command of voice and time, and the command slips out of the depressive's grasp. Solomon describes his slide into grammatical and semantic confusion in terms of feeling "the logic disappearing right out from under me."[428] Depressives are not able to bring words together and to formulate complete thoughts. Their thoughts face a similar inertia as that of their motor movements. Brampton's psychiatrist informed her that if she had taken an IQ test during a depressive episode her score would have been down by at least thirty points.[429] It is not that concepts and words completely lose their intellectual significance, but the bodily feelings that

[426] Merleau-Ponty, 1992, 164
[427] Ibid
[428] Solomon, 2002, 88
[429] Brampton, 2008, 10

customarily imbue concepts with 'existential meaning' are altered in depression. This loss of felt meaning leads to blurry and seemingly non-linguistically structured thoughts, what Kristeva refers to as "an unorderable cognitive chaos."[430] The aspects of cognitive life normally structured by language in non-depressives lose their shape and order in depression.

The fact that depressives often experience a linguistically confused, and what verges on a non-linguistically structured, cognitive life does not mean that the depressive feels trapped in silence. Depressives speak of inner turmoil and chaos, not stillness and silence. Other people might see the depressive as quiet and withdrawn, but the depressive experiences the world as loud and her own crying as piercing. Estrangement from language is not a form of deafness, although at times the depressive cannot discriminate among linguistic sounds. In depression, affective disconnection is a form of being unreceptive to the world. Sounds are processed as noise, unstructured and nonsensical. Nevertheless, the depressive can also be averse to silence. Both noise and silence can heighten the depressive's affective disordering. While the noise of being with people can be experienced as overwhelming, confusing, and distant, the silence of being alone can amplify the depressive's obsessive and painful thoughts. Manning writes, "In the total quiet, there is nothing to counteract the chaos inside me, the pain that reverberates more strongly because nothing balances it from the outside."[431] Without the cognitive structure provided by the mostly unnoticed and unnotable linguistically structured thoughts that

[430] Kristeva, 1989, 33
[431] Manning, 1994, 91

customarily constitute the guiding backdrop to everyday lived experience, depressives struggle to provide or find order and meaning for their lives.

David Wood addresses the linguistically structured reflections that have an orienting function on how we relate to ourselves and our natural and social environments. He points out that "in a great diversity of ways, our everyday experience is full of partial, and sometimes complete, 'narrative' reflections, projections, memories, imaginings, and so on."[432] In depression, however, these "*sequential constructions*" of narrative reflexivity become distorted. There are stages in depression in which depressives do not reflect on their lived experience in the way that non-depressives do. The depressive lacks the sense of time moving forward and also lacks the engagement with life that fosters narrative reflexivity. Rather than having grammatically structured reflections, the depressive often descends into repetitive – and at times nonsensical – mantras. The depressive even exhibits infantile behavior like rocking, crying, repeating words, murmuring repetitive sounds, and singing simple consoling tunes. Virginia Heffernan describes mumbling made-up lyrics to herself like "*I'm in real trouble* and *Ain't no solace.*"[433] She admitted that it made her feel better to "sing or say *shhhh* like you would to a baby."[434] These repetitive expressions mimic the recurring and inescapable *now* that relentlessly accompanies mental pain. The depressive's narrativity is limited to the present moment and confined to simple thoughts such as "Not again" and "I can't take it anymore." What is the semantic status of these partially muttered phrases or of the

[432] Wood, 2001, 353
[433] Heffernan, 2002,12
[434] Ibid

depressive's repeated cries? Is the nature of the depressive's pain such that it does not lend itself to "finer descriptions"?[435]

Throughout the dissertation I have relied on Kristeva's insightful descriptions of the depressive experience. From what reads like a sensitive firsthand account of depression in the opening pages of *Black Sun*, to her discerning observations of patients' symptoms, and to her depiction of melancholy in literature, Kristeva's writings give a picture of the depth of depressive affect. In addition, Kristeva's attention to and thematization of language-loss in depression gives voice to both the disruption of linguistic structures as well as the emergence of non-verbal and partial-linguistic expressions. However, while I wish to draw attention to her invaluable perspective on depression, I do so without fully ascribing to a psychoanalytic account of depression. In reference to the depressive symptoms that resemble a regression to colicky infantile states – uncontrollable crying, insomnia and hypersomnia, non-communicative babbling, helplessness, the inability to dress and feed oneself, the unfamiliarity of one's surroundings, a-temporality, limited space of the visual field, and so forth – Kristeva explains these symptoms in terms of a "surge of affect and primary semiotic processes."[436] For Kristeva, these infantile vocalizations reflect the emergence of primordial and preverbal states. She asserts that the sadness of the depressive is itself a "rudimentary representation, a presign or prelanguage,"[437] and that the depressive's

[435] Norman Malcolm suggests that "the *language* of sensation provides finer descriptions of sensation than would be possible with purely non-linguistic behavior" (Malcolm, Wittgensteinian Themes: *Essays 1978-1989*, 1995, 68).
[436] Kristeva, 1989, 64-5
[437] Ibid, 21

sadness is "insufficiently stabilized"[438] to enter into the realm of the symbolic. By positing two fundamental dimensions of meaning, the semiotic and symbolic, Kristeva is able to account for the loss of meaning and the surfacing of new meanings. While depression disrupts the function and structure of the symbolic order, both in terms of linguistic meaning and life meaning, it unleashes semiotic meaning and brings the semiotic out into the open. The 'semiotic' represents a realm of meanings that are expressed in rhythm, tone, and affect, and first and foremost they are expressions and meanings that come directly from the body.

Kristeva's depiction of meanings emerging from the body accords with Merleau-Ponty's account of the presence of the body coming to the fore in illness and obscuring lived meaning. In spite of the fact that I endorse these two features of Merleau-Ponty and Kristeva, I do not, however, subscribe to Kristeva's explanation of semiotic expression in terms of a residual trace of ineffective mourning for the mother's body. While this analysis may in some cases explain fundamental themes of the depressive's life and meaning, it is my position that her account of the depressive's relation to the maternal body does not *necessarily* provide either the most comprehensive or final explanation of depression. To briefly summarize her account, for Kristeva depression emerges from an incomplete mourning for the mother, and meaninglessness arises out of the inadequacy of language to compensate for the maternal non-object. The depressive longs to reunite with the prelingual *chora*, and this longing for the maternal body drives the depressive to "give up signifying and submerge in the silence of pain or the spasm of tears that

[438] Kristeva, Black Sun, 2002, 193

celebrates reunion with the Thing."[439] The depressive refuses language as an adequate symbolic substitute and desires the connection and unification with the maternal body.

Both Kristeva and Merleau-Ponty attempt to understand language by returning to its origins. Yet in terms of evolutionary history as well as individual human development, the functions of language expand along with human linguistic capacities. Thus the attempt to understand language by returning to its origins gives a misleading picture of how language operates in everyday complex and diverse forms of life. Furthermore, I contend that how and why language emerges is not necessarily implicated in how and why language breaks down. Accounts of language that are grounded on a view of language as primarily serving a compensatory function lead to an understanding of language-loss as primarily being a matter of the inadequacy of language. For instance, if we hold on to Kristeva's assertion that the child reaches for language when the mother is out of reach, then language will always be based on a fundamental, irremediable loss. If language has an originary compensatory purpose, then inadequacy is built into language; there can be no complete compensation for the lost *thing* or existential gap. In contrast to this view of language-loss as primarily being about the inadequacy of language to compensate for a fundamental loss, a loss which Kristeva argues explains depression, I contend that language-loss in depression is not fundamentally grounded in 'language.' Language is neither the problem nor the site of the problem in the depressive's problematic relation with language. Rather, linguistic disruptions ensue from the depressive's affective disconnection and disordering. Affective disconnection and disordering, among other things, disrupts the linguistic life of the depressive and in some

[439] Kristeva, 1989, 41

cases might disrupt a compensatory function of language. Nevertheless, in depression the primary problem is not that language stands in the way of or covers over a deeper reality. It is not the case that the language the depressive has cannot touch the reality of her experience; the problem is that she no longer has the language she once had.

Part 2: Recovery of Discursive Agency

Rebuilding and revitalization

Although the depressive becomes estranged from language, she does not lose language entirely or permanently. The depressive's experience of language-loss is not uniform throughout a depressive episode. Throughout this chapter I have focused on the linguistic disturbances that accompany the severe stages of a major depressive episode, yet even during a major episode the depressive may occasionally experience a brief reprieve, a glimmer of self and personality, a fleeting glimpse of connection, and a slightly discernible yearning for life. Fortunately, a depressed individual who survives a severe episode will find that her form of life is not entirely destroyed. Her sense of self and her ability to connect with others can be restored. However, after a major episode of depression, one cannot entirely recover one's prior way of living. Depression's life-altering disruption leaves a permanent trace, so that even when all the symptoms pass the effects of depression remain. In an interview with Andrew Solomon, Bill Stein portrays the destabilizing effect of depression on one's world: "I think you have to let go and

understand that the world will be re-created and may never again resemble what you knew previously."[440] For better or for worse one cannot experience a severe depressive episode and emerge unscathed or unchanged.

Even in recovery from depression, the depressive cannot simply return to her "original" form of life and identity. Simply because the depressive does not have the voice she used to have does not mean that she has lost *her* voice. New voices can emerge and traces of one's voice prior to depression can persist. The poet Chase Twichell came to understand, because of her experience with depression and her recovery from it, that she will "inhabit subtly new selves, which will think in subtly new language."[441] Rather than seeing these alterations as a threat to a 'true self' she remarks that it "no longer threatens my understanding of what it means to be a 'self'…"[442] José Medina's thesis of the 'polyphony of identity' addressed in the previous chapter provides a way for seeing how a loss of voice does not mean an end to one's voice. Rather than understanding 'voice' and 'identity' as referring to a singular and unified self, this conceptualization of agency in terms of a multiplicity of voices articulates the way that a person's voice can reverberate differently in different social contexts and in different stages of life.

The ability to rebuild one's self after depression partly depends on one's ability to forge and reestablish social connections. Merleau-Ponty highlights the role of re-engagement as a means for recovering one's voice. He shows that Binswanger's patient recovered her voice by opening herself up to existence and co-existence. He writes, "The

[440] Solomon, 2002, 75
[441] Twichell, 2002, 27
[442] Ibid

momentum of existence towards others, towards the future, towards the world can be restored as a river unfreezes."[443] While Merleau-Ponty notes that this opening up of oneself in depression can neither happen automatically nor by "an intellectual effort or by an abstract decree of will,"[444] he does not provide an account of how one can come to the place where she can be an active participate in her own life. Based on the reports of depressives as well as medical research, it is my position that the revivification of the depressive's voice first requires a restoration of her basic level of functioning. Ultimately, the depressive's brain needs to be restored. Studies have shown that in depressives the limbic system is hyperactive, while the level of blood flow and functioning of the cortical areas has decreased.[445] In other words, in depression the area of the brain involved in mood and emotion becomes more active, while the area of the brain involved in cognitive functioning becomes less active. In addition, the blood flow between these regions has decreased, indicating a weakened connection between the regulation of affect and cognition in depression.[446] Talk therapy is one means for restoring health to the depressive's affective life; however, with severe depression individuals typically require some type of medical intervention. The combination of medication along with talk therapy has proven to be the most effective means for combating severe depression. Without rebuilding the lower level processes such as sleep and digestion, the depressive cannot arrive at the place where speech can have a therapeutic effect. From antidepressant medication, to electroconvulsive therapy, to the experimental technology

[443] Merleau-Ponty, 1992, 165
[444] Ibid
[445] Mayberg, et al., 1999
[446] Mayberg H. , 2012

of Deep Brain Stimulation, *unfreezing the river* of depressive affectivity often requires intrusive physiological intervention.

In spite of the fact that the depressive's discursive agency is severely diminished in depression, it is in part through speech that depressives are able to heal. It seems counterintuitive that the depressive must rely on the very language from which she is estranged in order to recover and regenerate meaning. However, the depressive is building on a linguistic life that has become inert and weakened, not irretrievably obstructed. It is ultimately the felt meaning of language that needs to be restored in depression in order for the depressive to regain linguistic confidence and discursive vitality. Even when the depressive has regained her ability to speak and read, a sense of emptiness and disconnection can still persist. A recovery of voice requires the recovery of both language and affective meaning, and in order for the depressive to recover the felt meaning of language, she must experience some relief of affective disconnection and disordering in general. The revitalization of the depressive's voice must accompany an overall restoration of mental health.

People who make it through a severe depressive episode are survivors. They have endured a life-threatening and life-altering experience. While the depressive might rightly feel like a passive victim of a depressive disorder, she cannot remain passive in her recovery from depression. The depressive has to be rehabilitated in order to become resituated in the lived meaning of a form of life. As survivors of other severe illnesses know, simply surviving the traumatic experience is a vital first step of a multi-stage recovery. After his recovery from depression, John Bentley Mays referred to therapy as a

"re-education." He describes the healing process as "an intense, uncanny, radical relearning how to walk, act and feel…"[447] Similarly, Solomon speaks of the lengthy task of "rebuilding" the self after depression,[448] and Brampton explains the process of recovery as feeling like she was "learning to walk again."[449] Many depressives echo Solomon's sentiment about depression: "You need to be reborn after a severe episode."[450]

Even in the wake of lost meaning and lost voices, the hope of many small and significant resurrections can persist. Like Zarathustra, the depressive can mourn her lost self and celebrate the self that remains and that will be. In *The Tomb Song* Zarathustra proclaims "You are still alive…You have still broken out of every tomb…Indeed, for me, you are still the shatterer of all tombs. Hail to thee, my will!"[451] While the depressive cannot 'will' her way into recovery, Nietzsche's idea of the surviving 'will' as that which carries over, breaks through, and renews captures the features of agency that can outlast depression. The will for Nietzsche is procreative, commanding, and affirming, and these qualities point to the role that creativity and the creation of new meaning play in overcoming depression. While the destructive nature of depression is not intrinsically creative or productive, the experience of depression can, however, be revelatory of new possibilities. As Zarathustra points, "only where there are tombs are there resurrections."[452]

---

[447] Mays, 2003, 71
[448] Solomon, 2002, 19
[449] Brampton, 2008, 2
[450] Solomon, 2002, 104
[451] Nietzsche, 1961, 136
[452] Ibid

Recognition and Receptivity

According to Kristeva, depressives do not simply need an anti-depressant; they also need a "counter-depressant," a counter-life, a counter-meaning, a counter-world, a world that they have a part in creating.[453] Kristeva claims that a creative use of language can function as a counter-depressant to melancholy and suggests that the "cure" to a loss of meaning could dwell in the expression of the semiotic. She highlights the ability of poetry and art to give cathartic expression to the semiotic. In particular, she focuses on the capacity for literary arts to "bear witness to the affect."[454] Writing does not solely *bear witness* through the elaboration and explanation of depressive affect; the cathartic aspect of writing is that writing is itself an "imprint of an affective reality."[455]

The enhancement of the depressive's ability to speak is both an issue of recognition as well as articulation. The revitalization of voice cannot happen in isolation. A recovery of voice needs the generative force of a receptive interlocutor, as well as the restorative force of affective re-engagement. Kristeva focuses on the need and function of love and receptivity in the revitalization of language – a revitalization that is itself a counter-depressant. She draws attention to the fact that the depressive's regeneration of meaning and language requires a receptive and loving audience. The power to transform meaning is as much the effect of *to whom* one is speaking as it is the effect of *how* one is speaking. The ideal of a receptive audience, however, will not be the same for everyone. The ideal for many is not simply an *audience*, but a partner, a receptive and responsive

[453] Kristeva, 1989, 24-5
[454] Kristeva, Black Sun, 2002, 193
[455] Ibid

interlocutor. Many depressives find that the most receptive audience to be other depressives. For Kristeva, the loving audience can be an *imaginary audience.* She contends that a loving audience does not have to be a living, breathing interlocutor, and she promotes the restorative act of creating an *imaginary audience* through writing. According to Kristeva, the depressive can create a receptive audience through her own literary expression. Writing is a means for effective self-parceling; it is a self-splitting that allows for self-creation. In other words, in writing *I* forge my identity and voice. In writing *I* become my loving audience. I do not write to myself *per se,* but rather to an imaginary audience that *I* imagine. For the depressive, writing is not narcissistic self-love; it is love for the other, for the *stranger within*.[456] While literary creation does not cure depression, Kristeva claims that it can provide the amatory support that reestablishes a sense of connection. This love then draws the depressed person back into the symbolic; it draws the stranger back to the land of the living.

Kristeva focuses on the receptivity and not the agency of an audience. According to her view, the loving audience seems to exist only to let the writer speak. In contrast, Medina focuses on the "the *voices* of imaginary others."[457] He points out that "the conversation in which our identity consists remains meaningful only if new voices come in, even if they are the voices of imaginary others…"[458] He is speaking to people that do not feel at home in their form of life and who seek out a discursive environment that allows for their voices to be heard. He contends that one can seek out new language-

[456] "Strangely, the foreigner lives within us: he is the hidden face of our identity…" (Kristeva, Strangers to Ourselves, 2002, 264).
[457] Medina, Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency, 2006, 72 (emphasis added).
[458] Ibid

games and even create a "new social context populated by the voices of new, possible others."[459] Rather than imagining a loving, ideal audience, Medina advances the strategy of imagining other voices that can respond to, not just hear, one's voice.

For the depressive, writing can be a means for writing herself back into existence and *co-existence*. Gloria Anzaldúa describes writing as a means of survival for women of color. She describes the essays collected in *Making Face, Making Soul* as not only being "*about* survival strategies, they *are* survival strategies – maps, blueprints, guidebooks that we need to exchange in order to feel sane, in order to make sense of our lives."[460] Similarly, Barbara Christian portrays the act of writing as a form of self-rescue while also noting that she is writing to people who share her needs and desire for renewal. Christian explains, "what I write and how I write is done in order to save my own life…My readings do presuppose a need, a desire among folk who like me also want to save their own lives."[461] The writing of depressives can also be a means for one's own survival as well as a beacon of hope for other depressives. The depressive memoirs in particular appear to be a means for generating meaning, community, and receptivity, and they importantly serve as an assertion of the writer's discursive agency. Whether one suffers from social-silencing or the silence of depression, one not only needs to be heard, one also needs to hear the voices of others who share her burden.

While the model of writing as a means for the recovery of voice is promising for the depressed writer and artist, what about the majority of depressives who both before

[459] Medina, Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency, 2006, 72
[460] Anzaldúa G. , 1990, xviii
[461] Christian, 1990, 343-4

and after depression do not express themselves through literary creation? In order to write one's way through recovery one needs free time, linguistic fluency and literacy, cognitive clarity, civic freedom of expression, and a personal sense of freedom. One needs a form of discursive trust with the page, that is, a trust of one's own voice. While these capacities can be developed and encouraged, they are not *necessary* to one's recovery from depression or recovery of voice. Rather than focusing on the medium – writing – the essential component to the recovery of voice appears to be the practice of verbal expression within a receptive discursive community. Ultimately, the depressive needs a way of externalizing and connecting with something beyond herself. For some depressives, belief in a higher power can serve a function similar to the function of the loving audience of writing. John Bentley Mays spoke of his process of re-learning to speak as a matter of re-learning to pray.[462] For Mays the idea of an all-knowing, all-benevolent, and personal deity provided an ideal audience for regenerating his voice. For Jeffrey Smith, recovery was a matter of becoming connected with nature. He writes, "I'd felt replacing my small self a sustaining kinship with something larger: with animals, and plants, and landscapes…"[463] While the practices of writing, praying, and connecting with nature can help enable a person's recovery of her sense of self and voice, many depressives find that the most effective means for recovery is to be in communication with other depressives.

Discursive outlets like group therapy, support groups, and online social networks are mediums through which the depressive can learn how to give linguistic expression to

[462] Mays, 2003, 97
[463] Smith J. , 1999, 272

her previously unexpressed mental pain. Depressives speak of having a secret knowledge only shared by other depressives. They also talk about speaking a different language and being able to easily identify other depressives simply by their speech and their demeanor.[464] In an interview with Andrew Solomon, a woman describes having an insider's understanding of the language of depression. She explains that depression "speaks, or teaches you, an entirely different [language]."[465] Similarly, Virginia Heffernan writes, "I began to think that melancholy was a dialect that only some people knew – or could even hear – and in my conversations, I sought these people out."[466] Depressives, it would seem, have forged their own language-game and a discursive practice created through an understanding of each others' suffering. The depressive can begin to recreate her voice and identity in conjunction with others who are practitioners of the language-game of depression.

The depressive's identification with a community and the emergence of shared meaning-making practices do not permanently cure depression or the depressive's linguistic and semantic disturbances. Many depressives do in fact continue to struggle with depression in one way or another throughout their lives regardless of their engagement with a language-game of depression. Also, in the deepest moments of depression the notion of 'community' is unreachable for the depressed. The language-game of depression serves as a preparatory 'survival guide' for dealing with future depressive episodes, as well as a means for coping with the aftershocks of depression.

---

[464] Brampton writes, "These days, I find it easy to spot a depressive. The illness is scrawled across them like graffiti" (Brampton, 2008, 5).
[465] Solomon, 2002, 94
[466] Heffernan, 2002, 13

While I argue that the source of language-loss is the depressive's affective disconnection and affective disordering rather than social-silencing, the depressive's social environment largely determines whether she can recover from depression. People break down in different ways and people heal in different ways. Race, class, gender, sex, and various other forms social identities do affect how one experiences depression and how one recovers from it. Some individuals who have broken their silence about their depressive experience claim that other depressives who have recovered from depression have a moral obligation to speak out about depression. They contend that depressives need to not only speak for their own sake and their own recovery, but that they also have a responsibility for speaking up for the benefit of other depressives. Terrie Williams highlights the moral obligation of people with social and material resources to talk about depression. She focuses on the need for African American leaders, in particular, to break the silence about depression in the Black community. She explains that depression is "killing Black people by the thousands, and I have to talk about it."[467] Williams also references Charles J. Ogletree, Jr.'s call to speak out about depression: "It is time that we all talk about our depression, and fight with the same vigor we bring to the fight for racial justice…talking through our pain, and taking the mask off our helplessness."[468] Openness about the experience of depression helps to remove the mystery, stigma, and silence that pervade common conceptions of mental illness. Depression is disabling and deeply disruptive of agency regardless of the shame attached, but the stigma associated with depression can lead to more suffering and weakened resiliency. Releasing depression into

[467] Williams, 2008, xxi
[468] Ibid, 4-5

the universe of things openly discussed will not *cure* depression, but it can bring about various forms of relief.

CHAPTER VI

CONCLUSION

A comprehensive philosophical investigation into depression should give an account of the situatedness of depression, the inner-life of the depressive, and the embodiment of depression. My account of depression as an embodied disruption of agency and a disruption of a form of life speaks to these three levels of analysis. In this dissertation I give a phenomenological account of depression, based on firsthand written accounts, which provides the foundation for my analysis of the impact that depression has on agency and discursive practices. The phenomenological account of depression shows how depression leads to an estrangement from meaning, decontextualization of the self, disintegration of social relations, desynchronization of one's sense of time, and altered perception of the environment. My investigation into the impact of depression on agency and language reveals that depression entails the disruption of a form of life. The idea that depression disrupts a form of life speaks to the interconnection of the depressive's loss of language, loss of self, and loss of world. I argue that the disruption of the depressive's form of life, the decontextualization of the depressive's agency, and the depressive's loss of language are caused by the affective disconnection and affective disordering of depression.

Major depression is a disorder that cannot be explained exclusively in terms of the depressive's psychic economy. Though depression points to a dysfunction in a psychic economy, the sources, symptoms, and reach of depression exceed any purely psychological explanation. Likewise, depression cannot be reduced to a neurological or social dysfunction. I argue that the fundamental dysfunction of depression pertains to the depressive's affective disconnection and affective disordering, which involves a complex intermingling of physiological, psychological, and social causes and dysfunctions. Affective disconnection leads to the depressive's estrangement from the felt meaning of practices, relationships, ideas, places, and language. It contributes to the depressive's loss of familiarity, the depressive's inability to engage in a meaningfully structured way of living, and is expressed in the depressive's withdrawal from co-existence. While affective disconnection concerns an absence of feeling and connection, affective disordering entails the depressive's experience of overwhelming emotional states that typically have a negative character and often lack an intentional object. Inexplicable grief, inflated sense of guilt, and uncontainable sadness are just a few manifestations of depressive affective disordering. Affective disordering imbues the depressive's perception and experience of herself and her social and natural environment with a pervasive sense of pain and negativity. Both affective disconnection and affective disordering profoundly and painfully damage the depressive's ability to participate in a meaningful and shared life.

The phenomenon that initially inspired this dissertation is the depressive's experience of language-loss. However, it became evident to me that what is experienced by the depressive as a disruption of language cannot be explained by linguistic elements alone. Language-loss in depression points to the depressive's problematic relation with

language, a phenomenon that is not essentially a problem inherent to language itself. Language-loss ensues from the damage that affective disconnection and disordering does to the form of life and agency of the depressive. The depressive's estrangement from language is primarily grounded in a disruption of *felt* meaning and is inextricably intertwined with the depressive's diminished agential vitality. Based on the premise that language only has meaning within a form of life, I argue that language-loss functions in the context of the depressive's relation to various features of a form of life. Depressive desynchronization, altered spatialization, social withdrawal, loss of self, and diminished agency all contribute to the depressive's estrangement from language and meaning and the disruption of the depressive's form of life.

By looking at the relationship between language-use and a life-form, we can deduce the following about the relationship between the estrangement from language in depression and the disruption of the depressive's form of life: 1. Language-loss in depression does not have a single explanation, 2. Language-loss is a symptom that functions in relation to other symptoms of depression, 3. Language-loss is expressed in several forms, 4. Language-loss does not belong exclusively to a linguistic context, 5. Language-loss takes place in relation to other people, and finally, 6. Language-loss is socially and temporally embedded. Wittgenstein's concept 'form of life' helps to illuminate the interconnection of shared meaning, language-use, and agency. Ultimately, 'form of life' speaks to the situatedness of an individual in general, and the concept provides a way of understanding the embeddedness of the depressive and the meaning and function of her symptoms within a context of shared meanings and practices.

In this dissertation I give an account of the psychological life of the depressive based on a model of inner conflict and multiplicity. The depressive's experience of depression unfolds in developmental stages and changes throughout the course of a depressive episode. In line with Merleau-Ponty's view that there are "*several ways for the body to be a body, several ways for consciousness to be consciousness,*"[469] I argue that there are several ways for depression to express itself in the depressive's body and consciousness, and that these expressions can be conflictual and contradictory. Due to the pluridimensionality of body and mind, depression can take hold and express itself in a variety of ways. It inserts itself into the syntheses of the physiological and psychological, language and meaning, meaning and identity, identity and social relationality, social relationality and voice, voice and language, and so forth. More than a disorder of mood, depression is a disorder of meaning, identity, social relations, and voice. Major depression alters the depressive's perception of herself and her world. It disrupts the depressive's temporal life, body, relations with people, sense of self, capacity to function, agential vitality, linguistic facility, cognitive attachments, and personal identity. That an affective disorder can so deeply disrupt one's way of living reveals the interconnectedness of affective life with a form of life.

While the main fieldwork of depression lies within the rubric of psychiatry and psychology, philosophers do have a place in developing an account of the relationship between meaning, identity, and language in depression, and they have a place in investigating how these features of the depressive's life can be both disrupted and recovered. The role of the philosopher investigating depression is not necessarily to

[469] Merleau-Ponty, 1992, 124

provide new words to describe or new ways of speaking about depression, but to provide a forum in which the depressive's experience can be made visible and understood in the context of philosophical constructs. Rather than assimilating the depressive experience into pre-established theoretical structures, the attempt to understand the depressive in her own words can illuminate new conceptual connections, new meanings, and new ways of seeing. The meanings that emerge from a philosophical analysis of depression that are derived from the perspective of the depressive can in turn expand and challenge traditional philosophical discourse. For instance, a philosophical analysis of mental disorders resituates philosophical questions regarding the relationship between the mind and body, freedom and determinism, language and meaning, and so forth. Also, a philosophical evaluation of a disorder like depression helps reveal the multidimensionality of agency and reveals the interdependence of one's affect with one's apprehension and generation of meaning. By operating under the presumption of the norms of mental health with regard to subjectivity and agency, traditional academic philosophy has taken for granted many structures of intelligibility and sociality. A phenomenological account of depression demonstrates one of the ways that structures of intelligibility, sociality, temporalization, and spatialization can breakdown.

Philosophy can help create ways for the voices of the mentally ill to be acknowledged and counted as legitimate sources of knowledge. I do not claim that the mentally ill have been overlooked in academia as both objects of knowledge and subjects of knowledge, but they have been more or less quarantined to the halls of psychology, psychiatry, and biology. People with mental disorders represent a diverse group of individuals who have been largely overlooked as a source for epistemological

uniqueness, a source of knowledge that, when considered by philosophy, can contribute to the overall field of epistemology, philosophy of language, and philosophy of mind. David Karp laments that in most studies of depression "we hear the voices of a battalion of mental health experts…and never the voices of depressed people themselves."[470] People who experience depression do not need to be spoken *for*, but heard. A philosophical account of the recovery of discursive agency ultimately reveals the need for depressives to speak for themselves, as well as the need for depressives to have a receptive discursive community and generative discursive outlet. This dissertation aims at making the depressive experience intelligible by allowing the voices and perspectives of depressives to be heard. I use depressives' account of their own experiences to guide my theoretical investigation and argue that philosophy *of* psychopathology should allow the perspective of the mentally ill to both inform and guide further philosophical research.

I view the role of philosophy in the context of psychology generally and psychopathology specifically as being able to provide a critical analysis of the concepts at play, a phenomenological account of mental disorders, and a political genealogy of the social structures that have bearing on mental disorders. Depression does not operate in and disrupt a *generic* form of life. Likewise, the depressive's loss of self takes place in relation to specific social contexts. One role philosophy can play in expanding the knowledge of depression and the intelligibility of depressives is to provide an analysis of the social structures operative within the form of life of a particular culture, structures that are implicated in both the causes and experience of depression and the recovery from depression.

[470] Karp, 1996, 11

This dissertation is neither the last word on depression nor *my* last word on depression. There are many features of the depressive experience to uncover and many ways to take some of my insights in new directions. For instance, I have merely skimmed the surface of the social structures of depression and the social silencing of depressives. One disadvantage of my method of providing a comprehensive picture of depression by including a variety of first-person accounts is that at times this strategy can come at the expense of a more in-depth analysis of the perspectives presented, as well as the theories I present and use to analyze the first-person accounts. As more people inside professional philosophy find philosophy of psychopathology to be both a legitimate and valuable fieldwork in philosophy, my hope is that I and many others will work this complicated field with attention to both the plurality of identity and the function and structures of embodied and affective meaning.

BIBLIOGRAPHY

Abraham, K. (1985). Notes of the Psycho-Analytical Investigation and Treatment of Manic-Depressive Insanity and Allied Conditions. In J. C. Coyne, *Essential Papers on Depression* (pp. 31-47). New York: New York University Press.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Arlington, VA: American Psychiatric Publishing, Inc.

Anzaldúa, G. a. (1983). *This Bridge Called My Back: Writings by Radical Women of Color.* New York: Kitchen Table: Women of Color Press.

Anzaldúa, G. (1990). *Making Face, Making Soul. Haciendo Caras; Creative and Critical Perspectives by Feminists of Color.* San Fransisco: Aunt Lute Books.

Armstrong, K. (2004). *The Spiral Staircase: My Climb out of Darkness.* New York: Random House Inc.

Austin, J. (1970). *Philosophical Papers.* New York: Oxford University Press.

Beeman, W. O. (1985). Dimensions of Dysphoria: The View from Linguistic Anthropology. In A. Kleinman, & B. Good, *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (pp. 216-243). Berkley: University of California Press.

Bermúdez, J. L. (2005). *Philosophy of Psychology: A Contemporary Introduction.* New York: Routledge.

Binswanger, L. (1958). The Case of Ellen West. In R. May, H. F. Ellenberger, & E. Angel, *Existence: A New Dimension in Psychiatry and Psychology* (pp. 237-364). New York: Simon and Schuster.

Bourdieu, P. (2002). *Distinction: A Social Critique of the Judgment of Taste.* Cambridge, MA: Harvard University Press.

Bourdieu, P. (2001). *Language and Symbolic Power.* Cambridge, MA: Harvard University Press.

Bourdieu, P. (1977). Structures and the habitus. In *Outline of a Theory of Practice.* Cambridge: Cambridge University Press.

Brampton, S. (2008). *Shoot the Damn Dog: A Memior of Depression.* London: Bloomsbury Press.

Camus, A. (1991). *The Myth of Sisyphus and Other Essays.* New York: Vintage Books.

Casey, N. (2002). *Unholy Ghost: Writers on Depression.* New York: HarperCollins Publishers.

Cheever, A. (2000). Prozac Americans: Depression, Identity, and Selfhood. *Twentieth Century Literature*, 346-368.

Christian, B. (1990). The Race for Theory. In G. Anzaldúa, *Making Face, Making Soul. Haciendo Caras: Creative and Critical Perspectives by Feminists of Color* (pp. 335-345). San Fransisco: Aunt Lute Books.

Church, J. (2003). Depression, Depth, and the Imagination. In J. Phillips, & J. Morley, *Imagination and Its Pathologies* (pp. 175-186). Cambridge, MA: The MIT Press.

Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., et al. (2003). The Acceptability of Treatment for Depression among African-American, Hispanic, and White Primary Care Patients. *Medical Care* , 479-489.

Coyne, J. C. (1985). *Essential Papers on Depression.* New York: New York University Press.

Danquah, M. N.-A. (1998). *Willow Weep for Me: A Black Woman's Journey through Depression.* New York: The Ballantine Publishing Group.

Dockett, L. (2001). *The Deepest Blue: How Women Face and Overcome Depression.* Oakland: New Harbinger Publications, Inc.

Elliot, C. (2004). Mental Illness and its Limits. In J. Radden, *The Philosophy of Psychiatry, a Companion* (pp. 426-436). New York: Oxford University Press.

Elliott, C. (2003). Does Your Patient Have a Beetle in His Box? Language-Games and the Spread of Psychopathology. In C. J. Heyes, *The Grammar of Politics: Wittgenstein and Political Philosophy* (pp. 186-201). Ithaca: Cornell Press.

Elliott, C. (2000). Pursued by Happiness and Beaten Senseless: Prozac and the American Dream. *Hastings Center Report*, 7-12.

Falk, J. (2005). *Hello to all that: A Memoir of Zoloft, War, and Peace.* New York: Picador.

Foucault, M. (1988). *Madness and Civilization: A History of Insanity in the Age of Reason.* New York: Vintage Books.

Freud, S. (2005). Mourning and Melancholia. In S. Freud, *On Murder, Mourning and Melancholia.* London: Penguin Books.

Fricker, M. (2009). Epistemic Injustice: Power and the Ethics of Knowing. Oxford: Oxford Unviersity Press.

Fuchs, T. (June 2005). Corporealized and Disembodied Minds: A Phenomenological View of the Body in Melancholia and Schizophrenia. *Philosophy, Psychiatry, & Psychology*, 95-107.

Fuchs, T. (2001). Melancholia as Desynchronization: Towards a Psychopathology of Interpersonal Time. *Psychopathology*, 179-186.

Gendlin, E. (1997). *Experiencing and the Creation of Meaning: A Philosophical and Pyschological Approach to the Subjective.* Evanston, Illinois: Northwestern University Press.

Gert, B., & Culver, C. M. (2004). Defining Mental Disorder. In J. Radden, *The Philosophy of Psychiatry, A Companion* (pp. 415-425). New York: Oxford University Press.

Glannon, W. (2002). Depression as a Mind-Body Problem. *Philosophy, Psychiatry & Psychology*, 243-254.

Graham, G. (2004). Self-Ascription: Thought Insertion. In J. Radden, *The Philosophy of Psychiatry, a Companion* (pp. 89-105). New York: Oxford University Press.

Graham, G. (2010). *The Disordered Mind: An Introduction to Philosophy of Mind and Mental Illness.* New York: Roudledge.

Hanfling, O. (2002). *Wittgenstein and the Human Form of Life.* New York: Routledge.

Hansen, J. (2004). Affectivity: Depression and Mania. In J. Radden, *The Philosophy of Psychiatry, a Companion* (pp. 36-53). New York: Oxford University Press.

Head, J. (2004). *Standing in the Shadows: Understanding and Overcoming Depression in Black Men.* New York: Broadway Books.

Healy, D. (2000). Good Science or Good Business. *The Hastings Center Report*, 19-21.

Heffernan, V. (2002). A Delicious Placebo. In N. Casey, *Unholy Ghost: Writers on Depression* (pp. 8-20). New York: HarperCollins Publishers.

Heidegger, M. (1996). *Being and Time.* Albany: State University of New York Press.

Heidegger, M. (1971). The Nature of Language. In *On the Way to Language.* New York: HarperCollins Publishers.

hooks, b. (1990). Talking Back. In G. Anzaldúa, *Making Face, Making Soul. Haciendo Caras; Creative and Critical Perspectives by Feminists of Color* (pp. 207-211). San Francisco: Aunt Lute Books.

Horowitz, S. M., Weis, D. L., & Laflin, M. T. (August, 2001). Differences between Sexual Orientation Behavior Groups and Social Background, Quality of Life, and Health Behaviors. *The Journal of Sex Research,* 205-218.

Jack, D. C. (1993). *Silencing the Self: Women and Depression.* New York: HarperPerennial .

Jamison, K. R. (1996). *An Unquiet Mind: A Memoir of Moods and Madness.* New York: Random House Inc.

Kafka, F. (2004). *The Metamorphosis.* New York: Bantam Dell.

Karp, D. A. (1996). *Speaking of Sadness: Depression, Disconnection, and the Meanings of Illness.* New York: Oxford University Press.

Kaysen, S. (2002). One Cheer for Melancholy. In N. Casey, *Unholy Ghost: Writers on Depression* (pp. 38-43). New York: HarperCollins Publishers.

Kierkegaard, S. (1959). *Either/Or: Volume I.* Princeton: Princeton University Press.

Kleinman, A. a. (1985). *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder.* Berkley: University of California Press.

Kristeva, J. (2002). Black Sun. In K. Oliver, *The Portable Kristeva.* New York: Columbia University Press.

Kristeva, J. (1989). *Black Sun: Depression and Melancholia.* New York: Columbia University Press.

Kristeva, J. (2002). Strangers to Ourselves. In K. Oliver, *The Portable Kristeva* (pp. 264-294). New York: Columbia University Press.

Lee-Lampshire, W. (1999). The Sound of Little Hummingbird Wings: A Wittgesnteinian Investigation of Forms of Life as Forms of Power. *Feminist Studies*, 409-426.

Lugones, M. (1990). Playfulness, 'World'-Travelling, and Loving Perception. In G. Anzaldúa, *Making Face, Making Soul. Haciendo Caras; Creative and Critical Perspectives by Feminists of Color* (pp. 390-402). San Fransisco: Aunt Lute Books.

Malcolm, N. (2001). *Ludwig Wittgenstein: A Memior.* Oxford: Clarendon Press.

Malcolm, N. (1995). *Wittgensteinian Themes: Essays 1978-1989.* London: Cornell University Press.

Manning, M. A. (1994). *Undercurrents: A Life Beneath the Surface.* New York: HarperCollins Publishers.

Martin, M. W. (1999). Depression: Illness, Insight, and Identity. *Philosophy, Psychiatriy & Psychology*, 271-286.

Martin, M. W. (2002). On the Evolution of Depression. *Philosophy, Psychiatry & Psychology*, 255-259.

May, R. (1958). Contributions of Existential Psychotherapy. In R. May, H. F. Ellenberger, & E. Angel, *Existence: A New Dimension in Psychiatry and Psychology* (pp. 37-91). New York: Simon & Schuster.

May, R., Ellenberger, H. F., & Angel, E. (1958). *Existence: A New Dimension in Psychiatry and Psychology.* New York: Simon and Schuster.

Mayberg, H. (2012, May 29). Charlie Rose Brain Series 2: Depression. (C. Rose, Interviewer)

Mayberg, H. S., Liotti, M., Brannan, S. K., McGinnis, B., Mahurin, R. K., Jerabek, P. A., et al. (1999). Reciprocal Limbic-Cortical Function and Negative Mood: Converging PET Findings in Depression and Normal Sadness. *American Journal of Psychiatry*, 675-682.

Mays, J. B. (2003). *In the Jaws of Black Dogs: A Memoir of Depression.* New York: HarperCollins Publishers.

McMurtry, L. (2002). From 'Walter Benjamin at the Dairy Queen'. In N. Casey, *Unholy Ghost: Writers on Depression* (pp. 67-74). New York: HarperCollins Publishers.

Mead, G. H. (1967). *Mind, Self, and Society from the Standpoint of a Social Behaviorist.* Chicago: The University of Chicago Press.

Medina, J. (2005). *Language: Key Concepts in Philosophy.* London: Continuum.

Medina, J. (2006). *Speaking from Elsewhere: A New Contextualist Perspective on Meaning, Identity, and Discursive Agency.* Albany: State University of New York Press.

Merleau-Ponty, M. (1992). *Phenomenology of Perception.* London: Routledge.

Miech, R. A., & Shanahan, M. J. (June, 2000). Socioeconomic Status and Depression over the Life Course. *Journal of Health and Social Behavior*, 162-176.

Nietzsche, F. (1961). *Thus Spoke Zarathustra.* London: C. Nicholls and Co., Ltd.

Nolen-Hoeksema, S. (2001). Gender Differences in Depression. *Current Directions in Psychological Science*, 173-176.

Norden, J. (2007). *Understanding the Brain: Course Guidebook.* Chantilly, VA: The Teaching Company.

Nurius, P. S. (May, 1983). Mental Health Implications of Sexual Orientation. *The Journal of Sex Research* , 119-136.

O'Connor, P. (2002). Moving to New Boroughs: Transforming the World by Inventing New Language Games. In N. Sheman, & P. O'connor, *Feminist Interpretations of Ludwig Wittgenstein* (pp. 432-449). Philadelphia: Penn State University.

O'Nell, T. D. (1996). *Disciplined Hearts: History, Identity, and Depression in an American Indian Community.* Berkley: University of California Press.

Plath, S. (2006). *The Bell Jar.* New York: HarperPerennial Modern Classics.

Pugmire, D. (2010). Saying It. In P. Goldie, *The Oxford Handbook of Philosophy of Emotion* (pp. 373-384). Oxford Handbooks Online.

Radden, J. (2003). Is this Dame Melancholy? Equating Today's Depression and Past Melancholia? *Philosophy, Psychiatry & Psychology*, 37-52.

Radden, J. (2009). *Moody Minds Distempered: Essays on Melancholy and Depression.* New York: Oxford University Press.

Radden, J. (2000). *The Nature of Melancholy: From Aristotle to Kristeva.* Oxford: Oxford University Press.

Radden, J. (2004). *The Philosophy of Psychiatry, a Companion.* New York: Oxford University Press.

Ratcliffe, M. (2010). The Phenomenology of Mood and the Meaning of Life. In P. Goldie, *The Oxford Handbook of Philosophy of Emotion* (pp. 349-371). Oxford Handbooks Online.

Real, T. (1997). *I Don't Want to Talk About It: Overcoming the Secret Lecgacy of Male Depression.* New York: Simon & Schuster.

Roberts, J. R. (2001). Mental Illness, Motivation and Moral Commitment. *The Philosophical Quarterly*, 41-59.

Roxburgh, S. (2009). Untangling Inequalities: Gender, Race, and Socioeconomic Differences in Depression. *Sociological Forum*, 357-381.

Sadler, J. Z. (2004). Diagnosis/Antidiagnosis. In J. Radden, *The Philosophy of Psychiatry, a Companion* (pp. 163-179). New York: Oxford University Press.

Sartre, J.-P. (1956). *Being and Nothingness.* New York: Washington Square Press.

Scheman, N. (1996). Forms of Life: Mapping the Rough Ground. In H. a. Sluga, *The Cambridge Companion to Wittgenstein* (pp. 383-410). Cambridge: Cambridge University Press.

Sharrock, W. a. (1985). Criticizing Forms of Life. *Philosophy*, 394-400.

Shenk, J. W. (2002). A Melancholy of Mine Own. In N. Casey, *Unholy Gost: Writers on Depression* (pp. 242-255). New York: HarperCollins Publishers.

Shusterman, R. (2000). *Bourdieu: A Critical Reader.* Oxford: Blackwell Publishers Ltd.

Shusterman, R. (2004). The Silent Limping Body of Philosophy. In T. Carman, & M. B. Hansen, *The Cambridge Companion to Merleau-Ponty.* Cambridge: Cambridge University Press.

Smith, B. (2012). Depression and Motivation. *Phenomenology and the Cognitive Sciences*.

Smith, J. (1999). *Where the Roots Reach for Water: A Personal and Natural History of Melancholia.* New York: North Point Press.

Solomon, A. (2002). *The Noonday Demon: An Atlas of Depression.* New York: Simon & Schuster.

Styron, W. (1992). *Darkness Visible: A Memoir of Madness.* New York: Vintage Books.

Thompkins, E. (1990). A Farewell to Forms of Life. *Philosophy*, 181-197.

Twichell, C. (2002). Toys in the Attic: An Ars Poetica Under the Influence. In C. Nell, *Unholy Ghost: Writers on Depression* (pp. 21-28). New York: HarperCollins Publishers.

Van den Berg, J. (1972). *A Different Existence: Principles of Phenomenological Psychopathology.* Pittsburgh: Duquesne University Press.

Williams, T. M. (2008). *Black Pain: It Just Looks Like We're Not Hurting.* New York: Scribner.

Wittgenstein, L. (1980). *Culture and Value.* Chicago: The University of Chicago Press.

Wittgenstein, L. (1998). *Culture and Value, Revised Edition.* Oxford: Blackwell Publishing.

Wittgenstein, L. (1982). *Last Writings on the Philosophy of Psychology, Volume I.* Chicago: University of Chicago Press.

Wittgenstein, L. (1992). *Last Writings on the Philosophy of Psychology, Volume II.* Chicago: University of Chicago Press.

Wittgenstein, L. (1972). *On Certainty.* New York: Harper & Row Publishers.

Wittgenstein, L. (1993). *Philosophical Grammar.* Oxford: Blackwell Publishers.

Wittgenstein, L. (2001). *Philosophical Investigations.* Oxford: Blackwell Publishers Ltd.

Wittgenstein, L. (1984). *Philosophical Remarks.* Chicago: The University of Chicago Press.

Wittgenstein, L. (1978). *Remarks on Colour.* Berkley: University of California Press.

Wittgenstein, L. (1996). *Remarks on the Foundation of Mathematics, Revised Edition.* London: The MIT Press.

Wittgenstein, L. (1980). *Remarks on the Philosophy of Psychology Vol. 1.* Chicago: The University of Chicago Press.

Wittgenstein, L. (1980). *Remarks on the Philosophy of Psychology Volume II.* Chicago: The University of Chicago Press.

Wittgenstein, L. (1961). *Tractatus Logico-Philosophicus.* London: Routledge & Kegan Paul Ltd.

Wittgenstein, L. (1970). *Zettel.* Los Angeles: University of California Press.

Wood, D. (2001). *The Deconstruction of Time.* Evanston: Northwestern University Press.

Yalom, I. D. (1980). *Existential Psychotherapy.* New York: Basic Books Inc.