EPISTEMICALLY ADRIFT: MOOD DISORDERS AND NAVIGATING RESPONSIBILITY

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by

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ABSTRACT

This is a dissertation in philosophy of psychiatry and ethics focused on the question of how does one live and react responsibly to the experience of mood disorders such as depression and anxiety. In looking to the current state of psychiatry and cultural understandings of mental disorder, I identify what I call being "epistemically adrift" – the sense that individuals face too many conflicting opinions and a constant debate of how to live with depression that they are unable to process for themselves what their best options for living are. This feeling of being epistemically adrift is all the more complicated by the experience of mood disorder itself, which often makes individuals feel morally inadequate and pressured to do the right thing without clear direction. In the absence of a clear path regarding depression and anxiety, this dissertation proposes an ethics for depression and anxiety disorders – drawing a virtue theory from the existentialist tradition that focuses on the outskirts of mental disorder in order to create an inclusive ethical system for those generally excluded in moral philosophy.

The first chapter outlines the general theory of being epistemically adrift in relation to depression and anxiety and how the themes of uncertainty in these conditions inherently lead to different epistemic insights. This chapter establishes the dissertation's roots in existential phenomenology and epistemic injustice literature in order to sketch out how the combined uncertainty in interdisciplinary understanding of mental illness with the uncertainty experienced within mood disorders lead individuals to feeling adrift and unable to determine what they should do for themselves in living good lives.

Meanwhile I argue that the insights of depression and anxiety attune individuals to the world in different ways than their non-depressed peers, which imports interesting questions regarding our responsibility toward one another.

The second chapter explores a case study of this sort of insight, arguing that the experience of excessive or "delusional" guilt within depressive disorders can provide a deeper insight into our general moral responsibility towards one another. I compare this feeling of guilt to Karl Jaspers' conception of "metaphysical" or collective guilt in his analysis of the German people after the Second World War and Holocaust. These sorts of guilt feelings within depression is often incapacitating and hard to make sense of for individuals, but it additionally has a transformative ability to reevaluate moral life. I argue that parallel to the concept of "depressive realism" where individuals with depression have different and sometimes better insights than others, depressive guilt differently attunes individuals to how they relate to others and the world at large.

From there, the third chapter engages with how psychiatric diagnosis shapes and limits one's perceptions of their freedom and agency. More specifically, this chapter employs an existentialist analysis of how one can react to their diagnosis in bad faith – deflecting their own responsibility either by indulging into diagnostic patterns as inherent destiny or denying the condition's effect on their motivations. I argue that there must be a middle path where one takes responsibility for one's situation as being depressed or anxious, which both acknowledges the condition but also sees it as a personal challenge to improve on one's life.

The final chapter of the dissertation culminates in the development of an ethical theory that directly centers itself within the experience of mood disorders. This theory stems from both existentialism for its commitment to projecting meaning on uncertainty and absurdity along with virtue theory which allows for a sense of imperfection and improvement over time. I have been developing a set of virtues for how to be responsible for one's depression or anxiety. "Responsibility" in this sense is the question of how one *responds* to their moods and other symptoms related to mood disorders, that is, an account of responsibility that resists narratives of fault or blame. These virtues are meant to be a set of therapy-informed guidelines to help those with depression and anxiety counteract the worst feelings of being adrift and foster autonomy and dignity for themselves.

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TABLE OF CONTENTS

INTRODUCTION

A world that can be explained with bad reasons is a familiar world. But, on the other hand, in a universe suddenly divested of illusions and lights, man feels an alien, a stranger. His exile is without remedy since he is deprived of the memory of a lost home or the hope of a promised land.

– Albert Camus, *The Myth of Sisyphus* (1955/1983, p. 6).

This dissertation looks to the intersections of philosophy of psychiatry, ethics, social epistemology, phenomenology, and existentialism to address the problems of living with depression and anxiety and finding one's grounding in responsibility. The argument follows that the lack of scientific consensus and constant cultural debates about what mental illness is, what it is not, and how to treat it leaves individuals with mood disorders *adrift* as to how to live their lives in meaningful ways. The project is an examination of the social and ethical problems that come from the lack of scientific consensus and continual cultural debates surrounding depression and anxiety disorders and their treatment. At the same time, the lived experiences of these mood disorders often thematically revolve around a feeling of uncertainty and insecurity around one's moral worth. Depression and anxiety often makes an individual feel as though they are inadequate or unworthy of full moral consideration.[1] These feelings in conjunction with external social stigma leave individuals suffering from anxiety and depression feel as though they cannot be morally good agents therefore feel compromised when it comes to being "good" people. Depressed and anxious individuals thus face a double uncertainty: a

[1] Throughout this dissertation I use "they" as a singular pronoun to remove gendered connotations from my general example work.

lack of definitive answers about their conditions and a feeling of inadequacy that they could ever do the right thing to make themselves feel at ease. Philosophy has yet to take up an adequate and explicit ethics for living with depression and anxiety as disorders rather than temporary emotional states. The aim of this dissertation is to take up this challenge head on and consider the ethical ramifications, confusions, and social exclusions of living with these mood disorders.

This work rests (rather uncomfortably?) on the experiences of depression and anxiety being more often than not experiences of uncertainty. Thematically, these conditions are plagued with feelings of inadequacy and a lack of grounding. To be anxious is to feel as though one is not safe. This lack of safety is uncertain in the sense that one does not feel as though one can trust the world. Anxiety undermines one's sense of comfort and sense of home. Depression as well is something that makes one unsure and indecisive in their decisions. Across both conditions and their combinations and derivatives, there is a sense that anxiety and depression make individuals unable to trust in much of anything.

Depression and anxiety disorders share a history that predates psychiatry, albeit these conditions have not always been named. For a long time, these disorders were lumped together as "melancholy", a black bile from the humoral theory of medicine. While there is no black bile, the theme of darkness has continued throughout history and we can point to numerous fictional and historical characters who have suffered from long periods of deep sadness, lack of pleasure, or agitation (Jackson S. W., 1986; Radden, 2009). The typical starting ground for philosophers interested in mental illness is Michel

Foucault's *The History of Madness* (2006), originally published in English as the excerpted *Madness in Civilization* (1965). Foucault's account tracks the birth of psychiatry in asylums and confinement as a sign of modernity.[2] As fascinating as his accounts are of the shifts in psychiatric care, I am more interested in the 21st century's problems of finding meaning in an all-too-depressing and uncertain world. While there are many themes of melancholy that continue into contemporary depressions (Radden, 2009), this dissertation concerns itself with depression and anxiety and their social problems today. The boundaries of what is or isn't a particular disorder have changed (Hacking, 1999; 1998), but the abnormal and uncomfortable experiences of these feelings continue.

The dissertation's argument operates around the fact that as they currently stand, psychiatry and other disciplines have neither reached a consensus of what mental disorders (or illnesses)[3] are nor how to effectively treat them. This lack of consensus operates on several different conceptual lines. One is a lack of understanding whatever mechanisms underlie mental disorder, either in the sense of psychiatry being an 'immature' science or that it does not study the phenomena in the 'right' or 'full' context. Another is that there is no clear boundary of what unifies mental disorders altogether as

[2] Sociologist and social historian Andrew Scull (2019) however notes that Foucault's account within *The History of Madness* is rather too fast and loose with its distinctions and makes claims with questionable historical scholarship.

[3] Even the terminology carries some ideological import. "Disorder" to some extent includes a more social aspect in which those who have disorders resemble social disorder or upheaval. "Illness" invokes a medical lens: something to be cured or fixed. I for the most part have a partiality for the term "disorder" as I am much more interested in the social side than drawing strict medical etiologies, but for lack of a clear and altogether destigmatized terminology, I will use mental illness interchangeably as well.

one concept; there is no internal attribute or definition of disorder that covers all instances of mental disorder. Mental illness remains a "mystery" or a "final frontier" where it does not exist with a hard sense of certainty in terms of how we can understand it as a unifying concept. In the epigraph above by Camus, he writes of a world that is explainable with "bad reasons". When it comes to mental illness, many of our cultural understandings of the underlying mechanisms and treatments are bad reasons but there are also *good* reasons – there are plenty of explanations that we give about why a particular person's mental disorder has generated in certain ways – but there is little in the way of universal explanations.[4]

I am wary that there is any one scientific practice or paradigm that can crack what mental illness is. Psychiatry stands today for the most part as a bio-medical model of disorder that seeks to understand the processes of the mind and disorder. This came after the rise and fall of psychoanalysis which was regarded as too "unscientific" (Scull, 2019). Talk therapies seem to have the best advantage in treatment but are not "hard science" and typically are derided as being incapable of finding underlying mechanisms. However, the "biological turn" in psychiatry has failed to yield any mechanisms as of yet (Harrington, 2019; Scull, 2019). In fact, Thomas Insel, the former head of the National Institute of Mental Health (NIMH), has lamented that

> I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I succeeded at getting lots of really cool papers published by cool

[4] It is quite likely, I suspect, that there is no underlying universal scientific kind that unites disorder. Even those conditions that are lumped together by symptoms are so vastly different from one individual's experience of it to the next.

> scientists and fairly large costs—I think $20 billion—I don't think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness. I hold myself accountable for that. (Quoted in Harrington 2019, p. 270).[5]

This lament shows that psychiatry's gamble on establishing itself as an evidence-based hard science has yet to pay off – if it will at all. We have yet to make a breakthrough that solves mental illness at its mechanistic level. There have been some successes in psychiatry in understanding the mind and disorder but the absence of definitive answers and universal treatments, individuals with mental illnesses are left to fend for themselves in terms of figuring out what the best course of treatment is for themselves while navigating conflicting social expectations and stigma as well as legal policies. There are several overlapping public debates and discourses on what disorder is or isn't in which many individuals claim expertise or authority on the subject, making it hard for the layperson to discern what the "right" narrative is.

With so many different approaches regarding mental illness, individuals who are directly affected by disorder (either for themselves or with their family members and loved ones) are left to fend for themselves in terms of figuring out what the best course of treatments or other reactions to their conditions that one should take. The result is that individuals who are already vulnerable in the experience of mental disorder, whatever it is, find themselves lost and unsure what to do with themselves in a flux of too much

[5] Insel left the NIMH to work for a brief stint at Alphabet (Google), then on to co-found Mindstrong – a start-up for AI therapy chatbots. It is unclear how effective his new venture will be, albeit I believe that artificial intelligence will only worsen social problems for mental illness regarding infosecurity and personal privacy.

information, opinions, propaganda, and other epistemically-dubious claims about themselves. This problem is what I have coined as being *epistemically adrift*.

Being epistemically adrift is the experience of being unable to discern what the best course of action is for oneself while one encounters too many often-conflicting claims to knowledge. Epistemically adrift individuals are those who end up trapped between competing ideologies or between different disciplines or understandings regarding their condition and choices. While my focus is on mental illness, I believe that being epistemically adrift is possible for other aspects of one's identity or other conditions of being in the world. The epistemology and metaphysics of mental disorder can be just as contentious as those of race, gender, sexuality, etc. With shifting paradigms and approaches along with different popular trends in self care and treatment, trying to assess for oneself what the 'truth' of mental disorder is hard for any individual to assess, let alone for one who is grappling their way through cognitive issues and estranged moods. Additionally, some argue that there do not seem to be unifying natural kinds to mental disorder, but rather a series of interrelated clusters, some of which are seemingly more "socially-constructed" at least in the sense that social influences and pressures can shape and affect the individual's existence within disorder (Hacking, 1999).[6] All of these factors lead to a shifting epistemic ground that prevent a definitive knowledge of mental

[6] But whether or not some disorders are "socially constructed" or at least socially reinforced in looping effects, as Hacking (1999) suggests they still have a fundamental force or strength that make them all the more real for the individuals experiencing them.

disorder, which in turn directly affects an individual with mental disorder's self-knowledge.

The initial inspiration for my approach to this problem comes from Edmund Husserl's later philosophy regarding philosophy of science. In his final unfinished work, *The Crisis of European Sciences and Transcendental Phenomenology* (1954/1970), Husserl argues that scientific disciplines are different approaches to explicate the "life-world" (*Lebenswelt*). The life-world for Husserl is the pre-reflective world of experience where we find ourselves always already deployed. This is the world that we inhabit and experience, both as a collective society but also individually and for oneself. Different sciences (*Wissenschaften* – which for Husserl include social sciences as well as even other nonscientific disciplinary approaches such as literature) may give us a better understanding of the world, but this life-world is irreducible to any one disciplinary approach. The life-world as such is too complex; one can understand that different scientific approaches help explain the life-world but at the same time they are but an abstraction from the muddled, complex, and messy day to day lived experiences that we have. A theory can explicate the world we inhabit, but it does not in itself define all the parameters of experience that we have. Experiencing depression and anxiety is not just simply an internal experience of the condition itself, but as one navigates self-understanding about their conditions, they come across different pre-existing scientific and non-scientific conceptions of what these conditions are. Scientific and psychiatric theories of depression help outline our understanding of depression and anxiety, but they only trace models of these experiences and their mechanisms, they do not provide a fully-

immersive picture of what it means to live with depression and anxiety. These theories do have an effect on how people understand themselves, but they are merely a sketch or representation of what these conditions are compared to the lived experience.

Husserl argues that the "crisis" that sciences have found themselves in at the time of writing his *Crisis* is one of scientism as well as doubt. According to him, the sciences have lost their way in explicating the world both because they do not understand that the world is irreducible to any one unified method as well as forgetting that they are meant to serve human projects and flourishing. Husserl believes that the solution to this crisis is for the sciences to go "back to the things themselves" in remembering their place as a function of humanistic endeavors (1954/1970). My position is a little more cynical; yes, sciences should only be utilized as practices that help enrich all human life and counteract previous wrongs, yet it is unlikely that they will do so due to capitalist value systems keeping scientific funding in a stranglehold of what seems profitable. In the meantime of hoping for a more humane scientific revolution, the experience of mental illness is mired by external pressures of a lack of scientific consensus regarding their metaphysical grounding and a constant cacophony of different competing disciplinary approaches as well as "culture wars" which prevent certainty in individuals' experiences.

But the sciences are not always taken up solely on their projects and findings, but also as their reputations. Husserl writes in his *Formal and Transcendental Logic* (1969):

> whether sciences and logic be genuine or spurious, we do have experience of them as cultural formations given to us beforehand and bearing within themselves their meaning, their 'sense': since they are formations

> produced indeed by the practice of the scientists and generations of scientists who have been building them. (Husserl, 1969, pp. 8-9).

The sciences are not simply abstractions but are also cultural endeavors taken up by human actors. The scientist is not simply an agent who merely does "pure" science, but comes with their own biases and experience. These sciences each exist with their own histories, methods, and goals which are agreed-upon as cultural institutions by other members of that discipline. As a result, the psychiatry does not exist just simply as a pure science that comes from nowhere but is the culmination of years of study of the mind including its failures and successes. With psychiatry today, we still see the remnants of "darker" days. While psychiatry has made some great strides in understanding the human condition and pathology, it still is a branch of medicine borne from the confinement of asylums that today approaches the experiences and personalities of others as abnormal. Psychiatry to a large extent is a negative branch of medicine, only in search of what is outside the norm, disabling and distressing. As a result, there is a large amount of hostility and stigma that seems inherent within the practice of psychiatry as society sees it for its reputation of confinement, medicalization, medication, and dark history. Even a positive view of psychiatry has to elaborate critically on its history of asylums, sterilizations, lobotomies and involuntary treatment.

Where Husserl writes of sciences in a "crisis", the case of psychiatry and other behavioral sciences are not so much at an immediate or prescient crisis but a historical continuity that has been marked with many successes and failures with seemingly little tangible progress. Depression and anxiety, the so-called "common colds" of psychiatry, have yet to be determined for how they are caused or operate, and at this juncture it

seems rather unlikely that they will be "cured". Rather instead, it seems that depression and anxiety come from multiple possible causes that are existential to the individual. These conditions seem to be here to stay, and given worsening sociopolitical conditions, the COVID-19 crisis, as well as climate change, it is likely that trauma- and stress-related depressions and anxieties will only increase. Psychiatry itself may not be in an active crisis, but the conditions surrounding the field as well as the feeling of these disorders themselves put individuals in crisis.

However, while there is no clear certainty on the underlying mechanisms and science of mental disorders, I do not think that that is in itself a problem. Some messes are okay to remain messes. After all, there is the sense that *dis*order implies that there is an absence of a clean, *orderly* understanding of the world – even if it is merely the lack of disorder, as many seem to define health in general. On the other hand, there are no diagnostic criteria for being mentally healthy. No one goes to a psychiatrist for an annual physical, but instead only visits (or is forced to visit) when something is amiss. Taking disorder seriously requires some mess, and in the end some parts of this project will stay muddled. The trouble instead comes in when one attempt at understanding disorder is touted as *the* way to understand disorders. That is, while we only have partial answers, there is a rather constant push to conceptualize mental illness as something simple – that we can hedge our bets in *one* disciplinary focus or research program.

But the problem is even more complicated than the question of sciences and disciplines acting in good faith in disagreement. Mental health discourse is not only discussed in terms of rigorous disciplines but are constantly taken up by those who do *not*

have coherent approaches to improving mental health. There are countless quacks, cults, celebrities, social media influencers and others who speak on mental illness not with expert authority yet with the confidence and influence that overrides good faith attempts. Where philosopher Miriam Solomon (2015, p. 61) argues that expert disagreement "is, on the whole, good for science but bad for medicine", the situation is all the worse for psychiatry as so many individuals who are *not* experts too easily weigh in on what disorder is or isn't and many believe them over expertise. This is not just the case in psychiatry but in medicine and public health in general and while there are guides on how to avoid propaganda and false information in medicine such as pediatrician Paul Offit's *Bad Advice* (2018), harmful misinformation itself is abundant and altogether taken up as true or just-as-possibly-true as serious scientific, medical, or psychiatric endeavors.

The mass-scale example of the social experience of being epistemically adrift is the COVID-19 pandemic crisis. There are many unanswered questions and yet too many half-answers to keep track of. Because of the pandemic's effects being so universal and yet so existentially unique to each person's life, individuals feel at odds not only with the virus but with the very information that they have to process on their own to make the right decisions. Especially within the United States, where conservatives, conglomerate businesses, white supremacists, and the President each have come out as virulently anti-science arguing against the use of masks, social distancing, and other safety precautions, it has become impossible at times to keep track of what is the truth and what is political slant. Additionally, conspiracy theories have skyrocketed leaving those who are easily

susceptible to them all the more lost and endangered than usual.[7] At the same time, more good faith epistemic agents who intend to present truthful information can still share information of unproven or corollary side effects, treatments, and preventative measures that may or may not have a high level of truth in them. The COVID-19 crisis has spawned an accelerated storm of misinformation and information alike, leaving *all* individuals universally adrift to figure out who is a trustworthy source when few individuals have the sort of informational literacy to be able to figure out their best options.

In the wake of psychiatric doubts, anti-psychiatry and other voices that are just as dismissive or critical of psychiatry have gained epistemic status as trusted sources. While anti-psychiatrists – such as David Cooper (1967), R.D. Laing (1960), and Thomas Szasz (1974) – have come and gone in and out of popularity, the *doubt* that their works managed to produce have undermined more serious attempts at understanding disorder. I do want to be very clear in discussing that mood disorder does exist, at least proven in its lived experience alone. This is admittedly a strange stand that ultimately feels necessary due to the context of the typical discussion and debate around disorders. As Peter Zachar notes:

> because of the antipsychiatrists' claims about mental illness being a myth, nonpsychiatrists writing about classification and nosology who want to be taken seriously by psychiatrists and psychologists (and not lumped in with the antipsychiatrists) cannot afford to pass up an opportunity to present their bona fides and declare their acceptance of the reality of mental illness—especially if they are critically analyzing some aspect of

[7] Not to mention that the President has mused out loud that perhaps drinking bleach would prevent contagion, on top of all his other myopic anti-scientific beliefs.

> psychiatric theory or practice … The importance of declaring one's commitment to the reality of mental illness in order to be taken seriously is a fascinating problem and defies easy explanation. It is reminiscent of the importance placed on declaring one's acceptance of the evidence favoring evolution before offering critical analyses of specific evolutionary claims—especially if one is a philosopher. (Zachar, 2014, p. 12).

Because of the history of anti-psychiatric doubts on the very objectivity of mental distress, which still lives on in some academic and many public discourse circles, there is a need to distinguish oneself from those while still making criticisms of psychiatric practices. As critical as I am of psychiatric attitudes that do not engage directly with the lived experience of others, anti-psychiatric attitudes that flat out deny the experience of mental disorder or make claims that psychiatry is a fake science do nothing to help individuals directly affected.

All the worse is that while these debates on the validity of mental illness conception and treatment rage on, governments infringe upon human rights in the meantime. In the United States especially, there has been a policy and advocacy vacuum that has undermined any meaningful treatment of mental illness for those who do not have the socioeconomic means to take care of themselves and seek treatment. Police departments and the mass industrial prison complex have filled this void.[8] The de facto first responders for a mental health crisis are police officers, who despite any training in

[8] I regrettably had to omit a large chapter on prisons and police as the horrifyingly unjust de facto mental healthcare system in the United States because I could not narrow down its focus to just anxiety and depression not to mention that this landscape is dramatically shifting due to the COVID-19 crisis. In brief, however, the reliance on the justice system to provide for mental health is not only an appalling oversight, but it manufactures further anguish and pain for the most vulnerable members of our community. For further reading in the phenomenology of prison madness, I would recommend Lisa Guenther's *Solitary Confinement: Social Death and its Afterlives* (Guenther, 2013).

de-escalation they may receive, very often resort to brutality or killing individuals in mental health crises even when unprovoked.[9] Today in the United States after the loss of federal infrastructure and funding for psychiatric facilities, prisons have become massive in-patient centers for mental illness (Torrey, 2014; Erickson & Erickson, 2008; Slate & Johnson, 2008; Fuller, Lamb, Biasotti, & Snook, 2015; Kupers, 1999).[10] The largest in-patient psychiatric facility is in the Cook County Jail outside of Chicago, IL. Without any viable options for treatment outside of prison, many individuals end up not being able to have access to proper mental healthcare and end up going into crisis/committing crimes that lead to incarceration. As a result of the lack of viable care options that have been rolled back due to fiscally conservative public policies and an increasing medicalization

[9] The horror stories of police brutality towards individuals with mental disorder are innumerable. In 2019, US police shot and killed 1,004 people where 200 of those cases reported that the victim was suffering a mental illness episode of some sort or another (The Washington Post, 2020). This number however does not broach the full scope of police harassment and non-fatal altercations with citizens. Amidst obscene overfunding for military-grade equipment, the criminal justice system does not prioritize the health and safety of our most vulnerable populations, which thus causes more anguish, distrust, and uncertainty for these individuals.

[10] In 2019, the United States held "2.3 million people in 1,719 state prisons, 109 federal prisons, 1,772 juvenile correctional facilities, 3,163 local jails, and 80 Indian Country jails as well as in military prisons, immigration detention facilities, civil commitment centers, state psychiatric hospitals, and prisons in the U.S. territories" (Sawyer & Wagner, 2019). Of that population, roughly 40% are seriously mentally ill (Lyon, 2019), although it is hard to tell if these are "preexisting" conditions or exacerbated by prison environments. In addition, state psychiatric hospitals currently involuntarily detain or have committed about 22,000 people, many of whom are not convicted of any crime and some are being held indefinitely (Sawyer & Wagner, 2019). Further, U.S. Immigration and Customs Enforcement (ICE) is currently detaining roughly 49,000 people not for crimes, but because of their undocumented immigrant status (ibid). Out of 6000 cases in solitary confinement of those who ICE have detained between 2016 to mid-2018, the Project on Government Oversight has found that roughly 40 percent of these cases already had a mental illness diagnosis (Woodman & Saleh, 2019). The mass industrial prison system, including the concentration camps run by ICE, house many individuals with mental illness in cruel conditions, preventing them from being able to recover but instead further be harmed from alienation and separation. Prisons today employ many tactics that prevent for any social reintegration or recovery, but instead seem entirely motivated by racist policies and corporate greed (Alexander, 2012; Davis, 2003). As a result, prisons *manufacture* anguish, and prevent any sort of recovery for individuals.

of mental illness, many scholars have seen the deinstitutionalization within the United States as a move to create prisons as "the new asylums" (Torrey, 2014; Slate & Johnson, 2008; Erickson & Erickson, 2008; Rembis, 2014). Yet this discussion of claiming prisons as new asylums is a bit of an overstatement, as there are multiple factors outside of deinstitutionalization alone that has gone into the increase in prison populations.

Nevertheless, the debates and lack of consensus regarding mental disorder have very real and present effects beyond the level of personal conflict. Without a clearer direction of what avenues individuals with mental illness can take to encourage and foster their dignity, autonomy, and a chance at flourishing, many lives are ruined in the face of stigma beyond their own feelings and self-understanding. Being epistemically adrift is not simply a scholarly debate, but it is an everyday issue for those who are affected by mental illness both directly and through loved ones. Mental illness is not simply experienced in a vacuum, but it affects so many aspects of not only the individual's life but the lives of others around them just as others affect oneself.

Why Mood Disorders

Outside of being a problem taken up by scientific and medical research, depression is *popular.* Countless works of literature, pop culture, music, and internet memes upon internet memes depict depression and anxiety not simply as a pathology but as a way of life where so many have struggled and fought with themselves and their feelings. Some depictions, both nonfictional and fictional, present mood disorders in a way that is accessible, relatable, and accepting of the highs and lows of people's

emotional experience. But seemingly more common are stigmatizing portrayals which present these emotional experiences in a multitude of ways. Countless portrayals of depression and anxiety victim blame by suggesting that there is some sort of moral weakness to unhappiness. This is in part compounded by traditional western ethics that portray happiness as something that directly results from living a morally just life. Further, there are cultural and aesthetic pushes to *romanticize* mental illness. Many portrayals and cultural attitudes imagine mental illness as some sort of "gift": that creativity or success cannot be won without some suffering as a toll.[11] Even though this presents mental illness in a "positive" light, it is still an inherently-stigmatizing attitude that prevents many creatives from seeking treatment and instead indulging in their darker moods.[12] Even those who experience mental illness often have internalized stigma that perpetuates the harms of a hostile and confused society. Beyond more traditional forms of artwork and literature, internet memes have taken up just about every imaginable take when it comes to living with, interpreting, accepting, or rejecting mental illness.[13]

Besides carving out a theory of being epistemically adrift, this dissertation focuses on the experience of mood disorders (specifically depression and anxiety disorders).

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[11] My research on social attitudes regarding depression and moral responsibility was first sparked by a misguided eulogy in The Guardian by comedian Russell Brand after Robin Williams' death by suicide. Brand believes in a "divine madness" that is a gift to us as an audience, claiming that: "For me genius is defined by that irrationality … Always mischievous, always on the brink of going wrong, dangerous and fun, like drugs" (Brand, 2014). This belief is not unique to Brand, but represents a wider belief in a perverse utilitarian calculus that elevating art (in this case film and comedy) is more important than an individual's personal suffering and ruin.

[12] I have written on this sort of well-meaning but patronizing attitude and others in Jackson (2017).

[13] As much as I have been tempted, I have kept from using memes in my example work as they are so easily generated and almost ephemeral. It would be an interesting albeit maddening approach to write a dissertation on depression memes.

While I argue that being epistemically adrift applies to the wider gamut of mental disorders, mood disorders provide for a special case for a handful of reasons. The first of which is that mood disorders are highly prevalent in populations. According to the World Health Organization (WHO), depression is "the single largest contributor to global disability (7.5% of all years lived with disability in 2015)" while "anxiety disorders are ranked 6th (3.4%)" (World Health Organization, 2017, p. 5). Additionally, WHO projects that 300 million people suffer from depression at about 4.4% of the global population, with an increasing number of individuals suffering from depression especially in lower-income countries (ibid). With the prevalence rate and high cause of disability, depression and anxiety disorders are important focal points in terms of study. While often stigmatized as not being that dire or harmful, these conditions do have a high chance of causing further suffering and disability to the people who experience them. Further, philosopher Matthew Ratcliffe (2015) notes that the DSM-5 does not adequately explain the lived interconnection between anxiety and depression, saying that the APA's descriptions are rather cursory compared to the experience of depressions (2015, p. 5). As a result, I typically lump depression and anxiety disorders together as they are both along a similar continuum of what we used to see less distinctly as "melancholy". While I do not use the antiquated term, I also believe that many of the lines drawn between depression, anxiety disorders, and depressive-anxiety can at times be rather arbitrary where it is hard to label a person solely with one DSM entry mood disorder alone.[14]

[14] Another stopgap within this dissertation is that I do not examine mania and therefore do not have a nuanced account for responsibility within bipolar depressive disorders, but I hope to work on these conditions in the future.

This dissertation focuses more on depression and anxiety disorders as opposed to other disorders additionally for the sake of presenting a smaller scope when it comes to particular problems in later chapters having to do with building a fuller ethical account out of one's reaction to one's condition. The hope is that I can discuss elements that pertain to depression and anxiety disorders that then additionally may apply to other conditions. Writing on a more comprehensive account of mental disorders in general would be a much larger and unfocused project.

As a result of these sorts of problems, along with the fact that there seems to be no unifying concept or etiology across what we consider disorder in general, there has been a long contentious debate about what disorders are. There is a rather contentious debate as to whether there are hardline "natural kinds" or whether they are merely "social constructions". This debate has been taken up by psychiatrists, social scientists and philosophers alike. Comprehensive discussions of these conceptual debates exist within Derek Bolton's *What is Mental Disorder?* (2008), Rachel Cooper's *Psychiatry and Philosophy of Science* (2007), Richard J McNally's *What is Mental Illness?* (2011), Peter Zachar's *The Metaphysics of Psychopathology* (2014), and others. But for the sake of brevity and pragmatism, I am going to sidestep this debate and that while we may not have a unifying concept for what disorders are, they exist insofar as people experience them and they affect their lives and the lives of others. In the DSM-5, the definition of a mental disorder in general is the following:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or

> developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (American Psychiatric Association 2013, 20).

The major concern for defining a disorder is identifying that a disorder is usually *distressing* to the individual in some way. This overlaps with the sort of model of "harmful dysfunction" for disorder that Jerome Wakefield has advocated across his career (Wakefield, 1992). Wakefield's harmful dysfunction description does have some merit, but it does to a large extent assume that we can know what is as a corollary "functional" for the individual. "Functional" or "healthy" are both concepts which are poorly defined, just as physician and philosopher Georges Canguilhem who believes that "the sick man is not abnormal because of the absence of a norm but because of his incapacity to be normative" (Canguilhem, 1991, p. 186). Normalcy is an uncertain and unsubstantiated concept. It's hard to see what the line is between ill and well at times, but what is abnormal should not be considered "abnormative".

The trouble with depression and anxiety disorders however is that it is hard to determine where the line is between "normal" sadness and disorder. Horwitz and Wakefield (2007), for instance, hope to save the conception of "normal" sadness with a fear that depression is overdiagnosed and overmedicated. This is an understandable concern and with the uneven efficacy of SSRIs and other antidepressants and anti-anxiety medications, it is quite likely that drugs are overprescribed. Yet the issue then is that it is

hard to determine the line between mere sadness and depression. The DSM diagnostic criteria for major depression specifically notes that these episodes last two weeks or more (American Psychiatric Association, 2013, p. 160). This duration seems to be a rather arbitrary line in the sand to solve the sorites paradox of what is and what isn't depression as opposed to "normal" short-lived or "intentional" sadness.

There is additionally some care put into defining disorder in the DSM-5 not as a question of merely biological or merely social/cultural problems, as there has been much debate over the past few decades over the existence of disorders that seem merely socially-constructed or existing as a way of pointing out social deviance. The current criteria from the DSM-III to today's DSM-5 for disorders are instead concerned with "symptom clusters". Instead of speculating on the etiology of disorder, diagnosis is much more reliable (and hopefully valid) in looking to the phenomena itself. The avoidance of discussing etiology widens the definition of disorder, as one diagnosis can include genetic, environmental, and traumatic causes. The priority in the DSM-5 definition for disorder given above is that of identifying conditions that result in emotional, cognitive, or behavioral distress for the individual. The priority in discussing what is and is not a disorder is the concern of the individual's suffering and the condition's prevention of the individual being able to live a full "flourishing" life in comparison with non-disordered individuals.

The Structure of this Project

Depression and anxiety often feel as though they are inescapable traps. Many individuals describe their experience with mood disorder as being immobilizing and difficult to cope with even simple tasks. Many find difficulty leaving bed or their homes, that even doing the sort of normal things that are afforded so easily to others become too difficult of a task. As a result, the feelings of anxiety and depression can feel as though they stand in the way of being good moral agents. Even if one does well by others and lives what is more widely recognized as a good life, depression and anxiety can undermine one's perspective of their lives so much that one feels as though they are a wretch who can never do right. Many often remark that "depression lies" – that the overwhelming feelings of being worthless or guilty within depressive episodes makes it impossible for the individual to sus out the truth about themselves. Depression lies in the sense that the internal experience of depression is one that often makes the individual feel as though they are worthless and inadequate: unworthy of good things nor worthy of even doing good things lest they be found out as an impostor.

Barring any "miracles" in psychiatry, it is very likely that depression and anxiety are here to stay. This dissertation is an attempt to sketch out what those individuals with depression and anxiety can do for themselves and each other in the meantime. Without scientific consensus and too much cultural epistemic noise regarding how to engage with emotional experience, there have not been many attempts at building an ethical theory specifically tailored for the needs of depressed and anxious individuals that do not give in to ideological adherence to scientism, skepticism, or some form of cult mysticism. Believing wholeheartedly and faithfully only in one cause, treatment, or cure to

depression and anxiety appears not only to be dogmatism but woefully damaging to one's own mental health as it can perpetuate stigma and shame if and when one's feelings turn for the worse.

This is a theoretical project within an existential phenomenological framework to build an ethics for depression and anxiety. My interest in existentialism stems from their commitment to responsibility tied not from essentialism or a predetermined plan, but instead is reactive and responsive to the needs of individuals as they arise in hopes of fostering not only one's own freedom but the collective liberation and freedoms of others. The existential thinkers that I work with in this dissertation (Camus, Jaspers, Sartre, Beauvoir, and others) are already engaged in ethical projects that react to feelings of anxiety, despair, and guilt. [15] My phenomenological commitments stem from the idea that in order to understand anyone's experience or condition, one must take an account through empathetic listening to their experience.

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[15] I have for the most part avoided direct references to Heidegger's foundational work *Being and Time* (1927/1962) within this dissertation for a handful of reasons – particularly because of his damnably offensive political commitments to fascism and anti-Semitism in his personal life – but also because his account of anxiety is a little *too* value-laden. His work presents anxiety as something that is *inherently* meaningful in the way that it discloses Being-in-the-World and Dasein's thrownness into the uncanny (Heidegger, 1927/1962). While I do believe that the experience of anxiety *can* feature this, there is something within Heidegger's work that makes one's experience of anxiety seem universalizing and essentialist, where I tend towards the particularity of anxieties being something that doesn't inherently reveal meaning, but it is up to the individual to make meaning for themselves. The difference is that for Heidegger anxiety means that the world is to be discovered whereas I believe that anxiety is but one way to access the world in a unique perspective. This is also taken up as a problem by Jaspers, who writes that "I consider Heidegger's attempt [at explicating anxiety] to be a *philosophical* error in principle because it does not lead the student on to philosophise in his turn but offers him a total schema of human life as if it were knowledge" (Jaspers, 1959/1963, p. 776). I additionally want to avoid a dependence upon Heidegger as a source on anxiety (since he is a source *of* anxiety in the following point) since his attempts at creating a "new language of being" steeps itself in its own jargon that still today remains as inaccessible to the layperson as ever. I much rather would speak in a prose that non-Heideggerians can take up and use for themselves.

Phenomenology is useful and fruitful for our purposes because of its attention to lived experience in an attempt of being as if a detached observer. I am not building an overt phenomenological framework first in developing this project but instead am looking to engage with an empathetic understanding of the lived experience of depression. Whether we thematize it under phenomenology or not, depression exists first and foremost and puts individuals in search of answers regarding meaning.[16] Psychiatry and related sciences are helpful in engaging with an understanding of the mechanisms of depression and anxiety but do not themselves tap into the experience without empathy. Psychiatrist-turned-philosopher Karl Jaspers writes in his *General Psychopathology* that:

> Phenomenology sets out on a number of tasks: it *gives a concrete description* of the psychic states which patients actually experience and *presents* them *for observation*. It reviews the inter-relations of these, delineates them as sharply as possible, differentiates them and creates a suitable terminology. Since we never can perceive the psychic experiences of others in any direct fashion, as with physical phenomena, we can only make some kind of representation of them. There has to be an act of empathy, of understanding, to which may be added as the case demands an enumeration of the external characteristics of the psychic state or of the conditions under which the phenomena occur, or we may make sharp comparisons or resort to the use of symbols or fall back on the kind of suggestive handling of the data … An experience is best described by the person who has undergone it. Detached psychiatric observation with its own formulation of what the patient is suffering is not any substitute for this. (Jaspers, 1959/1963, p. 55).

Here Jaspers advocates not just for the rigorous science of psychiatry to take up an understanding of mental disorder but also the direct lived experience of the person living

[16] A similar notion is shared by Matthew Ratcliffe when he writes "I do not want to suggest that we first adopt a phenomenological stance and then apply it to depression. Depression is not just a subject matter to which I apply a pre-formed phenomenological method reflection upon disturbances of the world-experience is integral to my method" (Ratcliffe, 2015, p. 21).

with depression. The experience of depression is that of vast idiosyncrasies for the individual. At times, it would seem that there are just as many depressions as there are depressives, as many anxieties as the anxious. Depression and anxiety can be so personal to the individual that it is hard to discuss in an objective manner.

However, phenomenology is not the only tool at our disposal to understand the experience of others.[17] I also work within the epistemic injustice literature initially proposed by Miranda Fricker (2007). Epistemic injustice, originally conceived of as either testimonial injustice which ignores the testimony of knowers and hermeneutical injustice which prevents meaningful and helpful self-knowledge, is a form of ignorance that comes from the systematic exclusion of individuals as knowers. Individuals living with mental illness and disability experience both types of epistemic injustice (Carel & Kidd, 2014; Wardrope, 2014; Sanati & Kyratsous, 2015; Jackson J. , 2017). In writing about the experience of being epistemically adrift, I see it as being related to hermeneutical injustice as it has to do with the interrelation between individuals' self-understanding regarding information that is poorly conveyed and understood in society (Jackson J. , 2019). Additionally, this is a pluralist work at heart beyond philosophy alone just as depression and anxiety do not belong to any one realm or another. I draw from work in psychiatry and social sciences, popular culture, fiction, and autobiographies. The latter, autobiographies, are helpful pieces for understanding the experience of depression from its dark lows to its respites. The first-person narratives of memoirs are very helpful

[17] Many of the claims made within a phenomenological framework could also presumably be made through a standpoint epistemology framework, but I am not suitably versed in this literature.

in understanding a phenomenological understanding of a person's experience, almost to the point that narrative and phenomenology are often used interchangeably in some hermeneutical work. There is however some trouble in working from autobiographical narratives as their authors typically write them not when they are in the throes of madness but within a period of recovery and safety (Ratcliffe, 2015; Bortolan, 2019).[18] If we went by the word of depression autobiographies alone, we would imagine that the disorder predominately affects affluent white folks who are good with their words. Thankfully, more contemporary media has allowed for a much more open engagement with the experiences of minority voices across gender, race, sexuality, and class to show how depression and anxiety are not only universal but affect marginalized individuals at a higher rate.[19] When I use first-person narrative work I use it merely as illustrative example, not a be all and end all.

This dissertation consists of four chapters on how the experience of depression and anxiety leaves individuals adrift as to how to live good and responsible lives. The first chapter outlines the general theory of being epistemically adrift in relation to depression and anxiety and how the themes of uncertainty in these conditions inherently lead to different epistemic insights. This chapter establishes the dissertation's roots in

[18] More strengths and caveats of depression autobiographies can be found in Anna Bortolan's "Phenomenological Psychopathology and Autobiography" (2019).

[19] Unfortunately this project does not give a full account of the more particular and existential problems that beset people of color, queer individuals, and other intersectional identity axes that affect mental health. For instance, Bor et al (2018) have found that news of police killing black individuals has a spillover effect in the mental health of black individuals as opposed to white individuals who seem overall unaffected. Where I have opted to be more general, I have made a lot of exclusions that I felt uncomfortable speaking over in my own positioning as a white cisgender heterosexual-presenting male academic.

existential phenomenology and epistemic injustice literature in order to sketch out how the combined uncertainty in interdisciplinary understanding of mental illness with the uncertainty experienced within mood disorders lead individuals to feeling adrift and unable to determine what they should do for themselves in living good lives. Meanwhile I argue that the insights of depression and anxiety attune individuals to the world in different ways than their non-depressed peers, which imports interesting questions regarding moral responsibility towards one another.

The second chapter explores a case study of this sort of insight, arguing that the experience of excessive or "delusional" guilt within depressive disorders can provide a deeper insight into our general moral responsibility towards one another. I compare this feeling of guilt to Karl Jaspers' (1961) conception of "metaphysical" or collective guilt in his analysis of the German people after the Second World War and Holocaust. These sorts of guilt feelings within depression is often incapacitating and hard to make sense of for individuals, but it additionally has a transformative ability to reevaluate moral life. I argue that parallel to the concept of "depressive realism" where individuals with depression have different and sometimes better insights than others, depressive guilt differently attunes individuals to how they relate to others and the world at large.

From there, the third chapter engages with how psychiatric diagnosis shapes and limits one's perceptions of their freedom and agency. More specifically, this chapter employs an existentialist analysis of how one can react to their diagnosis in bad faith – deflecting their own responsibility either by indulging into diagnostic patterns as inherent destiny or denying the condition's effect on their motivations. Indulgence shirks

responsibility by claiming that one cannot be otherwise than depressed or anxious, seeing oneself as not the author of their actions in response to their feelings. Meanwhile denialism prevents any meaningful self-understanding or progress. I argue that there must be a middle path where one takes responsibility for one's situation as being depressed or anxious, which both acknowledges the condition but also sees it as a personal challenge to improve on one's life.

The final chapter of the dissertation culminates in the development of an ethical theory that directly centers itself within the experience of mood disorders. This theory stems from both existentialism for its commitment to projecting meaning on uncertainty and absurdity along with virtue theory which allows for a sense of imperfection and improvement over time. This chapter ends in a sketch of different virtues specifically written for depression and anxiety, following Lisa Tessman's (2005) work on "burdened virtues". "Responsibility" in this sense is the question of how one *responds* to their moods and other symptoms related to mood disorders, that is, an account of responsibility that resists narratives of fault or blame. These virtues are meant to be a set of therapy-informed guidelines to help those with depression and anxiety counteract the worst feelings of being adrift and foster autonomy and dignity for themselves.

In using the term "epistemically adrift", I'm evoking the sort of metaphors of being adrift at sea. Being adrift in this way is concerning, as it can mean life or death but also it is navigating with uncertainty. This can happen to anyone where one can lose their bearings and sense of direction, have too many crosswinds and tumultuous storms, a lack of power or steering, etc. Many personal accounts of depression and anxiety describe as if

they are drowning or insurmountably lost. The novelist William Styron, in describing his own depression writes that he felt as if he was “engulfed by a toxic and unnameable [sic] tide that obliterated any enjoyable response to the living world” (Styron, 1990, p. 16). Even the most seasoned and experienced sailors can become adrift and lose control. Being adrift at sea is a lurking potential terror, but often this danger can go unnoticed until a crisis. Disorder is often ignored until it hits a crisis point, where an individual’s experience is overwhelmingly bad and they find themselves at a loss. Between social stigma and lack of access to therapy and other psychiatric services, many individuals hold out from seeking help or being straightforward about their emotional states until it becomes all too much to bear. There is very little reliable guidance about what one should do about one’s emotional state. Many feel themselves as if blown through by great winds, ready to shipwreck, with little recourse or rescue. Or alternatively in moments of indecision or anhedonia, one can feel as though they are in doldrums with no motivation to choose or act. At times, doldrums in this sense seem all the worse as one feels as though they are simply wasting away without a chance for the future. This project is written for those trying to navigate very uncertain epistemic and emotional waters and discuss ways to guide oneself through the highs and lows, still waters and storms.

CHAPTER 1

ON BEING EPISTEMICALLY ADRIFT: MOOD DISORDERS AND UNCERTAINTY

The psychiatrist cannot show his patient what the meaning is.

– Viktor Frankl, *The Feeling of Meaninglessness* (2010, p. 46).

Depression and anxiety are often marked by the sense of being lost. Those depressed or anxious folks who seek meaning in their lives often at the same time feel as though they are absolutely alone in their uncertainty. In *The Feeling of Meaninglessness,* psychiatrist and philosopher Viktor Frankl (2010) describes the experience of those afflicted by mood disorder as an "existential vacuum". He sees that individuals are affected not solely by trauma and these conditions themselves, but also that this feeling of meaninglessness comes from a lack of clear direction in society itself amongst shallow consumerism and the absence of universal values. He writes:

> Unlike the animal, man is no longer told by his instincts as to what he must do. And in contrast to former times, he is no longer told by traditions and values what he should do. Now, knowing neither what he must do nor what he should do, he sometimes does not even know what it is that he basically wishes to do. (Frankl, 2010, p. 42).[1]

Depression and anxiety are both feelings that push individuals from feeling "at home" or comfortable. These feelings are unnerving and prevent an individual from feeling at rest or being able to relate to others. Depression and anxiety are *social* problems in that they

[1] To some extent, Frankl blames mental ills a little too much on "modernity" or the "death of God". While modern problems and secularism have provided for their own problems, I only see these as existential and particular rather than a need for clear rules or rigid guides for how to live a good and meaningful life. I will discuss the desire for rule-following and its own particular harms further in the third chapter.

make individuals feel vulnerable and afraid of relating to others. The feelings of depression and anxiety make individuals feel both vulnerable and insecure in their place in the world, only to discover that the supposed rules of this world are confusing, muddled, and conflicting. As a result, individuals with depression and anxiety can find themselves epistemically adrift. Being epistemically adrift is a situation in which an individual is presented with several inconsistent or competing sets of evidence or explanation about oneself – without clear policies or heuristics for weighing that evidence – yet needing to make a choice for oneself which requires already following one set of evidence or another. The result of this situation directly bears on one's self-understanding and well-being.[2]

Countless first-person narratives by authors writing on their own experience of depression, anxiety, and related conditions describe the feeling of being alone and lost, unable to connect with others in any meaningful way (Gask, 2015; Saks, 2008/2015; Styron, 1990; Hari, 2018; A. Solomon, 2001; Cvetkovich, 2012; Sartre, 1938/1964; Plath, 1963, etc. – just to name a few). This is all the more compounded not just by one's feelings alone, but the confused nature of talking about mental health. Even today while there have been large pushes to destigmatize depression and anxiety, there are still those who believe that negative feelings are shameful and ought to be avoided.

This chapter fleshes out my theory of being epistemically adrift regarding the social experience of mood disorders while also arguing that the lived experience of depression and/or anxiety often in itself is a feeling of being adrift in general in which

[2] I am grateful to Sydney Keough for her help with rephrasing this definition so succinctly.

one can feel morally inadequate. The uncertainty of being epistemically adrift is an experience that is exacerbated by the feelings of depression and anxiety, and in turn can further exacerbate these feelings in a feedback loop. I start with a background on how trust is hard to come by for depressed and anxious individuals when it comes to treatment and reaching out to others. Following that, I will draw from the phenomenology of anxiety and depression (or at times called angst and dread/despair in existentialist literature) to show that the feeling of disorder often engages with the sense of feeling morally inadequate. I then draw a comparison and distinction between being epistemically adrift with Miranda Fricker's (2007) conception of hermeneutical injustice. For Fricker, hermeneutical injustice is when individuals suffer from not knowing personally relevant information that would benefit them due to systemic identity prejudice and epistemic gaps in transferring knowledge that result from exclusionary practices. From there I discuss the DSM-5's description of Major Depressive Disorder (MDD) and a couple choice anxiety disorders in order to build on this theory. I then close out the chapter with a discussion of how ethics and philosophy of emotion typically exclude mental disorder from their positions, which is in itself a hermeneutical injustice that prevents meaningful ethical projects for depression and anxiety.

Lost, Losing Trust

In addition to feeling lost there is also a loss of trust that exists in depression and anxiety. Ethical thinkers such as Knud Løgstrup (1997) believe that trust is the most basic and fundamental foundation for ethics and being able to relate to one another. Løgstrup argues that trust is the most fundamental element of ethical relationships. He writes that

"we normally encounter one another with natural trust. This is true not only in the case of persons who are well acquainted with one another but also in the case of complete strangers. Only because of some special circumstance do we ever distrust a stranger in advance" (Løgstrup, 1997, p. 8). Trust is the very basic currency for ethical life and to live without it prevents for one to live at peace. Løgstrup continues that

> To trust … is to lay oneself open. This is why we react very vehemently when our trust is "abused," as we say, even though it may have been only in some inconsequential matter. Abused trust is trust that is turned against the person who does the trusting. The embarassment and danger to which we are subjected by the abuse is bad enough. But even worse is the fact that our trust was scorned by the other person. For the other person to have been able to abuse it, our trust must simply have left him or her cold. (Løgstrup, 1997, p. 9).

Trust leaves open a sense of vulnerability towards someone else. Without it, being able to live in solidarity with others is difficult. Unfortunately, trust is typically only able to be measured in instances where one *loses* trust, either in others or in the world by way of violation of that implicit trust (Améry, 1980; Bernstein, 2015; Gertz, 2014; Carel, 2016). If that trust is abused, one's sense of ethical relation to the world can become dark and foreboding, where one becomes paranoid not only of the particular agent who harmed them, but the world at large and any other individual who comes in contact. Matthew Ratcliffe (2015) writes that trust "is a habitual, confident style of anticipation, in the context of which danger and threat appear as localized anomalies or disruptions. Certain experiences can lead to an erosion of this confidence, replacing it with a pervasive sense of dangerous uncertainty" (Ratcliffe, 2015, p. 123). The absence of trust leads to a constant sense of uncertainty, even if it just lingers in the background. Without trust, one does not have the connection to the world that promotes mutual well-being.

Those who experience depression and anxiety disorders feel as though they cannot trust others or that they cannot trust themselves or are even worthy of trust. The alienation that results from mental disorder is often not simply the internal experience of feeling sad or a lack of pleasure, but also one feels as though one cannot unburden oneself to others. Where one of the symptom criteria of Major Depressive Disorder is an overwhelming feeling of being worthless (American Psychiatric Association, 2013, p. 161), individuals feel as though they don't want to be a burden upon others. One may find "fellow travelers" – those who also experience the same or similar mood disorders that are easily relatable in empathy – but to another extent, one's depression is one's own alone. The heterogeneity of experience and of depression makes it hard to be vulnerable and trusting with others. Frantz Fanon writes:

> the properly personal history enters into existence and begins at the moment when illness cuts an individual off from others and isolates him without any possible involvement from the entourage. A deep furrow is drawn that separates man from the world, leaving him alone with an evil that is strictly his. (Fanon, 2018, p. 382).

The particularity of one's personal experiences, traumas, and troubles prevents them from feeling at ease with others for fear that no one else can relate to them. The lack of trust in others that pervades the experience of mood disorder then becomes something that makes relating to others difficult altogether.

Beyond trust in immediate others, trust can be lost (sometimes never earned in the first place) when it comes to systems and different scientific attempts at understanding disorder. Individuals come across countless beliefs, claims to knowledge, institutional accesses, and other ways to learn about aspects of their condition as well as

hermeneutical gaps. There is always some conversation of some sort surrounding mental disorder, even if it is not a truthful or informed one. But additionally, even well-informed accounts of disorder often slip into confusions and attempts at claiming universals amongst a sea of idiosyncratic particulars.

While there are many who sow seeds of doubt and distrust in psychiatry as a practice, be it that they are anti-psychiatrists (Szasz, 1974; 1970; Laing, 1960; Cooper D. G., 1967; Thompson, 2017) or Mad Pride activists/"psychiatric survivors" (Socialist Patients' Collective, 1972/2013)[3] or just those with severe doubts on the practice and scope of psychiatry in general (Cvetkovich, 2012; Hari, 2018; Greenberg, 2010; 2013), there are many issues that individuals who try psychiatric treatment in good faith still face that frustrate the relationship of trust. One issue that arises that stands in the way of trusting psychiatry is the trial-and-error phase that antidepressants require. A successful antidepressant still takes weeks to adjust for the patient and may need further adjustment/replacement over time. Further, we do not understand the mechanisms behind antidepressants enough where one form of SSRI may not be helpful to an individual while another that is chemically similar might instead. While I do not discuss antidepressants much within this dissertation, one other lesson that comes from their variable efficacy is the way in which the mechanisms behind different people's depressions are just as idiosyncratic as their own lives, traumas, and stresses.[4] A similarly

[3] Additionally both Bracken and Thomas (2005) and Rashed (2019), while not Mad Pride activists themselves, provide important philosophical accounts on Mad Pride movements and their social and ethical importance.

[4] Philosopher Walter Glannon writes: "In MDD, variability in responses to different antidepressants supports the view that the efficacy of these drugs is not solely a function of their biochemical properties.

frustrating period of time is the process of therapy. This process typically re-traumatizes the patient at first, as the therapist seeks to flesh out the background and main themes of the individual's life and condition. In this way, therapy can seem like it causes more harm than good while the individual waits for their first breakthroughs. Depression and anxiety are motivation-sapping already enough, and finding the right therapist is an arduous journey that requires a heavy amount of self-advocacy.[5] When it seems that either medication or other therapy are too time-intensive, it undermines individuals' trust in these processes, which are expensive to treat and exclude many of the most vulnerable populations who cannot afford healthcare. There are few clear answers as to how to counteract this distrust, especially since not only has doubt permeated into the cultural consciousness, but the same old critiques arise again and again in new forms and new voices.[6]

Feeling Adrift

Being epistemically adrift is not an experience that is exclusive to having depression or anxiety, but rather instead these conditions prime individuals to be more

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Differences in how patients' brains are wired, genetic and epigenetic factors in neural function, the role of their mental states in the etiology of the disorder, and their attitudes toward the treating psychiatrist can influence these responses. The lack of a satisfactory explanation of variability in patient responses to antidepressants indicates that the mechanism of action of these drugs is not well understood" (Glannon, 2019, pp. 125-126).

[5] Author Andrew Solomon notes "Finding a new therapist when you are feeling up and communicative is burdensome and ghastly, but doing it when you are in the throes of a major depression is beyond the pale. I tried eleven therapists in six weeks. For each of my eleven, I rehearsed the litany of my woes, until it seemed that I was reciting a monologue form someone else's play" (Solomon, 2001, p. 105).

[6] A rather puzzling anti-psychiatrist text is psychotherapist M Guy Thompson's (2017) *The Death of Desire* which released its second edition decades after its initial release in the 1980's which only appears to have updated its sources to include more of his own articles rather than re-approach the landscape of psychiatry that had changed in the 30-year gap.

likely to become epistemically adrift. Where others find themselves more certain in their life plans and ethical projects, those who live with mood disorders feel uncertain and shaky in grounding their lives from everyday mundane tasks to planning and executing big life decisions or tasks. While the experience of being epistemically adrift is rooted in the external world of stigma and unclear epistemic narratives for individuals to follow, the *internal* experience of mood disorders undermines one's sense of certainty in the world around them. This means that depression and anxiety make individuals *feel* adrift, which can attune them to the experience of being epistemically adrift. Conversely, I believe that the experience of finding oneself epistemically adrift additionally can exacerbate one's depression and anxiety in a feedback loop.

Experientially, dark or negative moods put an individual in a more urgent direct relation to the world around them. In despair and depression, one finds oneself lost and unable to engage with the world in a meaningful way that may have otherwise not been a problem to them before. Depression as a sense of despair often presents a world that is cut off from the individual and meaning becomes lost to them. Anhedonia from depression is perhaps worse, in which pleasure is undermined altogether and a person cannot even escape into trivial pursuits. Anxiety shapes and orients the world for the anxious individual as a threat to be navigated and understood (Heidegger, 1927/1962; Sartre, 1943/1956). Where anxiety is a form of suffering/anguish that torments its inhabitant, there is a *need* to find answers. Depression and anxiety provide a possible "privileged" standpoint into the sense of groundlessness beneath oneself in making

choices for one's life.[7] Depression and anxiety provide for a gateway for an individual to find themselves epistemically adrift because of the vulnerability and lack of trust in the world that accompanies these conditions.

Illness can shift an individual's perspective of the world and open up a new sense of attachment to (or detachment from) the world. Havi Carel argues that the experience of illness "can illuminate philosophy" (Carel, 2016, pp. 204-205). She states that "illness is a unique form of philosophizing. While the execution of most philosophical procedures such as casting doubt or questioning is volitional and theoretical, illness is uninvited and threatening. Illness throws the ill person into a state of anxiety and uncertainty" (Carel, 2016, p. 208). Carel likens the experience of bodily illness to Husserl's conception of the epoché, that is it is a refinement or perspectival shift in the individual's attention from the 'natural attitude'. In brief, the natural attitude is the naïve sense in which one lives pre-reflectively (Husserl, 1913/1982; 1989). Where others who are not ill may take their experience for granted, illness directly estranges one from this sort of naïve everyday experience. Illness shifts the world for the individual, where many things that are taken for granted for other (relatively) "healthy" individuals. Carel centers her work on somatic illness but leaves open for the sort of work that mental disorder as well can change the way in which one views the world and thereby is a way of philosophizing.

Moods can be a forced awareness of the world in the sense that individuals shift their focus in different moods. Happiness can make one only look to positive aspects of

[7] Of course, I mean merely in the sense that epistemic privilege is the question of the individual's standpoint for being able to know a particularly helpful insight into the world. Anxiety and depression remain rather terrible conditions to live with, regardless of other privileges that one may have.

the world while despair can make them only see the world as something that is devoid of meaning for themselves. Where moods are not necessarily intentional experiences but project out into the world as a general state of being, they can redirect the individual's entire sense of existence. Within anxiety or dread, one feels a sense of urgency – that they must come to a decision about their life but find that they might not have the epistemic resources to choose what avenue of treatment they should take in figuring out their lives.

Anxiety acts as a motivating incentive or inclination for many. The feeling can keep a person "sharp" and attuned to their situation, scoping for potential threats. Common explanations for anxiety are that it serves a purpose in terms of survival. Anxiety shapes our attunement to the world as something that can be dangerous. The existential tradition imagines that anxiety does have a particular insight into ethical responsibility towards one another. Being under duress gives an individual the insight that one must make a choice. Yet, it is often a bad motivator; too much anxiety or unfocused anxiety can ultimately undermine an individual's ability to act altogether. Anxiety can make a person feel adrift or lost, faced with too many overwhelming choices, or not enough choices. The anxiety that appears within mood disorders makes their choices feel *urgent*. There is an immediacy that can appear within one's actions, that makes one feel as though they must only act in the moment or that one's actions are inevitably too early, or too late.

Part of the trouble that comes from discussing anxiety is the fact that it has a relatively difficult status regarding its intentionality towards things within the world. The general sketch for philosophers of emotion is that emotions such as fear are directed

towards particular items, where even counterpart moods (in this case anxiety) do not take an intentional object. When I have a fear of something, it is a very particular thing: this spider, dying alone, etc. But we typically understand and experience anxiety and other moods as more indirect. Anxiety is often very indistinct; I am anxious because there *might* be a spider, that my actions and relationships *may likely* lead to dying alone, etc.

Sartre (1943/1956) attributes the difference between fear and anguish (anxiety) to the individual's sense of freedom. In his passage on "The Origin of Negation" from *Being and Nothingness*, Sartre discusses the experience of vertigo standing near a ledge. This begins for him as a feeling of fear of falling, but then pervades as a feeling of anxiety/anguish that sticks with the individual even after one is no longer in the situation of being near the ledge. In brief, fear is intentional in that it is about a specific thing outside the self. But on the other hand, anguish is an inward fear. In discussing one's encounter with a ledge and drawing from the work of Kierkegaard (1980), Sartre writes:

> First, we must acknowledge that Kierkegaard is right; anguish is distinguished from fear in that fear is fear of beings in the world whereas anguish is anguish before myself. Vertigo is anguish to the extent that I am afraid not of falling over the precipice, but of throwing myself over. A situation provokes fear if there is a possibility of my life being changed from without; my being provokes anguish to the extent that I distrust myself and my own reactions in that situation. (Sartre, 1943/1956, p. 65).

Anguish/anxiety in this sense then is the experience of one encountering their own freedom. Freedom itself, one's possibilities as a free agent are *terrifying* to a certain extent. Standing near a ledge there is nothing that is stopping me from jumping other than myself. This is the terror, not of outside forces, but of one's own potential. Additionally, it is the anguish of standing near the ledge that makes one realize its danger. The danger

of the ledge is in oneself, not in the ledge and not in the abyss below. If I find myself standing at a ledge, it is up to *me* to decide what I do in relation to the world. I can create – I can destroy – and that creation or destruction can often be hedged in anxiety.

But the whole experience of one's freedom is one of anguish (or so Sartre says). The anguish that one feels around a precipice necessitates a choice in the agent. He later continues:

> Anguish is precisely my consciousness of being my own future, in the mode of not-being. To be exact, the nihilation of horror as a *motive*, which has the effect of reinforcing horror as a *state*, has as its positive counterpart the appearance of other forms of conduct (in particular that which consists in throwing myself over the precipice) as *my* possible possibilities. If *nothing* compels me to save my life, *nothing* prevents me from precipitating myself into the abyss … I approach the precipice, and my scrutiny is searching for myself in my very depths. In terms of this moment, I play with my possibilities. My eyes, running over the abyss from top to bottom, imitate the possible fall and realize it symbolically; at the same time suicide, from the fact that it becomes a *possibility* possible for *me*, now causes to appear possible motives for adopting it (suicide would cause anguish to cease). Fortunately these motives in their turn, from the sole fact that they are motives of a possibility, present themselves as ineffective, as non-determinant; they can no more *produce* the suicide than my horror of the fall can *determine me* to avoid it. It is this counter-anguish which generally puts an end to anguish by transmuting it into indecision. Indecision in its turn calls for decision. I abruptly put myself at a distance from the edge of the precipice and resume my way. (Sartre, 1943/1956, pp. 68-69).

The feeling of anguish that one encounters can insert suicidal ideation. Sartre's example is where one steps away from the precipice, but the *thought* is still there – the *temptation* in anxiety. There can be anguish either way – one can feel that one must die to relieve their sense of anguish in general – one can feel as well that death is something that scares them, that they have other projects to finish. There is a sense of double-bookkeeping here

in suicidality;[8] one can both make plans with others for next week while also mulling over plans to kill themself tonight. One can fixate on both possible futures, whether one wants to or not. Suicidal ideation is tricky in the sense that it encapsulates paradoxes like this without any sense of irony. One thinks doubly – one's options for better or worse are laid out to them and cause for distress. Sartre describes this doubling as indecision, which describes the phenomena in part, much like Camus' narrator's question in *A Happy Death*: "Should I kill myself, or have a cup of coffee? But in the end one needs more courage to live than to kill himself" (Camus, 1972). Both options lay themselves out for oneself whether one finds one more relieving or reviling or whatever. One must make a choice – the choice is within oneself but also at the same time is presented as an option only in the sense that one is anxious and near the precipice.

The death-related symptoms of mood disorders, either fear or obsession or desire for death each reinterpret the world in different ways. To be aware of the contingency of life and death can present different interpretive stances. Where others see just a simple height or rope or gun or other object that is more passive or neutral in its existence, the person who is thinking of death sees instead an active danger or "way out". Suicidal feelings reorient the world as a different set of potentials. The person experiencing overwhelming moods of sadness, anxiety, or even a lack of mood in anhedonia experience the world in distinctly different ways than the person who does not.

[8] "Double-Bookkeeping" typically refers to the experience of delusions, in which one is both experiencing a delusion while also aware that this experience is at the same time a delusion.

The anxiety/anguish itself is what gives the individual an outlining of their freedoms, even if that outline is something further unsettling. It is in this way that anxiety and other mood disorders provide a unique perspective into responsibility. The anguish over the precipice or any other decision not only reveals the choice, but it also reveals that there is something inherent in the choice that should be investigated. Anxiety reveals depth, at least in the sense that one engages with the things that anxiety reveals something to be anxious about, which in turn leads to wondering about a further depth to that worry.

The preoccupation of anguish/anxiety leads to obsession and mulling over the world as a series of problems. In the case of an anxiety disorder, oftentimes the entire world or person's sense of entire self is undermined and brought into focus as a problem for oneself. Anxiety exists as a focal point, better or worse it shifts the way in which the world exists for the individual. While the feeling in itself is something that is uncomfortable, often revealing a sense of emptiness or lack of stability for the individual.

There is additionally even an uncertainty that appears in trying to identify one's own emotions, either within or without a mood disorder. In psychopathological cases, one can have trouble knowing oneself and one's feelings. In many cases, one might not be able to recognize that they're depressed. Instead, one just imagines that one is just simply feeling merely sad or perhaps even doesn't notice the lack of interest in formerly pleasurable activities in anhedonia. Where the sadness of depression is often conjoined with feelings of worthlessness and inadequacy, it's easy for individuals to brush off their feelings when they do not feel "sad enough" or even "good enough" to have "earned" the pity or attention for their feelings of sadness or estrangement. Anhedonia itself seems to

be a "silent" symptomology for depression – where many do not realize that the absence of pleasure in their activities is depression or even something that is necessarily a problem. Anhedonia within the throes of depression can for some get bad enough that they have dulled senses, where even their sense of taste is muted. Stanghellini and Rosfort (2013) write that "a major problem about human feelings is that our understanding of them reveals that we are often wrong about what we think we feel, and when we form an appropriate opinion we often feel that we have only grasped a paltry part of what is actually going on in our emotional life" (2013, p. 100). It is hard for some to be aware of who they are as a result of not even being sure of what they are feeling in a given moment. Depression is often very elusive as I note above, just as anger can exist without being noticed by the person who is angry. Emotional feelings can put a person in or out of place with their surroundings, and whether or not they are aware of themselves can altogether warp the way in which a person interacts with the world and affect whether they are adrift in their actions or not. Without a clear, destigmatized discussion of mental illness in contemporary culture, depression and anxiety disorders often go unnoticed for what they are and leave individuals feeling marooned and unable to relate to others – even when others are often in the same boat with them.

While they are not the only avenue, mood disorders attune and highlight uncertainty in an individual's life. There is often a problem of comparison, where an individual feels that others can figure out what they are doing with themselves or how to live a "good" life without worry or distress, the way that Sartre's narrator in *Nausea* marvels over people next to him with much more "plausible stories" than him (Sartre,

1938/1964, p. 7). Much of the experience of mood disorder is this sort of alienation from others, an acknowledgment or belief that other people, "normal" people, do not worry about their existence as much. This estrangement is similar to what Sara Ahmed (2010) describes as "affect aliens", where an individual not only feels distressed by their current situation, but understands reflexively that their emotional state is not shared by those surrounding them. Ahmed discusses this as being a further estrangement from one's capacity to be happy. Many phenomenological accounts of depression or other mood disorders discuss this sort of feeling of separation between oneself and others, that happiness is inaccessible: something for others but not for oneself.

This estrangement, this being an affect alien, contributes to the sense of being epistemically adrift. While some individuals with mood disorders do find ways to cope with their episodes and their everyday, others do not and find themselves not only lost in terms of what to do for themselves, but also how to relate to others. The inability to relate to others is a major factor that stands in the way of allowing for a person to make choices in treating oneself. The sense of estrangement and alienation that individuals face within mood disorders are on par if not sometimes even worse than the general feelings of sadness, anhedonia, or agitation that are internal to the conditions. The trouble in having a mood disorder is the sense that one does not feel as though one can relate to others. Matthew Ratcliffe (2015) describes how this sense of alienation makes individuals further cut themselves off from others. He writes that "There is a *feeling* [for depressed individuals] that [non-depressed] others do not understand, which could be described as a feeling that they are unable to 'relate to' or 'connect with' the depressed person … [who]

does not *feel understood*" (2015, p. 202).[9] This sense of alienation and feeling that others cannot understand oneself leaves people adrift in the sense that they do not know who they can rely on or trust. One element that continues throughout this dissertation is the question of trusting others. There is a large lack of trust within the experience of mood disorders that is not necessarily the fault of particular others, but a manifestation of one's own symptomology of sadness, loss, feelings of guilt and worthlessness, and anxiety about their day to day relationships with others.

Depression and anxiety make one's world, social and otherwise, feel rather strained. As a result, Ratcliffe further discusses the feeling of being in a separate "world of depression" – where the depressed individual feels cut off from the meaningful and rich world of others surrounding them. Within a depressive mood, the meaningfulness of the world changes into something that may be accessible to others but is separate and not there for oneself. In depression one looks through the world darkly, with a differing sense of value and priorities. Ratcliffe writes that for depressives, their experience is "'mine and mine alone', and experiences of hopelessness are often similarly self-specific; others have hope and the depressed person is cut off from them, marooned somewhere else" (2015, p. 201). Despair and anguish are experiences that bring the capacity for understanding the world as a meaningful place to the foreground of an individual's attention. For many, experiences of despairing sadness or the lack of pleasure in anhedonia leads an individual away from being able to fully connect with the world in the ways that others do.

[9] Emphasis in original text.

This world of depression that separates and alienates oneself from others is an extreme form of being epistemically adrift. Or rather, these are ways in which being adrift become all the more present and recognizable for the individual. Depressive sadness or anhedonia, the two major necessary symptom criteria for Major Depressive Disorder (MDD) and other depressive disorders, often highlights uncertainty in the world and its capacity for value. While in a depressive episode, many feel as though they are unable to relate or cope with the world that is outside of them. Other individuals are happier, with more meaning and purpose, while depressed individuals are stuck brooding on a felt sense of inadequacy, worthlessness, or guilt. The alienation within depression and other mood disorders that is compounded by social stigma and exclusion leads to a sense of being unable to cope with others or make sense of the world for oneself. The moods within these disorders often creates a forced perspective on the world that shifts one's entire engagement with it. The world can feel hostile, cold, or distant to the individual within the experience of depression or anxiety which leaves the individual adrift as to how to engage with it, whether or not they otherwise have a sense of purpose in their life. The awareness and attentiveness to a sense of meaninglessness or contingency is a dangerous and unnerving experience.

In his book on place-specific anxiety entitled *Topophobia*, Dylan Trigg deliberately writes in an unsettling and triggering second person narration.[10] This is meant to work in a rather jarring way that attempts at giving his own phenomenological experience of vertigo and other forms of physiological and physiological experiences of

[10] A credit to this approach and Trigg's prose: reading this book repeatedly gave me vertigo spins.

anxiety. In doing this, he presents these experiences of anxiety as de-personalizing and shows how anxiety can preoccupy an individual's entire conception of the world. The anxiety instead becomes impersonal and exposing. One feels as though their interiority is lost, and instead that one just exists as an exposed live nerve. Anxiety is distressing and oftentimes can overwhelms an individual in its lack of location. Trigg writes

> You are anxious. But when you attempt to localize this anxiety, your thinking reaches an impasse. All that you are left with is the vague and horrifying sense that your home is now drifting away from you, leaving you stranded in an anonymous and silent world indifferent not only to your situation in the present, but also to the memories and histories etched within the home. (Trigg, 2017, p. 3).

Anxiety, both for Trigg and first-hand accounts, can undermine one's sense of home. Feeling at home is a sense of safety and balance, while anxiety tears through that sense of safety. To be anxious is to feel as though one cannot find one's bearings. Anxiety is not necessarily localized for the individual, but instead can be experienced throughout one's entire core of consciousness in the sense that it 'paints' or fills in a person's entire awareness of the world. Anxiety's lack of localization in this way is that it is not based in one particular intentional object, but spreads out. When one is anxious, one is not necessarily anxious about something in particular (although it may have one or more trigger points) but is generalized across other aspects of the individual's existence.

Many anxieties (and other distressing mood experiences) feature a sense of vulnerability. One feels exposed – even if others do not take in any account or mind of it – experiencing mood disorders can be a sense of being lost, adrift, and unable to justify oneself before others. Trigg writes while losing himself in the woods that "To be lost in

this way – in the fog, in the forest – is to invoke primal anxieties over being removed from home. Left vulnerable, the experience of being lost is forced upon us in a movement of oppression" (Trigg, 2017, p. 121). Being lost is distressing and undermines a sense of certainty or comfort. One looks for whatever sense of direction that one can.

The stakes for being adrift can be rather high, and not just the question of being simply nervous or sad. Feeling unable to cope with one's moods or being unable to determine what the best option is to continue with treatments can easily undermine one's ability to make good choices for oneself. Worse, feelings of anguish and being adrift can lead an individual through several 'dark' paths. Often individuals feel trapped in their circumstances, as if unable to move or make changes that would improve their situation. A typical example of this is explicated throughout Camus' *The Myth of Sisyphus* (Camus, 1955/1983). For Camus, a subject oftentimes comes across the absurd – a sense of meaninglessness in the world. One may at any point feel as though one's life has no purpose and that it is not worth living. Camus argues that then for many the most direct and suitable option is suicide, beginning the essay even so far as to argue that "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" (Camus, 1955/1983, p. 3). This is an extreme and dramatic form of being adrift. To encounter the absurd and deem that the solution is suicide is a quick and finalizing one. This is an alluring decision for many, as Nietzsche notes that "The thought of suicide is a powerful solace: it helps us through many a bad night" (Nietzsche, 1998, pp. 70, Aphorism 157). Not knowing what the best option for oneself leads many to self-harm, or

at least to dwell upon it. Paradoxically as shown in Nietzsche, sometimes there's a comfort here, that self-destruction is an option that one always has.

Matthew Ratcliffe's (2008) work on existential feelings is helpful for understanding how different emotional feelings may affect a person's engagement with the world. These feelings are not necessarily "diagnostic" or "diagnosable" per se, but are the way in which an individual interacts with the world. Ratcliffe sees existential feelings as a phenomenological category of emotional, bodily feelings that frame one's experience of reality and "belonging" in the world. The general draw of this alternative category is that it can cover both emotions and moods, although Ratcliffe admits that it is possible that some emotions and moods are not necessarily existential feelings (Ratcliffe, 2008, p. 56). Ratcliffe introduces the conception of existential feelings explicitly for a better terminology in discussing the rich experience of psychiatric conditions, as he sees that many mood disorder episodes and psychotic episodes revolve around the individual's sense of reality or belonging with the world. He identifies that "there is a considerable variety of existential feelings. They can be (a) short-lived, (b) sustained over a period of time or (c) retained over the course of a life as habitual temperaments; but the English term 'mood' only seems suited to (b)" (2008, p. 55). This variety in temporal experience I find is a particularly helpful. The emotional experience of mood disorders is not simply a question of moods as just a sustained period of time (b), but can be short lived (a) such as a panic attack, or seen as a periodic habitual part of the individual's persona or life-story (c). Existential feelings are not a simple category just like in the sense that existence at large is not simple and easily categorized.

Ratcliffe's existential feelings are in part also a rebuttal to the general stance within philosophy that treats the world as if it is a detached object. He writes that "However detached we might become in relation to a particular object of experience, that experience still presupposes a background orientation, a variable sense of belonging and of reality" (2008, p. 41). Our experience is directly tied to our situated position, which is more fully articulated by these existential feelings. Ratcliffe is concerned with the sense in which an individual finds oneself in the world, much like Heidegger's account of moods in *Being and Time* (Heidegger, 1927/1962). Our existential feelings reveal different possibilities and modes of being for the individual, but Ratcliffe avoids the same overbearing sense that these feelings necessarily mean anything beyond what the experiencing individual takes from them.

Ratcliffe's discussion of one's "sense of belonging and of reality" is especially fruitful. The lack of feeling as though one belongs or that one's reality is different or altered from that of others around oneself presents a problem where one's feelings make one's grounding in the world shaky at best. The feeling of being depressed or anxious is a feeling of being adrift, which opens the individual up to distrust in the world at large. This distrust in the individual, when met with too many differing opinions and ideologies about one's condition leads them to not only feel adrift, but to be epistemically adrift. Further, being epistemically adrift can exacerbate these feelings which then creates for a feedback loop of insecurity and uncertainty – both in feeling and understanding.

Hermeneutical Injustice and Being Epistemically Adrift

Because different epistemic authority figures have weighed in on the existence of mental disorders with such conflicting answers, individuals with mood disorders are left to their own devices in order to determine for themselves if they are to follow one treatment path or another. The issue is that any effective treatment for anxiety and depression requires a time commitment with trial and error, trying and failing to see what works and what doesn't work for the particular individual. Talk therapies are often difficult to engage in as they bring up trauma in a way that often begins as re-traumatizing the individual. Medications take a while to stabilize, if they work at all. This additionally means that the ability to seek and sustain treatment is dependent upon the individual's socio-economic privilege. Without accessible healthcare, there one has no options to taking care of themselves in effective and sustainable routes. Again, being epistemically adrift has some overlapping qualities with Fricker's conception of hermeneutical injustice where there are some missing elements to the patterning of social knowledge that leaves people unable to determine the best choices for themselves. However, when it comes to the case of disorders, there is also just too much information that may be relevant for one person but irrelevant for another. Further, being epistemically adrift is facing unreliable and often false information presented with the same "credibility" as truth, where hermeneutical injustice is merely the absence of knowledge.

Fricker identifies hermeneutical injustice as "the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource" (Fricker, 2007, p. 155). This means that a crucial part of one's own self-knowledge is blocked just by virtue of the collective hermeneutic resource and the prejudice that arises from it. Being prevented from knowing an important aspect of one's identity or social position can be completely deleterious to their existence and can prevent their flourishing as agents. Fricker writes:

> The primary harm of hermeneutical injustice … is to be understood not only in terms of the subject's being unfairly disadvantaged by some collective hermeneutical lacuna, but also in terms of the very construction (constitutive and/or causal) of selfhood. In certain social contexts, hermeneutical injustice can mean that someone is socially constituted as, and perhaps even caused to be, something they are not, and in which it is against their interest to be seen to be. (Fricker, 2007, p. 168).

The way in which one understands themself affects their very identity which in turn affects the way in which they have access to the world in different ways. This is where hermeneutical injustice and being epistemically adrift overlap; seeking self-knowledge can be obfuscated by hermeneutical resources and in turn affects who an individual is socially.

Hermeneutical injustice then is a phenomenon of absence; there are things that one does not know about oneself due to absences in representation or absences in determining what avenues of knowledge are worth pursuing. That is, one's social position and self-knowledge can be excluded due to those in power determining that the self-knowledge of those excluded is not an important knowledge. I believe that these two

phenomena are interrelated but distinct. Unlike hermeneutical injustice, epistemically adrift agents can still have access to information while nevertheless having difficulty then assessing what information is pertinent for their lives in terms of how to take care of themselves and navigate their mental disorder.

Where hermeneutical injustice more properly exists where there is an absence of identity-confirming knowledge, being epistemically adrift can occur when there are multiple avenues of understanding that complicate and confuse the individual in terms of the best option to take. Those who are epistemically privileged can still learn copious amounts of information and be unable to discern for themselves what the best course of action or life is. One can even feel as though one knows "too much" in being unable to discern between several just as seemingly viable options for oneself. To employ a very loose and distant analogy, being adrift in this sense is like choosing a career or college major; there are many options that are just as viable, each with a different lifepath associated with them. With determining what the best option is for someone regarding taking care of their mental health, there are many options and paths that appear that may or may seem just as viable and ethical in terms of self-regard. Choosing a career or major alters the path that one takes for their life. The difference, however, is that while choosing a career path may have a particular roadmap or guideline, living with mental illness often throws plans astray. In addition to *being* epistemically adrift in general, those with mood disorders *feel* adrift and lost, often within a maelstrom of different pressures that confuse their social existence as well as their own life decisions. Unlike a choosing a career which has an initial big decision and then subsequent affirming decisions to continue, the

condition of a mental disorder can undermine the individual's confidence in their initial decision, and they may try many different ways of engaging with their condition out of a sense of insecurity that is both internal to the condition and warped and undermined by external social pressures as well. An individual's confidence today in seeking a new avenue for treatment and taking care of oneself may dissipate in time when treatment takes longer than expected or brings up worsening moods in reflecting on past traumas as in the case of the start of therapy.

To push the analogy above, choosing a treatment option for a mood disorder is like choosing a career only to have continual and crushing self-doubt in how slow the process is taking, plus confronting constant unsolicited advice from others at all times who speak as if there is only *one* suitable career to have.[11] The problem for depression and other mood disorders is that it often becomes apparent that there is no *certain* option to take. Certainty in treatment efficacy itself is not necessary in taking up a treatment plan, but *worrying* about uncertainty can undermine treatments or one's confidence in going through with them, let alone even seeking help. An individual can take up so many different possible remedies yet still fail to find an effective, lasting, and safe strategy for handling for their feelings. The uncertainty of treatments before undertaking them prevent countless individuals from trying them, choosing not to choose by avoidance or despairing.

Knowledge and the Complexity of Disorder

[11] Perhaps however this shifting insecurity and self-doubt in one's decision is the norm for academic careers outside of the relative security of a tenure track job.

Mental disorder for the most part exists in an epistemological grey area that is not always tied to oppression. Without knowing what their root causes in many cases, or how to effectively treat them in any universal sense, mental disorders remain a questionable and partially unknown factor in many individuals' lives. Hermeneutical injustice is *not* the mere absence of knowledge of something that is as yet unknown by scientific inquiry. Fricker (2007) points out:

> If, for instance, someone has a medical condition affecting their social behaviour at a historical moment at which that condition is still misunderstood and largely undiagnosed, then they may suffer a hermeneutical disadvantage that is, while collective, especially damaging to them in particular. They are unable to render their experiences intelligible by reference to the idea that they have a disorder, and so they are personally in the dark, and may also suffer seriously negative consequences from others' non-comprehension of their condition. But they are not subject to hermeneutical injustice; rather theirs is a poignant case of epistemic bad luck. (Fricker, 2007, p. 152).

Part of the reason that mental disorder is not readily and widely understood is that much of it remains a rather under-researched phenomenon. While psychiatry has made advances that understand the scope and range of much of mental disorder, there are still many aspects that are unknown. Without a fully-developed science or basis of truth known behind the existence of mood disorders, it is an overstatement to claim that this lack of knowledge is an 'injustice' (depending on the reasons for the lack of knowledge) when it is more simply a hermeneutical gap. This is what Fricker believes is just more simply epistemic bad luck. The individual who suffers from a mysterious ailment that the

medical community cannot identify, or treat does not necessarily suffer from an injustice, just the bad luck of dwelling within an unknown.[12]

Yet within this part of Fricker's conception of hermeneutical injustice, there is a rather shaky assumption that there is certainty in knowledge or science today. Several of her examples of hermeneutical injustice rest on the idea that a truth has been uncovered and settled, but still is gravely inaccessible to individuals who would require such knowledge for a flourishing life. The trouble here is that hermeneutical injustice rests on a notion that the basis for scientific truths is static, that there is only one underlying truth. I do not necessarily believe that Fricker holds this view outright, but for demonstrative purposes, it seems that it was prudent for her to define hermeneutical injustice as something that is contingent upon a scientific consensus that is otherwise blocked from particular epistemic agents based on social identity prejudice. Fricker later (2016) admits that these sorts of cases are "*midway* and/or motivated cases of hermeneutical injustice" (2016, p. 176) but still is hesitant to call these full cases of hermeneutical injustice since they result not from a lack of knowledge in general, but an undermined knowledge based upon an individual's situatedness. Yet whether inaccessibility to a "collective" resource is more proper hermeneutical injustice or not, these still operate as being part of a hermeneutical marginalization and have very real harms on the individual who is trying to build themself in social life. Concerning oneself with hermeneutical injustice more simply as a collective knowledge of a concept or theoretical understanding is not

[12] It is possible however that one's condition is under-researched due to prejudice in the medical community, which would be a hermeneutical injustice.

sufficient to discuss whether an injustice is at play. (In)Accessibility to knowledge is much more of a trouble for individuals than whether or not this knowledge even exists across the sum total of human collective resources. For example, take access to books. Books exist within the "collective understanding" of human knowledge. In order to access a book and the knowledge resources within, however, there are several prerequisites. First, one has to be literate or for someone else to relay its information clearly and effectively. Then one has to have access to the book itself, which can have several different possible avenues, but is overall complicated by whether the book is affordable, available in a library, whether one is permitted in that library, etc. These complications can easily stand in the way of an individual's access to knowledge of the work that is in that book.

But even if we concede that hermeneutical injustice rests upon the question of knowledge as an established fact, there are still epistemic/hermeneutical problems that arise and affect those with mental disorder in dynamic and shifting ways in terms of ignorance. An individual who suffers from a mood disorder does not necessarily suffer an *injustice* from not knowing more fully about their condition if knowledge hasn't been uncovered by anyone, albeit they can suffer as a result of their lack of self-knowledge and are still *adrift*. Oftentimes, there is no hierarchical or marginalizing structure that blocks the mentally ill individual from access to knowledge about their condition, but that there are many different claims to knowledge that complicate the individual's capacity to understand oneself. Where some epistemically adrift gaps are caused by hermeneutical injustice, there are additionally problems that arise just from the sake of it being a

difficult-to-solve scientific issue. Individuals with mood disorders may be in a privileged position in which they can understand the experience and limitations of their condition and yet at the same time be unsure of what choices to take in taking care of oneself.

Further, with increases in awareness campaigns and pushes to destigmatize and make personal narratives of mood disorder known more widely, there is less hermeneutical injustice affecting mental illness in terms of awareness. Where one is confronted not by a lack of knowledge but too many claims to knowledge(s), one can be just adrift and lost in terms of what to do with themselves as in the case where one is blocked from knowledge by virtue of their identity.

Being epistemically adrift within the experience of mood disorder is the sense of having to determine how best to take care of oneself in relation to one's condition while presented with many similarly convincing (or unconvincing) and often conflicting options. Some options are effective, others are not, often being dependent upon the individual and their willingness to commit. Trying to assess what the best course of action for oneself in treating one's condition is difficult. Again, many options, such as therapies or medications, require a long-term course of treatment. While many of these treatments are not mutually-exclusive, many times individuals are goaded into thinking that one course of treatment is better than all others, or that particular treatments are directly harmful and will undermine their sense of identity.[13] This appears as well with an often fatalistic, all or nothing attitude towards the world that can appear in mood

[13] This is the case often with medications, where individuals fear that they will no longer be themselves if they take a mood-altering drugs. This can be a legitimate concern as medications do in fact often change the individual's general comportment within the world through their moods, but the question becomes whether this change along with the associated side effects are worth feeling the world less drastically.

disorders such as depression, where one feels that their options for a full life may be limited (Ratcliffe, 2015; Carel, 2016).

Another distinction between being epistemically adrift versus hermeneutical injustice is the question of blame or fault. In cases of hermeneutical injustice, Fricker points out that "hermeneutical injustice, whether incidental or systematic, involves no culprit. No agent perpetuates hermeneutical injustice—it is a purely structural notion. The background condition for hermeneutical injustice is the subject's hermeneutical marginalization" (Fricker, 2007, p. 159). While much of being epistemically adrift has to do with structural patterns blocking the production or transfer of knowledge that are not with any singular author as Fricker points out, I contend that there are additionally agents who propagate further confusion regarding self-knowledge. Within the discourse and treatment of mental disorder there are many individuals with self-serving or other ulterior motives who sell false or at the very least ineffective treatments either for themselves or out of bad faith.

The trouble within depression and other mood disorders is that there is a widespread uncertainty in theories about how to address them.[14] Each of these come from different research programs or paradigms, different disciplines, and different motivations in terms of engaging with the individual's sense of freedom, authenticity, and experience. Society exists by and large for the most part as a melting pot of different opinions, some better formed or informed than others. Mood disorder does not belong under the auspices of any one science or discipline, but instead is a constitutive part of human experience

[14] As with other branches of medicine.

and thereby exists across several different interdisciplinary inquiries. The experience of mood disorder is taken up as a problem by not only psychiatry, but social sciences, literature, religion, pop culture, and a whole mess of other complicated interpretive threads. None of these different inquiries sufficiently get at the root of what disorder is, but each illuminate different aspects of an altogether complex and dynamic problem.

Consulting the DSM-5

Perhaps simultaneously the best place and worst place to start in discussing mood disorders is within the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition* (DSM-5 2013). Within this section, I will provide the DSM-5's criteria for several mood disorders in order to discuss key symptoms that present across many of them in order to get a sense of clinical descriptions of these disorders outside of phenomenology. It is a bit of a herculean task to assess, compare, and contrast the symptomology across all mood disorders as categorized, so I am more concerned with presenting the criteria for more statistically-prevalent disorders or disorder types in general. The manual is useful in its discussion of symptoms, although its approach is merely that of categorizing and listing rather than giving a positive sense of meaning within disorder. The DSM-5 is often naively referred to as the "bible of psychiatry", and perhaps this analogy is apt to a certain extent, but not in the way that people seem to think. While there is an epistemic authority to the DSM that psychiatrists adhere to, it also has the cultural status of the bible in the sense that psychiatrists can say that they believe in it without knowing fully its purpose and context, let alone its full (and sometimes inconsistent) contents.

Under this aim for diagnostic consistency under a psychiatric/medical lens, there has been a loss of the account of lived experience in discussing disorder. In this same way, Nancy Andreasen argues that the unintended consequences of the DSM step away from the most important aspects of psychiatry, writing that "History taking—the central evaluation tool in psychiatry—has frequently been reduced to the use of *DSM* checklists. *DSM* discourages clinicians from getting to know the patient as an individual person because of its dryly empirical approach" (Andreasen, 2006, p. 111). Andreasen further mourns the loss of phenomenological accounts within psychiatry in favor of this checklist-ticking. Further, Nancy Nyquist Potter writes that "the DSM works together with other epistemic practices that constrict many clinicians' access to knowing well. Thus clinicians shape themselves into, and are shaped into, a privileged way of knowing that elides many crucial factors that influence the experiences and needs of the person in front of them" (Potter, 2016, p. 160). In this way, the DSM and psychiatry removes the subjectivity from a science *of* subjectivity. People experience depression and anxiety disorders, yet psychiatry's aim in establishing itself as a biological science often strips away that lived experience in the aim of validity and verification.

While there is a clear problem with the DSM in its design, it seems that it is more likely a question of tool use. Kenneth Kendler (2016) examines the inadequacy of DSM diagnostic categories in terms of explaining the full symptomology of depression. In doing so, he compares the basic diagnostic criteria for major depression with several different medical textbooks that do so. Kendler from there argues that the DSM has often been misapplied, mistaking "taking an index of a thing for the thing itself" (Kendler,

2016, p. 771). For Kendler, it is not that the DSM is poorly written but used beyond its scope. The DSM is not meant to be the be all and end all of disorder but rather a tool among tools to diagnose. Yet the DSM is still the forefront of diagnostic criteria of mental disorders and must be addressed. It's not the most universal tool, but nevertheless the tool we have. Jumping directly into the DSM-5's taxonomy is helpful in terms of getting a concrete working definition of terms and conditions yet is nevertheless an ahistorical look at the problem of mental suffering. This ahistoricism has its merits in treating these disorders as live problems, but additionally ignores its own grounding and the problematic history of psychiatry itself.

Major Depressive Disorder

Major Depressive Disorder (MDD) is one of the most prevalent mood disorders. While there are other forms of depression, my examination will more directly discuss MDD because its high prevalence leads to it being seen as the more paradigm depressive condition which others are drawn in comparison in order to present a differential diagnosis. Additionally, MDD has a high co-morbidity rate with other mood disorder and often is seen coupled with injury or illness. The symptoms of MDD are as follows:

> 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.
> Note: Do not include symptoms that are clearly attributable to another medical condition.
> 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

> 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
> 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
> 4. Insomnia or hypersomnia nearly every day.
> 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
> 6. Fatigue or loss of energy nearly every day.
> 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
> 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
> 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. (American Psychiatric Association, 2013, pp. 160-161).

In dry terms, the APA presents depression as a shifting and heterogeneous condition that affects a multitude of aspects of the individual's day-to-day life. The variation of possible symptoms for MDD is interesting in the sense that multiple individuals can have the same condition without much overlap in terms of their experience within episodes. Unlike popular conceptions of depression, it is not merely marked by bouts of sadness, but can alternatively include periods of anhedonia, where one lacks interest in normally pleasurable activities. The absence of interest and pleasure is often overlooked as a symptom by individuals contributes to cases of anosognosia, where many individuals are unaware of their conditions. The 2-week period length of time is diagnostically relevant in differentiating from shorter periods of mere sadness co-present with somatic symptoms that could be from a different source. Longer depressive episodes with the symptoms of MDD, those spanning at least 2 years are further diagnosable as Persistent Depressive

Disorder (Dysthymia), a "new" diagnosis amalgamation of DSM-IV conditions chronic major depressive disorder and dysthymic disorder (American Psychiatric Association, 2013, p. 168). The difference between these two diagnoses besides the duration is unclear, just as why 2 weeks or 2 years are seen as non-arbitrary measurements of time is also unclear. Yet where the time duration choice may be somewhat arbitrary, the concern point is more that there is a point that this is a long-lasting sadness or lack of feeling rather than it being about a particular problem or concern for the person.

It is additionally important to note the physiological symptoms, namely the sleep and energy issues. Depression is not merely a "mental" illness or affliction, but one that affects the entire body and engagement in the world. It is because of the somatic symptoms that Matthew Ratcliffe (2015) argues that the distinction between psychological and somatic illness is hard to trace phenomenologically. Ratcliffe notes that the sleep and energy symptoms are parallel to symptoms of flu or other inflammatory diseases (2015, 87-94). The *feeling* of a major depressive episode is a bodily feeling, as evidenced by the DSM-5 symptomology. MDD and other depressive disorders present several problems in terms of preventing an individual's ability to act, ethically or otherwise. While depression is often seen as a form of brooding, it nevertheless is an inhibition against clear deliberation. While there is a wide range of possible bodily afflictions within MDD, it is clear that they block an individual's actions or feeling of free will. Lethargy and agitation make intentional action difficult for the individual. Fatigue and sleep issues can cause further health problems. The cognitive issues as well are a problem as focus and the inability to think clearly makes for problems in

deliberating clearly, just as indecision obviously does as well. The obsessional thoughts about death and suicidal feelings possible under depression additionally become all-consuming for the individual.

Anxiety Disorders

We typically understand anxiety as distinct from fear in the sense that it has less intentionality and is often disconnected from a particular object (more on this later). An anxiety disorder is more specific to the series of problems that occur when anxiety becomes overbearing or "excessive" in one's life. Where anxiety is already a sense of discomfort for the individual, an anxiety disorder exists when that discomfort does not easily dissipate with time and overrides one's motivations and behaviors. The DSM-5 describes anxiety disorders as disorders that feature excessive fear and anxiety with related behavioral disturbances. More specifically these disorders:

> differ from developmentally normative fear or anxiety by being excessive or persisting beyond developmentally appropriate periods … Since individuals with anxiety disorders typically overestimate the danger in situations they fear or avoid, the primary determination of whether the fear or anxiety is excessive or out of proportion is made by the clinician, taking cultural contextual factors into account. (American Psychiatric Association, 2013, p. 189).

Anxiety in this form then is not stress-induced, so much as a continual or persistent. There are a multitude of anxiety disorders that are organized not so much on the degree or feeling of anxiety so much on the more specific ways in which anxiety manifests, so I am more interested in discussing these in terms of their general themes or symptomology. Anxiety disorders often leave an individual avoidant from acting.

Often anxiety disorders (besides General Anxiety Disorder) come hand in hand with panic attacks. The DSM defines panic attacks as"

> abrupt surges of intense fear or intense discomfort that reach a peak within minutes, accompanied by physical and/or cognitive symptoms. Limited-symptom panic attacks include fewer than four symptoms. Panic attacks may be *expected*, such as in response to a typically feared object or situation, or *unexpected*, meaning that the panic attack occurs for no apparent reason. Panic attacks function as a marker and prognostic factor for severity of diagnosis, course, and comorbidity across an array of disorders, including, but not limited to, the anxiety disorders (e.g., substance use, depressive and psychotic disorders). Panic attack may therefore be used as a descriptive specifier for any anxiety disorder as well as other mental disorders. (American Psychiatric Association, 2013, p. 190).[15]

A panic attack is inherently uncomfortable and comes with a multitude of physiological symptoms alongside the emotional distress of intense fear or anxiety. The longer form diagnostic criteria for physiological and other symptoms are as follows for a panic attack:

> 1. Palpitations, pounding heart, or accelerated heart rate.
> 2. Sweating.
> 3. Trembling or shaking.
> 4. Sensations of shortness of breath or smothering.
> 5. Feelings of choking.
> 6. Chest pain or discomfort.
> 7. Nausea or abdominal distress.
> 8. Feeling dizzy, unsteady, light-headed, or faint.
> 9. Chills or heat sensations.
> 10. Paresthesisas (numbness or tingling sensations).
> 11. Derealization (feelings of unrealization) or depersonalization (being detached from oneself).
> 12. Fear of losing control or "going crazy."
> 13. Fear of dying.
>
> Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms. (American Psychiatric Association, 2013, p. 214).

[15] Emphasis original to text.

There is a serious lived-experience concern here in this symptomology, where experientially one can easily confuse criterion 6 for a heart attack. Even though a panic attack is not deadly or dangerous compared to a heart attack, the perceived threat and feeling of discomfort becomes all but impossible for the individual experiencing one. Phenomenologically, panic attacks close off one's experience of the world and keep them from being able to focus. One's world-directedness becomes an impossible and unbearable project, as well as one's sense of self when it comes to derealization or depersonalization. Where anxiety is usually played off as just merely being "in one's head", the experience of a panic attack is a very bodily problem. Anxiety has a very real effect on an individual's body and thereby affects one's perceptions, motivations, and ability to make decisions as an agent.

Most anxiety disorders are often situated on particular triggers. Phobias especially are conditions in which one has a specific fear (usually although not always fixated from a particular trauma) where one's relation to that fear object or situation is especially distressing. Phobias as well as social anxiety disorder prevent an individual from feeling at ease when the issue or situation is at hand. One can often become avoidant in these conditions, as one does not want to engage directly with the issue that causes them stress.

Another symptomology that I want to focus on is Generalized Anxiety Disorder (GAD). Where other anxiety disorders have a particular trigger that causes for distress, GAD is much less dependent upon one's immediate circumstances. Yet, while there is no particular focus to the anxiety, that means that the feelings of anxiety bleed through to the rest of the individual's experiential life. The diagnostic criteria are as follows:

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
   Note: Only one item is required in children.
   1. Restlessness or feeling keyed up or on edge.
   2. Being easily fatigued.
   3. Difficulty concentrating or mind going blank.
   4. Irritability.
   5. Muscle tension.
   6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional believes in schizophrenia or delusional disorder). (American Psychiatric Association, 2013, p. 222).

GAD is a rather immersive condition in which one's entire experience of the world ends up being enveloped by anxiety and worry. One cannot focus on anything other than their anxiety, making for a rather insular and fraught experience. The experience of anxiety within GAD is not just a question of worry, but also rather intense physiological symptoms. While anxiety is often played off as something that is just worrying about things frivolously, anxiety disorders do have very real concerns about pain and anguish for the individual. The experiences along criterion C are extremely distressing and can

even be painful and cause of self-harm. The desire to brush off anxiety as something that is not serious or is merely needless should be challenged here. It also is important to note that the exclusions in criterion F shows that this symptomology is common among many different anxiety disorders, not just GAD.

The Moral Stakes of Being Epistemically Adrift

In part, this is a dissertation in response to something that's missing, both intentionally and unintentionally. Depression and anxiety disorders would be bad enough on their own if it weren't for a stigmatizing and altogether confusing society that leaves them epistemically adrift on top of these experiences. Throughout the more mainstream literature of philosophy of emotion, there is a concerning *absence* of discussing mood disorders. This carries over into the realm of moral philosophy as well, especially where some philosophers of emotion explicitly seek to create ethical theories *built* on emotional experience yet do not want to fathom the implications for those with mood disorders. Some philosophers ignore the problem outright without so much as an index entry on depression or even the blanket term "mental illness"; others straightforwardly state that their formulations do not cover mood disorders. This explicit exclusion exists perhaps most puzzlingly in Charlie Kurth's *The Anxious Mind* (2018) whose subtitle is "An Investigation into the Varieties and Virtues of Anxiety." Despite focusing and building an ethical theory extolling on anxiety as a morally-useful experience, Kurth and other scholars of this sort avoid disorder outright. Kurth does not even give an explanation, just argues that he wants to focus on "nonclinical" anxiety. This avoidance is understandable to some extent; mood disorders (and mental illness in general) evade theoretical lines. It

is hard to make a clean-cut theory about causal or ethical theories of emotion when in psychopathological cases, there is no clear cause for one's suffering within depression or other mood disorders and one otherwise would want to build a theory of reasons. Yet, I see this avoidance as a fatal flaw – a hermeneutical injustice that leaves individuals further epistemically adrift.

Once again though, this is a hermeneutical injustice/case of being epistemically adrift that has willing agents. This is a case in which one is willfully ignorant or just avoidant of a difficult puzzle. The missing account of mood disorders in the philosophy of emotion leaves the literature making normative claims that directly exclude those who experience mood disorder. If one creates a normative or epistemic theory of emotions and their practical uses without considering their applications to the more extreme conditions of mood disorders, then one precludes individuals with mood disorders as full moral or epistemic agents. Anyone living with a mood disorder who turns to philosophy of emotion to make sense of their condition is not going to find much insight into how to live with their extreme emotional life.

So why is this a hermeneutical injustice? One common theme in a lot of people's lives is whether or not they are a good person. Granted, not everyone worries about this,[16] but for many this question is a gnawing one – a question that comes in at different times and different stages of one's way through life, especially for those who experience mood disorders. This question can arise when one has to make a tough decision, makes a

[16] It may likely be the case as well that some individuals never concern themselves with this question at all.

mistake, has a string of bad luck, or alienates oneself from others. Establishing whether one is a good person gives an individual a certain amount of confidence in their actions as well as a sense of social currency. Having others believe that you are a good person allows for them to trust you, hold you accountable, be inspired to also be good, etc. Many deep relationships are forged on this sense of mutual trust and admiration of each other's good qualities.[17] A lot of one's sense of worth can hinge upon one's sense of whether or not they see themself as a good person in relation to others. Feeling as though one is not a good person can make them feel as though they are not worthy of another's company. One can disengage with others based on one's perceived sense of being unworthy. In being excluded from discussions of what it means to be a good person or to have "moral emotions", individuals with mood disorders feel further adrift and excluded from full moral agency.

This question of whether an individual is a good person or not appears oftentimes at the root of one's experience within mood disorders. Living with major depression or other depressive disorders can feature feelings of worthlessness. These feelings are often either delusional or otherwise counterfactual, where one may know for a fact that they are loved, that they have done good things, or that they are worthy of good things, but nevertheless the individual feels undermined at every step, an impostor. One of the central claims of this dissertation is that mood disorders oftentimes if not always position oneself directly into questions of whether they are living a good, ethical, or even merely

[17] Of course there are other sense of social currency that are not dependent upon whether or not one is a good person or not, such as regular monetary currency. But, it's hard to state or establish that the sort of relationships that are made through an attraction to one's wealth are anything other than transactional.

"adequate" life. Anxiety itself is especially pernicious. The concept of anxiety covers many different possible feelings; it can be sharp or dull, persistent or fleeting, returning on and off across one's life, about a particular object or just a lingering unattached feeling, etc. Anxiety manifests in so many ways, and often will latch onto other experiences or objects despite not being the aspect that triggered it. It's hard to describe anxiety or other moods without resorting to metaphors. Anxiety can blanket one's entire existence, or flood one's focus, or can tighten a knot in one's chest, etc.

Further, there is no clear metric for whether someone is a good person. This has everything instead to do with a feeling of comfort in oneself and with the engagement or opinions of others who affirm that one is good or not. When an individual seeks to know whether one is a good person one is looking through several different possible lenses or senses of morality. There are plenty of competing explanations or justifications for whether a person is good, or good enough, but very few of these give one a sense of *certainty*. One can ask different individuals who are each engaged in what it means to be a moral person and come short in terms of whether they are a good person. Different people have different answers, different justifications, different reasons as to why or why not. Further, different people have different answers as to what depression and anxiety mean. I argue throughout this dissertation that anxiety and depression do not have to mean anything, but existentially one can create meaning through these experiences. If one obsesses, one can lose the plot in terms of whether or not they deserve good things for themselves. Those who are more 'naturally' insecure in who they are as a person end up feeling more vulnerable as to whether they are good. This sense of insecurity can chip

away at one's very sense of stability. One can worry so much about whether they have been a good person that they end up doing bad things, or not acting at all. Being epistemically adrift is the sort of experience that further alienates an individual and makes them feel as though they cannot do the right thing as there are too many conflicting options, or that they are not good enough to do the right thing. The rest of these chapters argue for how to navigate living with depression and anxiety in responsible ways despite this epistemic noise.

CHAPTER 2

DEPRESSION, EXISTENTIAL GUILT, AND COLLECTIVE RESPONSIBILITY

Perhaps there are healthy neuroses? In any case, where there is an awakened sense of the human abyss, and no possible pretext for ordering the world, no possible human ideals or genuine outlook on the world, madness and psychopathy acquire a human significance. They are an actuality in which such possibilities are revealed, which the healthy person conceals from himself, avoids and guards himself against. But the healthy person who keeps his psyche marginally exposed and who investigates the psychopathological will find there what he potentially is or what is essentially there for him, distant and strange though it may be, a message beyond the actual margins of his experience.

– Karl Jaspers, *General Psychopathology*, (1959/1963, p. 786).

Guilt is a *moral* feeling in the sense that it engages us with questions of responsibility, fault, and reconciliation. To feel guilty is to feel as if one is responsible, either as the cause of some moral wrong or as an agent compelled to correct some wrong. In this way guilt feelings can become rather integral to a person's moral experience of the world as they are shaped by one's actions and in turn inspire other actions. Yet these feelings in themselves are not always necessarily intentional, as there are many instances of guilt feelings that are not apparently tied to one's actions. If we understand guilt as a moral feeling, then what do depressive, *existential* guilt feelings mean for morality? This chapter challenges typical accounts of the moral psychology of guilt in the face of excessive, even delusional guilt feelings that appear within mood disorders such as depression. These overwhelming and typically non-intentional feelings of guilt are what philosopher Matthew Ratcliffe (2008; 2015) describes as "existential feelings". Ratcliffe introduces existential feelings as an overlapping category between emotions and moods where the emotional, bodily feeling becomes the root of the individual's perspective and

experience within the world. Guilt feelings are a paradigmatic and existential experience within depressive disorders. Within the DSM-5, one of the symptom criteria for Major Depressive Disorder (MDD) is "[f]eelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)" (American Psychiatric Association, 2013, p. 161). In this chapter I argue that despite its ruinous and painful effects on the individual experiencing it, the existential guilt that is often felt within depressive disorders provides an added ethical and epistemic insight into collective responsibility in that it forces the individual to consider their ties to the world, and that these feelings of guilt need to be heard and understood in order to better conceptualize guilt and responsibility. As a result, depressed individuals ought to be listened to when they convey these guilt feelings to others in ways that push back on their more overwhelming feelings yet still engage in active listening to the problems they feel are important.

This chapter centers itself amongst recent work in phenomenological philosophy of psychiatry and illness which argues that illness can force an individual to philosophize as it changes their engagement with the world. Again, philosopher Havi Carel argues that "illness is a unique form of philosophizing. While the execution of most philosophical procedures such as casting doubt or questioning is volitional and theoretical, illness is uninvited and threatening. Illness throws the ill person into a state of anxiety and uncertainty" (Carel, 2016, p. 208). Illness and disorder provide a different context and positioning within the world that is not readily-accessible for healthy individuals. There is a sense of estrangement within illness where one feels alienated from the experience of the world that others engage in, but as a result experience the world through a differently-

attuned lens. More particular to depressive disorders, Ratcliffe (2015) describes this sort of estrangement as if the person is in their own 'world of depression,' where the possibilities of a depressed individual seem for them to be less than nondepressed individuals.[1] Our moods shift our perspective of the world and change our sense of being attuned with the world (Heidegger, 1927/1962; Stanghellini, 2017; Ratcliffe, 2008; Ratcliffe, 2015; Jaspers, 1959/1963). Even guilt feelings that are not tied immediately to one's actions can still shift one's engagement within the world and affect one's very existence. This paper is also inspired by empirical findings on "depressive realism" – that mild depression provides more accurate predictions regarding contingency and social standing (Bortolotti & Antrobus, 2015; Antrobus & Bortolotti, 2016; Alloy & Abramson, 1979). At least in part, experiences of depression provide a different perspective in the world that has its own epistemic insight.

Moral philosophers of emotion are typically wary of including excessive or delusional feelings within their theoretical commitments, deeming them as "irrational". I suspect that this because it is too hard to create a tight-knit theory that encompasses mood disorders. Yet guilt feelings, whether depressive or not, draw us towards feeling responsible before one another. In response to these exclusions, I am not looking to engage in a full literature review, but only to discuss the elements of philosophical, psychological, and moral accounts of guilt that are useful in building a morality of depressive guilt feelings. I argue that depressive, existential guilt shows the possible depth of interconnections between individuals. The question of whether one's feelings of

[1] Or similarly in Wittgenstein's Tractatus 6.43: "The world of the happy is quite another than that of the unhappy" (1922, p. 88).

guilt are “excessive”, “inappropriate”, or “delusional” shows that guilt feelings are not an adequate measurement of actual guilt or wrongdoing. While experiencing delusional guilt, one can understand that these feelings are delusional, yet still find oneself unable to shake these feelings. For depressed individuals, there is an overwhelming sense of “feeling responsible” more than others experience. I believe these guilt feelings give special insight to conceptual levels of guilt, particularly that of moral and collective guilt as outlined by Karl Jaspers (1961). While depression and suffering may provide continual avenues for self-destruction and failure, the forced brooding within existential guilt brings a further depth of the interconnections between individuals and a wider perspective of responsibility that is not readily recognized by nondepressed others. If we engage with depressed individuals more seriously as a society, we should be able to have a better sense of the depth of moral responsibility that we have towards one another that is not easily accessible or understood by non-depressed individuals. This chapter will discuss the bridge between guilt as feeling and guilt as conception, present Jaspers’ conceptual account of moral and collective guilt, discuss the feelings of guilt within depression, and conclude on a discussion of testimonial injustice and the need for these guilt feelings to be heard and understood by others.

Guilt as Feeling, Guilt as Being

There is first a distinction to be made between the ‘objective’ fact of *being* guilty versus the experience of *feeling* guilty. To *be* guilty is to have actually done wrong; to *feel* guilty is to hold that one is in the wrong and to hold oneself accountable. Feeling and fact are not the same. In writing this chapter, I will follow the distinction that Martin Buber gives in his essay “Guilt and Guilt Feelings”, where “guilt” is the concept or

"objective" sense of intersubjective blame for an action and "guilt feelings" refer to the feelings of guilt that one faces connected or disconnect from blameworthy actions (Buber, 1965). One can easily be guilty of some transgression and feel no sense of remorse or recompense, even if one knows that one has done something harmful. We often find individuals express no remorse for harms that they have committed, often times even if they meant to harm someone else, but more commonly one avoids the feeling of guilt through knowing that they had no ill will or cruel intentions.

Alternatively, guilt feelings are oftentimes disconnected from 'actual' wrongdoing or corresponding to wrongdoing but exaggerated in scale to the point that one feels much too guilty for minor indiscretions. That is, guilt feelings can be delusional or excessive when compared to the individual's actual actions. While feelings of guilt suggest a sense of being guilty, it does not readily follow that one is actually guilty in feeling so. Guilt feelings often act as if they are a recognition of wrongdoing, but can often be completely detached from the experience that one has within the world regarding their interconnections and responsibility for what they have or haven't done.

In guilt feelings, one feels that one owes others. There can be a phenomenologically coupled feeling of loss, or that one has gained at the expense of harming or cheating others. A common theme to writings on guilt is its analogy to debt (Katchadourian, 2010; Ricoeur, 1967; Jaspers, 1961; Steinbock, 2014). For the person feeling guilty, that guilt suggests that they have done something wrong, something that must be corrected or atoned. In guilty feelings, one must overcome through repaying a debt of some sort, although some debts are too burdensome or even impossible to pay. Guilt marks what we owe one another, whether felt or "actual". It is because of this sense

of debt that several thinkers have chastised guilt as a limit to one's freedom, and we would do better without it altogether (Kaufmann, 1973; Nietzsche, 1998; Bruckner, 2010). Yet, guilt is a call for responsibility before others, where even if it is a negative feeling that causes undue pain in many instances, it cannot just simply be thrown out as a moral motivation. When directly acknowledged, guilt motivates a person to overcome their faults and to do better to others. Unfortunately, the pain of guilt more often inspires shame leading to retreat or hiding one's feelings before others instead, that is, guilt inspires shame and alienation from others. Acknowledging wrong before others is additionally painful, in some cases more than the initial feeling.

Guilt is an uncomfortable and at times unbearable feeling. Philosopher Anthony Steinbock describes guilt as "a rupture of a style" that "intervenes in the 'natural' unfolding of events and calls into question what occurred or (in some cases) what may occur" (Steinbock, 2014, p. 107). This "rupture" is a command to attention and preoccupation. Guilt shifts one's perspective, looking to past events and changing one's attitude towards their present (and even future) situation and actions. Phenomenological psychologist Roger Brooke argues that experiencing the world as a guilt-free individual is being "fully open, present and responsive to … a harmonious, trustworthy world" and that "[t]he guilty person does not live in this world … He appears to live in it only by concealing aspects of his existence and the fact that his relationships with others are ruptured … the guilty's existence is isolated" (Brooke, 1985, p. 44). Guilt not only changes one's experience, but the very feeling of one's access to the world in general and interrelation with other human beings. The feeling of guilt can sometimes estrange us

from one another and implies that something is so fundamentally wrong that one cannot even live within the same world as those who we believe are pure or good.

It is in this way that the feeling of guilt is a moral feeling, that is, it engages us with moral questions of how to be good to one another, how to mitigate that guilt, etc. It is our sense of guilt that keeps us in check in many social situations yet also has the capacity to be rather self-destructive. Guilt's existence and force of motivation makes it hard to bear. Guilt can keep a person within a relationship, whether or not one loves the other, regardless of whether the relationship is mutually-beneficial or harmful and abusive. One can feel that one owes the other too much to walk away for their own sake, even when staying in the relationship can cause worse suffering than the guilt of leaving. Academics are often heavily influenced and motivated by guilt in our cultures and institutions; the pressure to 'publish or perish' leads to an instantiated, continuous feeling of guilt for many who feel that they are not doing enough. Throwaway lines such as "I should be writing" have become jokes within academic circles, but nevertheless the guilt of writing, working, and performing academic tasks does not become easily abated. Even these more mundane, non-disordered feelings of guilt are difficult to navigate or understand for individuals.

Guilt as Existential Feeling

The experience of guilt feelings within depressive episodes is such that it changes the individual's sense of possibilities. Ratcliffe identifies the feelings of guilt that appear within depressive episodes as being "existential". That is, the excessive or delusional feelings of guilt affect the individual's very day-to-day existence within the world. These

guilt feelings become the very center of one's lived experience.[2] The term existential guilt is taken up by several authors, including philosopher Martin Buber in his essay "Guilt and Guilt Feelings" (1965), psychotherapist Irvin Yalom in *Existential Psychotherapy* (1980), as well as Matthew Ratcliffe's *Experiences of Depression* (2015). These thinkers have a similar enough concept to one another in mind that I will apply to the excessive and delusional guilt feelings within depressive disorders. Martin Buber identifies existential guilt as "guilt that a person has taken on himself as a person and in a personal situation" (Buber, 1965, p. 126). This guilt is not just simply a passing moment but is something that appears immediately as a direct problem for the individual. Buber continues:

> [t]he bearer of guilt of whom I speak remembers it again and again by himself in sufficient measure. Not seldom, certainly, he attempts to evade it—not the remembered fact, however, but its depths as existential guilt—until the truth of this depth overwhelms him and time is now perceived by him as a torrent. (Buber, 1965, pp. 126-127)

Existential guilt is hard to evade. One may try to run but cannot only leading to worsening feelings. The repeating nature of existential guilt models the same variety of Ratcliffe's existential feelings that "[t]hey can be (a) short-lived, (b) sustained over a period of time or (c) retained over the course of a life as habitual temperaments" (2008, p. 55). While one may forget or pass over the guilt feelings that one has, it still can return at some moment as an interruption of other feelings. To remember guilt feelings can often

[2] It is possible, I suppose, that one could have the experience of existential guilt that is outside of a depressive episode, but I would more readily assume that overbearing feelings of guilt isolated from depression would still nevertheless inspire or trigger depression rather than persist without the saddened or dulled mood.

re-trigger the same feelings again and again, especially if the individual has not fully processed these feelings.

In discussing his own theory of existential guilt, Ratcliffe identifies different levels of feeling guilt. He discusses intentional and non-intentional forms of guilt feelings. Intentional guilt feelings can include "…about something specific … about something but not knowing what… [or] that one really is guilty of something specific" (133). On the other hand, non-intentional, existential guilt feelings that are either just simply feeling guilty without any object or feeling "irrevocably" guilty. Ratcliffe identifies this existential guilt as the excessive, delusional guilt within depression that consumes an individual's attention and very comportment within the world. Depressive feelings of guilt are either not tied directly to a tangible event or are well beyond the pale of what one "should" experience in respect to the action. He writes:

> Irrevocable guilt, however, involves the sense that being guilty is integral to one's essence: one could not have been otherwise and could never be otherwise (although I grant that there are in-between cases, such as feeling that one has become guilty but that this guilt is now inescapable). (Ratcliffe, 2015, p. 133).

This sense of guilt is unshakeable. This sense of being integral to one's essence makes such guilt difficult to bear. Without the chance of 'redeeming' this guilt, as it is baseless, individuals who feel delusional, irrevocable guilt find themselves in distinct problems in relating to the world and others.

Existential guilt cannot be redeemed just simply by actions or some retribution cycle. Ratcliffe continues:

> In the case of existential guilt, no alternatives present themselves. When a person is judged to be guilty of something, there can be a cycle of guilt and retribution … Existential guilt is different. The loss of future

> possibilities includes that of redemption; the guilt is inescapable. It is not experienced as a contingent feeling that can be overridden by some course of action. In the absence of any conceivable alternative predicaments, it seems essential to one's being. For the sufferer, there is no possible world in which she is not guilty or will one day not be guilty. (Ratcliffe, 2015, p. 142).

These perceived feelings of guilt will seemingly never go away for these individuals. Guilt follows the individual, much like Winston Churchill's metaphor of his stalking black dog of depression. The sense of guilt defines the individual's self-narrative. Irrevocable guilt cuts off possibilities for the individual. The person who feels irrevocably guilty understands their position within the social world as one where they need to remove oneself or make oneself small out of a sense of shame. They may also continuously act in such a way that infringes upon their own capacity for dignity, easily giving into the will of others in an uneven sense of retribution or justice. While other individuals may not deem the depressive as guilty of anything at all, the self-judgment in the feelings of guilt is hard if not impossible for the depressive to break out of.

Existential guilt can present as if an infinite demand; a demand that the individual's life has gone wrong and must be reconciled or redeemed. This type of guilt is hypervigilant and hyperperceptive of the connective ties that bind us as individuals. This guilt is insurmountable because it has everything to do with the individual who feels it. Just as much as one tries to see oneself as being a productive member of society, one fails to fight this feeling. Further, the very existence of depression is something that one often feels guilty for, as one can feel guilty for their sense of sadness or lack of feeling when others are happy around them. As Ratcliffe quotes from his depression survey "I know depression is an illness but at the same time I feel like I caused it" (2015, p. 153). Beyond guilt being a symptom of depression, one can even redouble one's sense of guilt in

believing oneself responsible for one's illness. Where I argue against the rationalization of victim-blaming illness narrative, there is still a responsibility in the sense of being attuned to one's bodily and emotional limits as an individual.

The guilt that one feels about one's own depression is still in part an indicator that one needs to work through one's feelings and very approach to the world around oneself. Yalom discusses existential guilt directly in relation to the conception of responsibility. He writes that "the full acceptance of responsibility broadens the scope of guilt by diminishing escape hatches" (Yalom, 1980, p. 277) and further stating that guilt is "intimately related to possibility or potentiality" (ibid). To feel guilty, even excessively so, is to feel responsible for the world and one's engagements with it. To understand the depth of responsibility is an accounting for guilt feelings in such a way that one meaningfully recognizes where one's culpability lies. Unfortunately, this sense of insight does not readily mean that one *will* act or engage in ways that will right wrongs – but the point is to listen to these feelings and reach out to others without indulging too much in its temptation for ruin or immobility.

Conceptions of Guilt

While my concern with this chapter is more based upon the issues of *feeling* guilty as opposed to *being* guilty, there is some need to explicate different conceptual engagements with the latter. Where *feeling* guilty suggests *being* guilty, any discussion of guilt feelings would be remiss without engaging with conceptions of guilt. Guilt is connected to our understandings of fault or blame, but as Paul Ricoeur (1967) notes it is not directly synonymous with fault and it is harmful to immediately assume it as such. There are different stratifications of the concept of guilt that show that we can have guilt

for actions of which we are not ourselves the author. That is, we can feel guilty through our associations with others; guilt is infectious and often one feels guilty merely by being in a close relationship with someone else that they find detestable. Ricoeur notes that, even conceptually, guilt is physically felt as if a weight or a burden. Within *The Symbolism of Evil*, Ricoeur argues that (religious) notions of defilement, sin, and guilt are each experienced and felt not merely as concepts but are felt as physical ailments.[3] He writes that

> What is essential in guilt is already contained in this consciousness of being "burdened," burdened by a "weight." Guiltiness is never anything else than the anticipated chastisement itself, internalized and already weighing upon consciousness … guilt is a moment contemporaneous with defilement itself … it is because man is ritually unclean that he is "burdened" with fault; he need not be the author of the evil to feel himself burdened by its weight and the weight of its consequences. (Ricoeur, 1967, p. 101).

One can be weighed down by their feelings of guilt. These feelings can be uneasy and hard to bear or carry. To feel guilty is to be held down by the weight of one's actions (or inaction). Ricoeur's attempts at discussing guilt in terms of physicality are not merely a metaphor, discussing the use of physical language used in discussing defilement, sin, and guilt. Ricoeur believes that at least for these ancient accounts that guilt cannot "*express* itself except in the direct language of 'captivity' and infection'" (Ricoeur, 1967, p. 152). In guilt, one feels "dirty" and becomes preoccupied in trying to "come clean". Beyond metaphor, guilt is a felt experience and not just merely conceptual. Personal accounts of guilt also feature physical descriptions, suggesting that even if guilt is not felt within the

[3] While Ricoeur is concerned with religious conceptions of guilt, there is still a religious force within the so-called secular west.

body, that at the very least it is hard to conceive or describe guilt without some sort of physical tie-in.

Following the fall of the Nazi regime, Karl Jaspers gave lectures on Germany's awakening to the guilt of their atrocities from the preceding years. While many of the German people did not directly/actively participate in the Holocaust or the war, nevertheless those without 'dirty hands' felt a considerable amount of guilt. Within *The Question of German Guilt*, he identifies four different levels or concept of guilt consciousness that apply to Germany's ongoing relationship to Nazism. His terminology is as follows:

(1) *Criminal guilt*: Crimes are acts capable of objective proof and violate unequivocable laws. Jurisdiction rests with the court, which in formal proceedings can be relied upon to find the facts and apply the law.
(2) *Political guilt*: This, involving the deeds of statemen and of the citizenry of the state whose power governs me and under those whose order I live. Everybody is co-responsible for the way he is governed. Jurisdiction rests with the power and the will of the victor, in both domestic and foreign politics. Success decides. Political prudence, which takes the more distant consequences into account, and the acknowledgment of norms, which are applied as natural and international law, serves to mitigate arbitrary power.
(3) *Moral guilt*: I, who cannot act otherwise than as an individual, am morally responsible for all my deeds, including the execution of political and military orders. It is never simply true that "orders are orders." Rather—as crimes even though ordered (although, depending on the degree of danger, blackmail and terrorism, there may be mitigating circumstances)—so every deed remains subject to moral judgment. Jurisdiction rests with my conscience, and in communication with my friends and intimates who are lovingly concerned about my soul.
(4) *Metaphysical* [Collective] *guilt*:[4] There exists a solidarity among men as human beings that makes each co-responsible for every wrong and every injustice in the world, especially for crimes committed in his presence or with his knowledge. If I fail to do whatever I can to prevent them, I too am

[4] It is important to note that Jaspers seems to interchangeably use the term "metaphysical guilt" and "collective guilt". The term "metaphysical" carries a lot of connotations that are unrelated to both Jaspers' and my own use here. It appears that Jaspers' concern is to call this species of guilt metaphysical as it pertains to God's judgment. In order to avoid confusion with contemporary analytic metaphysics, I will refer to this form of guilt as collective as opposed to metaphysical.

> guilty. If I was present at the murder of others without risking my life to prevent it, I feel guilty in a way not adequately conceivable either legally, politically, or morally. That I live after such a thing has happened weighs upon me as indelible guilt. As human beings, unless good fortune spares us such situations, we come to a point where we must choose: either to risk our lives unconditionally, without a chance of success is impossible. That somewhere among men the unconditioned prevails—the capacity to live only together or not at all, if crimes are committed against the one or the other, or if physical living requirements have to be shared therein consists the substance of their being. But that this does not extend to the solidarity of all men, nor to that of fellow-citizens or even of smaller groups, but remains confined to the closest human ties—therein lies this guilt of us all. Jurisdiction lies with God alone. (Jaspers, 1961, pp. 31-32).

I believe that this categorization of four different concepts of guilt are extremely helpful in understanding responsibility, yet they are not necessarily mutually exclusive. Each of these conceptions of guilt can be implicated by the feeling of guilt, however for our purposes within this chapter collective guilt is much more important, along with one aspect of moral guilt discussed in the next paragraph. Criminal and political guilt are relatively straightforward concepts that are at least better explained by legal study, political theory, and history.

Moral guilt, for Jaspers, needs to be *felt* to be understood. Moral guilt is much more familiar to those who study moral philosophy; it is the burden that one bears for transgressions or the burden that one imagines in making a moral decision on how to move forward with one's life. Moral guilt occurs when one actively does wrong or harms another through their actions, whether intentional or not. One can mask their culpability for their actions by claiming that they could not do otherwise by way of bad faith, but nevertheless this concept of guilt has directly to do with doing harm or wrong, whether intended or not. Moral guilt occurs when one actively does wrong. Jaspers believes that moral guilt is only understood or felt "for all those who give room to conscience and

repentance. The morally guilty are those who are capable of penance…" (63). That is, to recognize and understand moral guilt and responsibility, one has to *feel* guilty in some way. Where guilt is a painful experience that forces an engagement with one's actions, it allows for the individual to understand their actions and consequences. Morality in Jaspers' conception then requires a felt attentiveness to feeling guilty in some way. If one is emotionally-numb to the consequences of their actions or to the others that they affect, then they are not motivated to reflect on these actions.

Moving on to collective/metaphysical guilt, Jaspers is arguing for a deeper, less-immediate level to one's actions and everyday life. Jaspers believes that there is an inherent indebtedness to one another by way of collective guilt. He writes that this guilt:

> is the lack of absolute solidarity with the human being as such—an indelible claim beyond morally meaningful duty. This solidarity is violated by my presence at a wrong or a crime. It is not enough that I cautiously risk my life to prevent it; if it happens, and if I was there, and if I survive where the other is killed, I know from a voice within myself: I am guilty of being alive. (Jaspers, 1961, p. 71).

Jaspers here describes something that we now called survivor's guilt; the feeling of guilt that one has when one survives a traumatic event while others perish brings about such great suffering. One is not often at fault for surviving when others have perished, yet these feelings often appear for individuals. The idea that one is inherently connected to the rest of humanity by way of guilt suggests that guilt is not only a moral feeling, but it is one of the most important moral feelings as it sets all individuals as co-responsible for one another. While Jaspers' focus is more concerned with the concept in *being* guilty, he shows that one *feels* collectively guilty as well as part of one's everyday life and interaction with other individuals.

Yet, Jaspers argues that even if this guilt is felt for things outside of the control of the individual feeling it, it is still the inspiration for a transformative responsibility. One becomes responsible for the things that one has witnessed just as one is responsible in more mundane events for the things that one knows. While Jaspers is concerned here with what to do with the question following Germany's crimes against humanity—a fault against the moral and collective responsibility that we all share—nevertheless his conception still applies to today in new ways.[5]

In the face of this insurmountable collective guilt, Jaspers believes that the only viable response is that of renewal through recognition and directly engaging with it on a community level. If the entire German nation of the late 1940s is guilty of the Nazi regime, then it must counteract the genocides and atrocities through directly engaging with this guilt and building something new. He writes that

> By our feeling of collective guilt we feel the entire task of renewing human existence from its origin—the task which is given to all [individuals] on earth but which appears more urgently, more perceptibly, as decisively as all existence, when its own guilt brings a people face to face with nothingness. (Jaspers, 1961, p. 81).

Collective guilt presents a moral call here: a call to right wrongs and create a new and better society. The guilt that Germany had for the crimes of the Nazi party was clear and devastating. On a culture-wide level, Germany *feels* guilty for Nazism – even today when

[5] Collective guilt is perhaps more visible now than it has ever been. With the advent of mass media and the internet age, we now have a wider scope of world and even local events. We have become witnesses of a larger context and see not only our everyday immediate experience, but additionally are exposed to atrocities across the nation and world. The awareness of economic, political, gender, and racial oppression has increased exponentially in recent years, making us all witnesses, making many of us feel collectively guilty. This growing sense of responsibility by way of guilt is increasingly hard to bear and many feel they are helpless in the face of cruelties at home and abroad. While a different scope and focus than before, Jaspers' understanding of guilt being the basis of collective responsibility seems to remain true, however unlike his situation, many are able to remain complacent and numb to harms committed in their name.

its initial perpetrators have all but gone extinct over time. The guilt of Nazism lies across all four concepts that Jaspers lays out, but his arguments are meant for those who do not have dirty hands, those who stood witness or were partially complicit in their actions. Whether one intervened or not, in secret or openly, there is still the pressure that one could have done more to stop the Holocaust.

There was no way to shirk this guilt, as Germany had been defeated in the Second World War and its leaders had been arrested and put on trial to recount the extent of the evils that they had done. It was either rehabilitation or ruin. Jaspers argues for using this insurmountable and irrevocable guilt as an impetus to change altogether. There is no undoing the harms and atrocities that the Nazi regime had committed and no viable authentic way to move forward without individuals admitting at least the collective guilt of surviving in the environment of Nazism and genocide. Guilt leads to the responsibility of moving forward, being able to forge forward. Again, this is an extreme case, but the extreme cases still nevertheless show the level of complicity that we all share.

There has been a resurgence of guilt within American culture since the 2016 presidential election as many liberal moderates and left-leaning individuals (and perhaps even some conservatives) were shocked at the election of Donald Trump, who gained such a large momentum by directly channeling bigotry.[6] There is now a collective guilt that appears in response to Trumpism and the so-called alt-right, an inescapable feeling of remorse of what individuals thought their country stood for in the face of growing white nationalism, corrupt political cronyism, the ubiquity of sexual predation, eliminations of

[6] This is far from the United States' only guilt-worthy moment, of course, but in present times the discourse around guilt has become so ubiquitous that it is inescapable except in moments of extreme bad faith and active avoidance.

environmental protections, threat of nuclear war over petty altercations and on and on with a multitude of new stressors that seem to compound each news cycle. The election and subsequent time since Trump's inauguration have been rather transformative in terms of collective guilt feelings, as many feel that they must do something, anything in the face of such a seemingly dramatic and overnight change of the country. Meanwhile in reflecting on this guilt, many have pointed out trends in American culture that allowed for such a rampant rise in nationalist movements and find it unsurprising yet still just as painful that the nation has turned to this direction. So many personal conversations amongst liberals and leftists since seem to return to Donald Trump and the threat of far-right politics, in a sense of dread and guilt that one must do something. This guilt appears to be insurmountable and universal, as if once again we can talk of collective guilt altogether and not be ignored.[7]

Moral and collective guilt both have wider implications regarding what one must do as a human being amongst other human beings. Where Jaspers argues that one must have a conscience in order to understand these levels of guilt, I find that responsibility for these levels of guilt requires an attunement or tendency towards guilt feelings. Where guilt consciousness was very clear in the aftermath of the Second World War in Germany, this awareness of one's complicity in harms either done directly by an individual or done one one's behalf is not typically transparent to most individuals. Even though many have awakened today to a sense of guilt or moral responsibility in the face

[7] This guilt has altogether refocused and reformed in the wake of the COVID-19 crisis, particularly and especially in response to Trump's overt incompetence regarding handling supplies and federal relief for states. The problem of living and surviving while others die seemingly at random is too much to bear. And then, it got all the worse: the uprisings of summer 2020 against police violence initially sparked by George Floyd's murder in the streets of Minneapolis has been not only a moment of collective outrage, but collective (white) guilt that police violence has made it to this point again and again.

of growing far right movements, there are still many avenues that one can take to eschew one's sense of responsibility.

My contention is that depressive guilt, or other forms of uncontrollable and apparently delusional guilt can provide a higher amount of genuine insight into the realm of moral and collective guilt. That is, the experience of depressive guilt presents a fuller awareness of the sorts of connective ties that bind individuals to their surroundings and each other. Even when delusional or excessive, feeling guilty better attunes us to our interconnections with one another. While this insight may not be perfect, as delusions typically are imperfect epistemic avenues and depressives are more often than not too hard on themselves, nevertheless the guilt within depressive episodes present a deeper, richer understanding of the connective moral and collective ties between individuals that are often otherwise overlooked.

Delusional/Excessive Guilt

The trouble with guilt in mood disorders is the psychiatric claim that it is "without cause". That is, the cause of the guilt appears to be rooted in the condition itself rather than within the individual's actions or having to do with their transgressions. Much like Josef K. in Franz Kafka's *The Trial* (1998), the feelings of guilt within depression appear as if the individual is irrevocably judged as guilty from the outside by unclear criteria. Josef K., while not *actually* guilty by any clear means, perceives himself as guilty because he is pre-judged. This feeling then follows him much like the magistrates of the court until he dies "like a dog!" (Kafka, 1998, p. 231). This paranoia of being found out and judge is also taken up by the narrator/"judge-penitent" in Camus' *The Fall,* who remarks: "I was aware only of the dissonances and disorder that filled me; I felt

vulnerable and open to public accusation. In my eyes my fellows ceased to be the respectful public to which I was accustomed" (Camus, 1956/1984, p. 78). Guilt makes one feel exposed, especially within depression and anxiety where one cannot feel comfortable explaining oneself. Delusional or excessive guilt feelings are to some extent self-imposed but are not always arbitrarily chosen projects. One may of course decide to brood and take on their guilt feelings as true and claim that one *is guilty* of some act or has made one's life situation untenable. The feeling of guilt suggests fault, and when the feelings of guilt are delusional or excessive, one takes oneself to be the fault not only of particular actions but for the state of the world. Depression's delusional feelings of guilt provide for a strange relationship to conceptions of being guilty as one overexaggerates one's sense of responsibility.

The APA identifies the guilt felt within Major Depression (and other conditions such as Acute Stress Disorder) as being "excessive" or even "delusional". In discussion of what this criterion means within Major Depressive Disorder, the APA states:

> The sense of worthlessness or guilt associated with a major depressive episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings (Criterion A7). Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. The sense of worthlessness or guilt may be of delusional proportions (e.g., an individual who is convinced that he or she is personally responsible for world poverty). Blaming oneself for being sick and for failing to meet occupational or interpersonal responsibilities as a result of the depression is very common and, unless delusional, is not considered sufficient to meet this criterion. (American Psychiatric Association, 2013, p. 164).[8]

[8] One curious part of this statement is the final quoted sentence that feeling guilty for the state of one's illness or the subsequent failures to meet expectations due to depression is not seen as pathological unless also delusional.

The guilt within depression is either excessive or delusional as it seems either as an overreaction to trivial events or completely baseless. The connection between feelings of worthlessness and guilt feelings is pretty strong and can exist within a recursive cycle; feeling guilty over one's failings undermines one's sense of self-worth and feeling worthless can inspire feelings of guilt when one feels that one does not deserve their status.

Delusional guilt appears to be rather easy to identify, at least from an outsider's perspective, in pointing out that a singular individual cannot be blamed for large-scale troubles (such as the example of world poverty given in the quoted passage). Delusional guilt can also include feelings of being guilty for being born, taking up space, for being otherwise happy when others are not, etc. Even when defeated with reasons as to why one should not feel guilty, delusional guilt persists and can be harmful for the individual's own self esteem or sense of worth in interacting with other individuals. One can know that one is not guilty of such things, yet rational argumentation does not easily face down the strength of guilt feelings.

On the other hand, identifying excessive guilt feelings would appear to be less easy. Feeling excessively guilty seems to entail some action or event for which guilt feelings are socially acceptable. Yet where it may make sense that one feels some guilt for these actions, the problem is that the amount of guilt that the individual feels is an undue burden compared to the harms that the actions may have caused. This is hard to track. We do not have a precise sense of what is an appropriate amount of guilt feelings for one's actions. Where the justice system is an attempt at judging and exacting guilt

conceptually, it has no effective means of establishing a metric for the *feelings* of guilt, and nor do we culturally. Additionally, within a depressive state one can feel guilty even regarding achievements or accomplishments that would be a cause for pride in others; one can overcriticize oneself in guilt feelings, perceiving that one could have done better. This seems to be another form of excessive guilt feelings, where one is overburdening oneself with perfectionist expectations.

Whether one feels excessively guilty for a trespass can only be judged in comparison with one's (perhaps non-depressed) peers. Since feelings of guilt are typically shameful and many avoid disclosing or confessing their feelings of guilt, it is hard to gauge how many individuals suffer in relative silence with an overbearing guilt that is incomparable with the harm they may have caused. While we do have rather everyday conceptions and social pressures that one *must* feel guilty for certain actions or moral dilemmas, there is no explanation or modeling for how much guilt one ought to feel in a situation. The social pressure that one should feel guilty is crushing for depressive individuals as they already internalize excessive amounts of guilt and this only triggers heavier feelings.

Depressive Feelings as Insight

As overwhelming and unbearable as existential or depressive guilt may become, it does present a vital question regarding the status of guilt feelings and their relation to moral responsibility in general. Philosopher Havi Carel claims that illness forces an individual to shift their focus and experience within the world, that is, undergoing illness changes one's perspective to a philosophical one. She describes illness as what can be a "crisis of meaning in one's life" (Carel, 2016, p. 214). Where depressive episodes are

experiences of illness, the feelings of depression including existential guilt present a forceful reengagement with the world that those who are not ill do not experience. The crisis of existential guilt, where "[e]ven a very short-lived existential feeling can present itself as eternal" (Ratcliffe, 2015, p. 143), forces depressed individuals to evaluate (if not over-evaluate) their position in the world and relation to others. This section looks to the possible benefits (and drawbacks) of depressive guilt.

There does seem to be some epistemic merit in minor depressive distortions, particularly in the literature on 'depressive realism' (Bortolotti & Antrobus, 2015; Antrobus & Bortolotti, 2016; Alloy & Abramson, 1979). In brief, depressive realism is the theory that despite the delusional nature of depressive disorders, there is a particularly helpful social insight that depressives have. This theory initially comes from a study by psychologists Alloy and Abramson in 1979 that measured that students with mild depressive symptoms had better judgments of the efficacy of their actions than non-depressed students. Within the initial experiment, the students who had experience with depression were better able to predict whether or not their actions were able to manipulate the outcome pattern of a blinking light, and if so, how much of an effect there was. As a result, depressive realism suggests that those who experience depression are better able to judge how actions effect one's environment. The general claim of this theory is that depressive individuals have a more correct awareness of the world than non-depressed individuals.

There are however some accounts of depressive realism that make it seem as though depressive feelings are some sort of superpower, or a mark of genius. One such account is Colin Feltham's *Depressive Realism* (2017), which seems to take the theory

for granted and presents a picture of depressives as a cult of genius. Taking the studies for granted, Feltham depicts depression as some sort of inherent mark of genius and more-readily paints a history of great male figures who were creative or brilliant in some way in conjunction with being depressed or melancholic. This and similar accounts appear to be cherry-picking. While depression or melancholy are often traits of many intelligent and creative figures, it does not readily follow that being sad is the same as being intelligent and certainly not the same as being successful in one's intelligence or creativity.

More nuanced discussions of depressive realism such as within philosophers Bortolotti and Antrobus/Antrobus and Bortolotti (2015; 2016) show something more humble; depression has some epistemic gains while also some epistemic losses. While a depressive may not have an accurate perspective on their own engagement with the world of others, they can provide better insight for the social interconnections between other individuals in their own separate lives. If this theory is true, then the guilt that depressive individuals feel provides a better insight to the moral and collective guilt/responsibility that we have towards one another, even if the depressive's own life is compromised by guilt delusions. What this research shows more realistically is that mild depression provides for better insight in some judgments and that those who suffer from depression should be taken more seriously regarding their testimony than society typically gives them credit.

Failure and Alienation

Of course, excessive guilt has a major downside in the shame and alienation that individuals experience in their feelings of failure. The ultimate defeater for moral action

from guilt is that these feelings inspire retreat. Embodying the judgmental perspective of others, whether real or imagined, guilt feelings can fill the individual with a sense of worthlessness and lack of social currency. Again, where debt is often a metaphor for guilt, one tries to avoid their debtors when unable to repay. In the case of delusional and excessive guilt feelings, this avoidance is a natural temptation.

In its exaggerated form, depressive guilt is one of the factors that inspires a sense of estrangement between oneself and others. One shields oneself from others with the fear that they will never understand them. Once again as to requote Ratcliffe's (2015) note that: "There is a feeling that [non-depressed] others do not understand, which could be described as a feeling that they are unable to 'relate to' or 'connect with' the depressed person . . . [who] does not feel understood" (p. 202). Where guilt is hard to bear or explain to others, one shirks away from the social world in order to save face, keep up appearances, or to distance oneself from those who they feel they do not deserve to know. Several novels that deal with guilt feature this sense of exile and alienation when one feels one's harms are too much. This leads to the individual to brood and fester and excuse oneself from society at large with a fear that one cannot be understood otherwise. This happens to the judge-penitent in Camus' *The Fall* (1956/1984) and to Dostoevsky's nameless Underground Man in *Notes from Underground* (Dostoyevsky, 1861/2010). Both characters decide for themselves that their sins are far too wretched to ever live among their society again. While they both are unsavory actors in their pasts, this self-exile only makes them worse as it cuts them off from being able to do anything good for themselves or others, only to engage in their rambling confessionals to an audience who

cannot absolve them. Guilt feelings can be transformative not for social or moral good, but can undermine one's entire life and mental health – and the lives of others.[9]

One especially noteworthy recent pop culture narrative of guilty exile is Luke Skywalker within *Star Wars: The Last Jedi*. Where in the original trilogy depicts the buildup of Skywalker's training and heroism, this film shows a defeated man who has found the most remote planet he can hide from everyone he has ever known. In secrecy and shame, Skywalker has vanished to escape his own sense of guilt. When challenged by Rey, Luke reveals that the reason that he "came here to die" was his attempt at assassinating his own nephew Ben Solo to prevent Ben's fall to the dark side. In narrating a flashback, Luke states that

> I saw darkness. I'd sensed it building in him. I'd seen it in moments during his training. But then I looked inside, and it was beyond what I ever imagined … He would bring destruction, and pain, and death, and at the end of everything I love because of what he will become. And for the briefest moment of pure instinct, I thought I could stop it [by murdering Ben in his sleep]. It passed like a fleeting shadow. And I was left with shame, and with consequence. And the last thing I saw were the eyes of a frightened boy whose master had failed him. (Johnson, 2017).

The flashback depicts Skywalker hesitating in killing Ben Solo, who instead wakes up to catch him in his attempt. Ben then instead brings down the walls of his room upon Luke, leaving him for dead, then murdering the rest of his peers and then assuming control of the evil First Order. Luke believes himself to be the sole cause of Ben's turn to the dark side, arguing that it was the hubris of the Jedi religion and himself that consistently leads

[9] The Underground Man himself is especially comical in his self-ruin: ""I'm a sick man… a spiteful man… an unattractive man, that's what I am. I suspect there's something wrong with my liver. But I don't understand a damn thing about my illness, nor do I know for sure what is wrong with me … All the same, if I'm not being treated it's entirely out of spite. There's something wrong with my liver – well, let it get worse!" (Dostoyevsky, 1861/2010, p. 7).

to destruction. Despite its leading to further failure, guilt is Skywalker's moral guide. In ruminating on his failures, he understands where he and Jedi before him have gone wrong and is correct in pointing out that the cycle of destruction by evil forces is constantly triggered by the Jedi's strict adherence to rules and useless asceticism.

In a nonfiction example, Elyn Saks narrates the stream of consciousness of her feelings of guilt and worthlessness in her memoir, stating that she felt that "It's wrong to talk. Talking means you have nothing to say. I am nobody, a nothing. Talking takes up space and time. You don't deserve to talk. Keep quiet" (Saks, 2008/2015, p. 55).[10] Saks' feelings of guilt and worthlessness described in *The Center Cannot Hold* prevent her from ever expressing her "true" or authentic self before others, including her closest friends and her family. While the guilty feelings that she has experienced give her a great amount of insight into the types of things to worry about, they also have kept her from being able to express who she is and what her goals are to others. It was not until after treatment and admitting to her own condition that she was able to have a better sense of her desire to help others with mental disorder, eventually founding the Saks Institute for Mental Health Law, Policy, and Ethics. Saks' ambition for helping others with mental disorder as rooted in her own struggles with disorder is rather common. There is a need to break through one's guilty feelings and in that struggle one can find a solidarity with others also afflicted by troubled moods.

Guilt feelings can shutter oneself away from the social world, often feeling that one does not deserve the pleasures or even basic sustenance that others enjoy, often

[10] Saks' lived experience is not "just" depression, but additionally that of schizophrenia and eating disorders. However, the guilt feelings that she describes is still paradigmatic of existential guilt.

leading to self-harm. The guilt spirals that depressive individuals face can make even justifying one's own self-care and maintenance impossible. Even minor or everyday tasks become seemingly impossible for the individual and they set themselves up for failure. In describing her experience as a philosophy student at Oxford, Saks writes that

> I needed to present another paper in my weekly seminar, but I could not write. A feverish all-nighter produced three or four pages of pure drivel. Gobbledegook. Junk. Nevertheless, I read it aloud. Eyebrows rose. But there was no laughter, only silence. I had thoroughly humiliated myself in front of my Oxford colleagues. *I have come to oxford and I have failed. I am a bad person. I deserve to die.* (Saks, 2008/2015, p. 58).[11]

While the reaction of thinking that she "deserves to die" is an overreaction to embarrassing herself in front of her peers, this feeling is still rather common and has to be mitigated in some way. Guilt feelings become a question of what the person "deserves". One can feel that one deserves to die over a minor to moderate infraction or embarrassment.

Another aspect of depressive disorders can be feeling that one does not *deserve* to take care of oneself unless one has "earned" it. For example, it is common for one to actively withhold from feeding oneself because one has not made the benchmark that they set for oneself; "I'm hungry but I don't deserve to eat until this draft is sent out and it's already late." These sorts of cycles, even when mundane or minor are still harmful and undermine one's own sense of self-worth. While guilt feelings may allow one to understand responsibility on a larger scale and the need to take care of others, it is too detrimental to the self when these feelings question whether one deserves to be a part of society, to take care of themselves, etc. Seemingly alienating oneself from others is not

[11] Emphasis original.

the answer to guilt feelings as destroying oneself or one's social standing prevents one from doing good or express their insight into problems.

While understanding and investigating depressive feelings can be overall good, to indulge too much into one's feelings of guilt can be vindictive and harmful in forming mutually-enriching relationships. After all, the judge-penitent in *The Fall* looks not to create lasting relationships but to dwell so deeply in his guilt that he solely wants to bring others down into it. He chastises himself and his audience in the end of the novel: "I have a superiority in that I know [my guilt] and this gives me the right to speak. You see the advantage, I am sure. The more I accuse myself, the more I have a right to judge you. Even better, I provoke you into judging yourself, and this relieves me of that much of the burden" (Camus, 1956/1984, p. 140). The judge-penitent does not look to build or create something new like Jaspers hopes collective guilt would, instead he drags whoever he meets in the gin bar down to his level of depravity and wallowing. Instead, we need to foster communication about guilt that is reciprocal and mutually affirming, looking to build something new through testimonial justice and unburdening.

Testimonial (In)Justice and Unburdening Guilt in Dialogue

For guilt feelings to be unburdened, one must return to a social environment where one feels safe and understood. Phenomenological psychiatrist Roger Brooke writes that there is an authentic way of dealing with guilt feelings where one unburdens in a healthy way. He writes

> Authentic ways, on the other hand, close the rupture, and restore the subject's open presence in the world. To be more specific, an attempt to resolve guilt is inauthentic when the subject magically tries to disown the responsibility that at the prereflective, involuntary level of experience he

> has nevertheless appropriated. There are several ways of authentically resolving guilt, however. Firstly, the subject may genuinely disappropriate guilt that he recognizes is unjustified. Secondly, the subject may forgive himself, and it is interesting to note that self-forgiveness, like self-accusation, is always mediated by adopting the perspective of an imaginary other. Thirdly the subject openly and unequivocably confess himself as a damaging, guilty person to a significant other. (Brooke, 1985, pp. 39-40).

In brief, guilt is authentically dealt with through direct recognition of the feeling, while any attempt at escape from responsibility is inauthentic. To evade one's guilt feelings seemingly only further worsen them, only let them bubble under the surface of the individual resentfully. The three different ways of authentically dealing with guilt that Brooke discuss are each hard in their own way and require a certain amount of reflection and bravery in the face of painful emotional feelings. To be able to forgive oneself for one's actions is additionally hard, especially for depressives who feel that they are themselves worthless. Further, to be able to confess to another, to be vulnerable and unburden oneself in claiming mea culpa requires a certain amount of confidence in the face of shame and exclusion, as well as a considerable amount of trust in the other.

However, coming clean to others about one's guilty feelings is not a cure-all for these feelings, especially when these others are not a receptive audience to feelings. The *social* problem of existential guilt is that it is hard to gauge before others. There is the fear that individuals with depressive guilt will not be taken seriously in their explanations of their feelings and experience. An actively stigmatizing society such as our own constantly doubts the testimony of atypical minds. Trusting others, especially others who do not experience the same depth of moods, is extremely difficult for depressive

individuals. For the depressed individual wrapped up in guilt, there is a sense that others will never understand this feeling.[12]

Whether or not others understand the depressed individual, the sense of guilt and worthlessness within depressive disorders prevents them from feeling able to reach out or engage with others in any meaningful way. One's depression is an uncomfortable condition for others as well, and many feel that they cannot engage with depressed individuals out of the (sometimes justified) fear of "infection" or ruining one's own happiness. The perceived stigma of depressed individuals being a "burden" upon others is ubiquitous and prevents many from seeking help, often doubling-down on their darker feelings as a result. The cultural adherence to "good vibes only" in public discussion gaslights and undermines those suffering from depression and anxiety in ways that stigmatize them all the more. Depressed individuals often fear that admitting to their feelings will result in chastisement or exclusion. Depression reveals a darkness to the world, and being told that that darkness is unseemly or inappropriate for discussion undermines their ability to be part of a community.

The fear in expressing one's depressive guilt to others is that whatever trust one puts in them will be undermined. Depressed individuals face testimonial injustice and gaslighting in discussing their feelings before others. Testimonial injustice, as coined by Miranda Fricker (2007), is a form of epistemic injustice in which one's credibility as a knower/testimony-giver is undermined resulting from their social identity's prejudice. Further, gaslighting is the psychological phenomena of undermining one's credibility by

[12] While this absolute is perhaps too superlative, it still is common for depressed individuals to think in such fatalistic all-or-nothing terms.

negating their testimony and ability to be a knower outright (Abramson, 2014). Those with depression and other mood disorders face both testimonial injustice and gaslighting in social situations, even from those who have the best intentions (Jackson, 2017). Where cultural understandings of depression are scattered and conflicted, there is still a great amount of widespread stigma that prevents depressed individuals from feeling safe in opening up about their experience. As those with depression give testimony that is steeped in one's disordered feelings, the expression of guilt may outright be discredited only as blowing things out of proportion. Most non-depressed (and even other depressed individuals who are looking out for their own) individuals do not seem to want to engage wholeheartedly with depressed people. Society looks down on overly emotional testimony in general, as discussing feelings is seen as weak. Or alternatively, there is the fear that one will be taken too seriously, that others will believe their excessive feelings of guilt to be "true" and judge them as being morally unworthy or irredeemable wretches. That is, depressed individuals face the fear that others will confirm their guilt feelings. This is not a case where one necessarily wishes to be correct. While there is a need to be heard and understood, revealing even admittedly delusional guilty feelings is a very vulnerable confession.

While this is typically understood through the realm and context of therapy, there is still a need to engage and unburden guilt in interacting with others in one's social milieu. Buber writes that "The doctor who confronts the effects on the guilty [individual] of an existential guilt must proceed in all seriousness from the situation in which the act of guilt has taken place … The doctor who confronts such a guilt in the living memory of [their] patient must enter into that situation; [one] must lay [one's] hand in the wound of

the order and learn…" (Buber 1965 p. 127). Even metaphorically in "laying one's hand in the wound", depressed individuals need a comforting person to help. Similarly, Irvin Yalom writes that "The therapist must help the patient distinguish between real guilt … and existential guilt. Existential guilt is more than a dysphoric affect state, a symptom to be worked through and eliminated; the therapist should regard it as a call from within which, if heeded can function as a guide to personal fulfillment" (Yalom, 1980, p. 285). Feelings of guilt need not only to be heard, but to be challenged by others. Where the guilt is often excessive or delusional for depressed individuals, it often requires a helpful, friendly, but firm guide to help the individual engage with their guilt feelings. While both Buber and Yalom are more specifically writing about the role of the therapist, dealing with guilt authentically requires more than just a professional to listen.

As much as the person enduring existential guilt must speak out to unburden oneself, they need to be heard. This requires finding the right people who are able to put in the emotional work, which is all the more defeated by the depressive feelings of guilt and worthlessness in general. These feelings need to be taken seriously and not just simply taken as merely irrational; one needs to unburden and discuss their responsibility openly in a back and forth dialogue in order to not only feel better, but give a better account of our connective ties.

CHAPTER 3

PSYCHIATRIC DIAGNOSIS, BAD FAITH, AND DEFLECTING RESPONSIBILITY

The diagnostic Scylla is reductionism, the Charybdis, confusion and ambiguity.

– John Z Sadler, *Values and Psychiatric Diagnosis* (2005, p. 425).

In a modern fable, a scorpion asks to ride upon a frog's back to cross a large river.[1] Knowing the danger of scorpion stingers, the frog is hesitant and asks what assurances the scorpion can give that it won't sting the frog during the journey. "I would die too," the scorpion says. The frog agrees, but as they are midway across the river the scorpion stings the frog, condemning both to death. As its body seizes up from toxin, the frog asks "why?" and the scorpion merely replies "it is my nature" as they both sink to their doom. This fable presents an ill-fated determinism to behavior, that despite one's best stated intentions, one can still feel compelled or incontinent to self-destruct in the face of danger. The scorpion blames its instincts and believes it could not have done otherwise.

Oftentimes, there is a self-perception of defeatism and determinism within mood disorders that is informed not only by the conditions themselves, but by social pressures and diagnostic classification and description. The frog may end up tentatively trusting the scorpion, but the frog still points out its bias and prejudice, which already puts the two in a strained relationship. Engaging with the explicit stereotype that scorpions sting, the

[1] The origin of this parable is rather puzzling. Despite reading like one of Aesop's fables, it seems that the very first recorded instance of it may be in the 1954 script for Orson Welles' 1955 film *Confidential Report* (Livraghi, 2007).

scorpion's self-conception of freedom is limited to whether it will doom them both; the choice presents itself from an outside influence as if there is only the dilemma between being like one's nature in choosing death or going against this nature and surviving. Much like the scorpion, many individuals with mood disorders feel that they cannot be otherwise than the way that they are or that their freedom has been compromised by their condition or what others expect of them. But further, for many there is often a sense of resentment of being reduced to a stereotype, or alternatively relishing in the stereotype as a way to deflect blame and criticism or being able to *identify* with it.[2]

Psychiatric diagnosis often reinforces a sense of defeatism. In a stigmatizing society that limits our understanding of mental disorder to a negative aspect of one's identity, it is difficult to accept oneself when diagnosed. With these sorts of limiting pressures, those with mood disorders find themselves at a loss when it comes to understanding their own sense of freedom and autonomy within a stigmatizing social world. A psychiatric diagnosis presents a perspective shift in one's own self-understanding of their responsibility for their actions. Adrift in terms of how to feel and act "naturally" in a prejudiced society, individuals with mood disorders navigate this world feeling different and alienated from those whose emotions are not as hard to bear or process – often engaging within the same sorts of self-destructive or misery-inducing patterns.

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[22] Blame, for our purposes, is a reactive attitude that is an *attempt* at holding an individual accountable for their actions, but instead comes with it a range of negative reactions such as shaming, anger, resentment, and hate. Blame in itself is not productive morally according to philosopher Hanna Pickard (2013) because it more typically undermines accountability due to making the individual who is blamed feel either worse or disengage from criticism. It is understandable that people shirk blame, as the negative attention can worsen their feelings.

Those experiencing depression or anxiety disorders end up within a bind, facing social expectations regarding non-disordered behavior as well as their own behavior and feelings that could be explained by diagnosis. There are social expectations regarding emotional life, that is, a general pressure to feel and act in reaction to everyday events. We encounter pressure to feel happy with success, sad with loss, etc. There are additionally pressures to feel and react in an "appropriate" degree. These pressures as a result socially exclude mood disorders, leading to claims or assumptions that those who experience "inappropriate" moods disconnected from their experience of the world are irrational or less than those who do conform to expectations. Those with mood disorders experience not only the social expectation and pressures to conform with what are "typical" reactions to everyday life events, but also face the further stigma of what society expects and understands of those who have disordered moods. One thus experiences disorder doubly: both within the experience itself and the recognition that it does not adhere to social expectations.

Where freedom and determinism have long been contested in philosophical literature, there is a value to putting this debate within the context of mood disorder as disorder's very existence affects the individual's perception of their freedom, responsibility, and accountability for their actions. That is, emotional experience can change one's *feeling* of being free. Whether or not one's actual free will is diminished, the feeling of determinism is what often exists as an inhibition on their actions. For many who suffer from depressive disorders, there is a sense that one's freedom has been compromised and all their options seem equally doomed or joyless. While one may feel that one's freedom is limited or changes with one's moods, it is unclear that one

necessarily loses their freedoms at the same time as feeling as if one has. While one may feel more or less compelled to do something due to their emotional experience, it does not follow that their freedom has in itself diminished, rather only their own self-confidence in their freedom has. Matthew Ratcliffe writes:

> …people with depression not only decline to act; they say that action seems impossible. Realizing that one will not get any satisfaction from an action is not the same as regarding it as beyond one's abilities. Furthermore, it is plausible to maintain that motivation and anticipated satisfaction often come apart in the course of everyday life. (Ratcliffe, 2015, p. 156).

Depression's effect on one's feeling of freedom is such that action seems not simply "impossible" but that it is not worth doing. Deep sadness can prevent individuals from feeling like anything is worth doing, and anhedonia can prevent any satisfaction from completing tasks, even those that normally are pleasurable. Where there are debates and discussions regarding how much depression may diminish autonomy (Ratcliffe, 2015; 2013; Radoilska, 2013), I am more concerned not with the disorder in itself diminishing autonomy but rather instead how one's encounter with diagnosis changes their *perception* of their autonomy. That is, when faced with diagnosis as a *type* or trope, one may feel as though one either has to conform or rebel against these sorts of social patterns.

Within this chapter, I work mostly from Jean-Paul Sartre's (1943/1956) position that one is "condemned to freedom" where one cannot choose one's situation within the world – yet still one must make choices in reaction to their situations. This sort of condemnation is a common theme within the experience of depression and anxiety, where one feels trapped to having to make choices while additionally feeling inadequate and unworthy. This chapter discusses how an individual with mood disorder's experience

of their own freedom and autonomy is affected by social expectations and stereotypes regarding mental disorder. I will argue that stigma and stereotypes regarding mood disorders shape and limit the sense of freedom of those afflicted by them. Diagnostic categories, as categories can appear to the patient as a limiting sense of who they are and can be as individuals. Lists of symptoms can feel as though they are "destiny" to the individual, an inescapable natural force rather than patterns that are recognized for the sake of diagnosis and treatment. Faced with limited representations and stigmatizing social attitudes, those with mood disorders find themselves conforming to the expectations of others or constantly at odds with them oftentimes through a diagnostic lens.

Anyone questioning their mental health finds oneself facing stigmatizing tropes. Mental disorder is seen as something that is universally bad, and even the more common conditions of anxiety and depression disorders carry a difficult harmful stigma that undermines one's ability to feel comfortable with their condition. Stigma then provides a trap that cannot easily be escaped; individuals often feel that they must hide their actual feelings or else they feel they are merely reducible to one role or another. To a large extent, the experience of diagnosis is to enter into the categories and rules of others; one suddenly understands one's life not on one's own terms but the way that an expert authority does. One can feel as though the diagnosis is damning, much like how Sartre claims that anti-Semitic stereotypes ensnare Jewish people to feel as though they must either conform or rebel (Sartre, 1946/1965). Where Sartre believes that bigots impose oppressive social roles upon marginalized individuals to ensnare them, many of those who are critical of psychiatry believe that diagnosis does the same thing; setting rules and

limits upon others in ways that prevent them from meaningfully engaging with their lives but instead gives them a dilemma between conforming to order or defying it. I believe, like Sartre, that this is a false dilemma that leads an individual to act inauthentically.

In this chapter, I identify two different opposing poles in reacting to one's diagnosis: denialism and indulgence. Denialism is pretending that one is not suffering, often leading to more suffering and eventual self-destruction for the short-term benefit of appearing fine and "normal" in front of others. This suppression of oneself comes often from a misplaced emphasis on responsibility and autonomy. To insist against seeking help, to insist constantly against feeling anguished or unwell can often be rooted in a sense of not wanting to take away resources and attention may be more necessary for others. "I'm fine," "don't worry about me," and other similar phrases and behaviors are put up as a front for fear of being pitied. Indulgence – the other side of this false dilemma – is where one instead embraces the "mad" role and eschews all sense of responsibility to say that one is given an excuse or a free pass for their behavior.

Both of these attitudes are forms of *bad faith* – lying to oneself to escape one's responsibility or freedom (Sartre, 1943/1956; 1946/1965). These two bad faith attitudes towards psychiatric diagnosis are ways in which one inauthentically slips into either blaming oneself too much for one's situation or reprieving oneself from their actions altogether. There are many ways to engage with one's mood disorder, but a very alluring attitude is to take it up as a set of rules for oneself in what the existentialists call "seriousness". Seriousness is taking everything as a methodical, rule-oriented existence. The assumption within seriousness is that there are rules that make sense for the world outside of us. While these rules are put up often in arbitrary ways without objective

grounding, seriousness is the attitude in which one takes the world as essentialist. Seriousness in response to psychiatric diagnosis is an indulgence in one's condition as a limitation for who they can be.

An alternative to indulgence or denialism is to be open and honest about one's moods and condition and find oneself constantly navigating these stigmatizing roles regardless. This is a call for authenticity, which even outside of mood disorder is a difficult state of being. To be authentic regarding one's diagnosis requires that a person actively engages with the ambiguity between being free yet unable to choose the situation of their freedom. This would require not only a recognition of the stereotypes regarding one's condition and resistance, but also a recognition that one may easily slip into stereotypical behaviors despite that resistance. One may fall and fail from their own perspective in combatting these experiences, however so long as one's life still continues, one has new chances to create and build themselves anew. This avenue is especially hard in that it doesn't have much guidance in the initial moment of diagnosis. Typically, learning to live with one's condition (or more generally with oneself) is a generative, dynamic, and continual process; oftentimes within the context of mental disorder this is aided by talk therapy, which is inaccessible to the poor. Individuals diagnosed with mood disorders often feel as though they have to go it alone; the isolation and alienation that they feel inherent within these conditions are compounded by a rather typical inability to connect with others in sustained or stable relationships. Disorder can often complicate one's relationship with others and oneself in such dynamic ways that are not readily explained by diagnosis. This chapter employs both work from existentialist thinkers as well as the philosopher and therapist Hanna Pickard. This sort of path, a virtue between

extremes perhaps, would take responsibility for the ambiguity of one's feelings and experiences and understands that while one is not reducible simply to one's diagnosis or type, diagnosis can provide a helpful narrative understanding of their own human condition. To paraphrase Simone de Beauvoir: diagnosis is not destiny (Beauvoir, 1949/2011, p. 283) – yet diagnosis can ideally provide a set of possibilities for one to expect and cope with while living their everyday lives.

Bad Faith and the Roles We Play

Bad faith (*mauvaise foi*) is an existentialist concept initially introduced by Jean-Paul Sartre. His primary account appears within *Being and Nothingness,* although early elements of the theory additionally factor in his previous works. In brief, bad faith is when an individual deceives oneself regarding the extent of their freedom in social roles. Sartre envisions bad faith as the way in which one deflects their responsibility for their actions. This deflection appears in the form of relying on social expectations for guidance and playing that role. Sartre's famous example is that of a waiter; in working as a waiter one *plays the role* of a waiter. One conforms to the expectations based on how other waiters act, snapping to attention of one's patrons with a courteous smile. In doing so, one's sense of individuality wipes away and one pretends that their actions are not theirs but belonging to the role. They pretend at playing the role expected of them, and as a result feel less responsible for their actions but claim that they were "only following orders" or whatever preestablished social scripts were expected of them. To a large extent we do need these sorts of roles, and it seems rather inescapable to follow what one perceives are the rules or the archetype to model in being one particular thing or another,

but nevertheless playing a role is not a full dissociation from oneself. One is still oneself even when playacting.

Bad faith is a state of consciousness in which one lies to themselves about their very conditions of freedom. For existentialists such as Sartre and Beauvoir, human beings exist as both beings who are simultaneously radically free, yet unable to have chosen the context for that freedom. This is a life in between transcendence and facticity. In brief, facticity (sometimes referred to as immanence) is conceptualized by existentialists as the "in-itself" of one's existence. Facticity includes the conditions under which one exists, be it their physical body, their mortality, the place and time that one was born as well as even social constructs such as class, gender, race, or sexuality.[3] One cannot easily choose one's facticity, but it shapes the way in which one views and experiences the world. Transcendence is the "for-itself" of one's existence, that is the projects that one takes up as an individual. We experience our transcendence through experiencing the world and being self-aware. Here it is important to note that there is no transcendence without being entrenched within facticity. There is no free agent that is not at the same time embodied and situated within certain factical limitations. Human beings exist not merely as either mortal bodies or free agents but both at the same time. We are finite beings who are "condemned" to freedom in existing and relating to one another.

In order to live an authentic life, one must actively maintain a balance between transcendence and facticity. To a certain extent, one can talk of facticity along the lines of

[3] While some of these identity features are social constructs rather than natural kinds, there is still a factical reality to them in the way that they are projects that one can be seen, interpreted, and understood by others. While one may project a different identity and even *authentically* identify as something other than how they appear there is still the facticity of how they are interpreted and seen by others.

being “brute facts” about one’s existence – things that just are the way that they are or that everyday saying: “it is what it is”. The fact that human beings are both transcendence at the same time as facticity is the problem that sparks bad faith. Despite being free, there are elements about our lives that we cannot control. Bad faith comes from the interplay between these two aspects of being human. The bridge between transcendence and facticity is what Simone de Beauvoir calls ambiguity (Beauvior, 1947/1948). We are ambiguous in the sense that we are not any one thing, but dynamic and changing subjects amongst objects. Beauvoir argues that the project of ethics often tries to escape or eliminate this ambiguity “by making oneself pure inwardness or pure externality, by escaping from the sensible world or being engulfed in it, by yielding to eternity or enclosing oneself in the pure moment” (Beauvior, 1947/1948, p. 6). Her claim here is that ethical theories often try to reduce human agents either to their transcendence (inwardness) or their facticity (externality). Ethical theories then often fail to get the full breadth of what it is to be human, trying to either say that agents are purely free and without limitation or that they are determined by external forces and factors. These can both be modes of bad faith in the sense that a purely inward model of freedom imagines that there are no obligations or constraints upon the human subject but the determinism of being solely external alienates the sense of choice and radical freedom that people do have. The existentialist ethical project is one that acknowledges and adjusts to this ambiguity throughout.

For Sartre, the *bad* in bad faith is that this deflection to social expectation is lying to oneself over the conditions of one’s freedom. One’s self-perception and awareness are wrapped up not in a “transparent” understanding of one’s conditions of freedom but

rather that they see themselves only in regards to what they perceive is expected of them socially. Sartre writes that for the individual in bad faith:

> Their condition is wholly one of ceremony. The public demands of them that they realize it as a ceremony; there is the dance of the grocer, of the tailor, of the auctioneer, by which they endeavor to persuade their clientele that they are nothing but a grocer, an auctioneer, a tailor. A grocer who dreams is offensive to the buyer, because such a grocer is not wholly a grocer. Society demands that he limit himself to his function as a grocer, just as the soldier at attention makes himself into a soldier-thing … There are indeed many precautions to imprison a man in what he is, as if we lived in perpetual fear that he might escape from it, that he might break away and suddenly elude his condition. (Sartre, 1943/1956, p. 102).

Sartre is here concerned with the extent to which individuals 'imprison' themselves to a particular role based on social expectations. Others guide, shape, and limit one's roles within society by way of presenting certain stereotypes and expectations. Not all of these expectations are harmful to the individual, but they still present a precedent for the individual to follow. Individuals take on these roles in different ways in order to engage in various occupations and social positions. There is a role we expect people to play, and in turn, many people play up those roles as a result. However, these roles and expectations present as a way of being in bad faith at points in which the individual feels forced to comply with them or live in relation with them in some way. Bad faith is the point at which one denies one's responsibility for one's choices or the limitations and determinations of one's freedom as a way of self-deception.

Predating and perhaps inspiring Sartre's account, Karl Jaspers (1959/1963) argues that psychiatric patients themselves go through a sort of performance in interacting with other individuals. Jaspers writes:

> If we conceive psychic life in terms of its *performances* and the individual as the sum of his performance-capacities we find ourselves restricted by

> the fact that the context of performance is affected by something which disturbs the regularity of the performance and renders it less calculable. Apart from a few performance-tests that are purely physiological (belonging to the psychology of perception, fatiguability and memory) almost all performances take on the shape of culturally conditioned events. (Jaspers, 1959/1963, p. 753).

While Jaspers here is writing on the other side as a physician engaging with the patient's behavior and determining what is clinically relevant, he understands that these patients are behaving in ways that are mired in cultural backgrounds and expectations. These are still "performances" to a certain extent here for Jaspers in the sense that the way that patients act in the clinical setting is not fully authentic (unless some trust or rapport is established) and that the patients do perform for others. Jaspers is additionally cognizant that this performance is not unique to patients, but that all individuals to a large extent perform their behavior in conforming to their social milieu.

Mental disorder itself is not something that can be chosen as a transcendent project, and for our purposes is a part of one's factical determination within the world that shapes their transcendence. Disorder often limits one's ability to do things to some extent but is also a significant factor that can be a part of one's personality, disposition, and other aspects of one's identity. Emotional experience as part of mood disorder is not something that can be controlled but must be addressed instead as something that one is still responsible for in terms of their reaction or attitude towards disorder.[4]

[4] However, there is a tension within the work of Sartre regarding the status of emotional states. Within his 1939 text *The Emotions: An Outline of a Theory*, Sartre discusses emotional experience as a "magical transformation of the world", in such a way that suggests that this magic is a form of bad faith. He writes that sadness is an *avoidance* of responsibility, writing that "[t]he emotional crisis [of sadness] … is an abandonment of responsibility, by means of a magical exaggeration of the difficulty of the world" (1939/1962, 70). This seems rather unfair of course to the individual experiencing a depressive episode. The experience of sadness is not directly an abandonment of responsibility but often appears as an uncontrollable perspectival change in evaluation of one's experience. Yet within this same book, Sartre seems to make a distinction between the active emotions that he sees as being these sorts of escapes and

Bad faith in and of itself is an understandable position to be in; it is *alluring* to be in bad faith and frankly it is hard to blame individuals for these positions when it is so much easier. Being in bad faith is an easier position to be in than trying to forge one's own path. The position of bad faith is one of trying to escape how *awful* it can be to keep making choices and being responsible for oneself – especially for those who live with anxiety and depression, as I discuss in the first chapter. When it comes to depression, bad faith is all the more alluring due to its stigma as well as the condition's own internal experience of making one feel inadequate. Bad faith often is the faith in something external to the individual that rules over their sense of autonomy or denying the conditions of one's freedom – both are highly tempting for depression and anxiety.

Much of the problem of bad faith in depression and anxiety has everything to do with the question of identity. Mental disorders do take up a constitutive part of one's identity, but the conception of madness-as-identity is a factor that does not fully track along the same lines of social identity as other more "visible" factors such as race, gender, sexuality, etc. There are many attempts at establishing madness-as-identity within the mad pride or mad studies political movements, but they often lose momentum or are

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passive emotions which seem to be uncontrollable yet still the basis of one's experience. The passive emotions in this account appear to be more like moods, the underlying emotional backdrop or milieu that an individual dwells within. Sartre is not explicit in discussing the role of these passive emotions, yet his later work puts a lot of stock into anguish/anxiety and dread as moral feelings that guide individuals into making responsible choices (1943/1956). He writes later on in the essay "Existentialism: A Clarification" that "anguish, far from being an obstacle to action, is the very condition for it, and is identical with the sense of that crushing responsibility of all before all which is the source of both our torment and our grandeur" (2013, 89) and that "despair is inseparable from will" (90). Clearly emotional life is not merely chosen or in bad faith if one's despair and anxiety are intertwined with one's will, but rather Sartre's *Emotions* appears to only be attacking a small subset of emotional life where one escapes from difficult problems either in despairing defeatism or willful ignorance.

not taken as seriously as other identity politics claims.[5] One defeating factor is that mental illness itself is not a community, but affects people from all sorts of different walks of life, not to mention that the experience of mental illness is often alienating and full of shame. Yet there are identity-like aspects to mental disorder that envelope individuals in the sense that they affect one's motivations, abilities, and social standing. There is something about depression that becomes an individual, in that an individual can identify as being a depressed person as if it is a characteristic of their personality.[6]

Disorder and Diagnosis

The word diagnosis itself comes from the Greek *diagignōskein*, to distinguish or discern, conjoining *dia* (apart) and *gignōskein* (to know). As a result, the initial move of diagnosis is not only to figure out the underlying pathology affecting an individual, but also to discern and set them apart from other individuals. A diagnosis separates an individual from others in pointing to difference, but also can unite one with others in the sense of who one is compared to those who have the same diagnosis. To have a diagnosis when it comes to a psychiatric condition is to show that one's experience is in some ways similar to that of particular others. Psychiatrist John Sadler writes:

> Diagnostic characterization involves a movement away from viewing an individual's illness as an exemplar of a general phenomenon that has been experienced by other individuals and, in this sense, shares features with those of other individuals. The diagnostic name (e.g., 'major depression') is the signifier of this shared, general phenomenon of illness experience. (Sadler, 2005, pp. 419-420).

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[5] In depth philosophical discussions of Mad Pride movements can be found in Rashed (2019), Bracken and Thomas (2013, 2005), and Potter (2016).

[6] Further, it could very well be in bad faith to identify with depression enough that one goes so far as to write a dissertation on it, or at least that writing a dissertation is something that becomes vocational – one's project often consumes them.

Diagnosis projects and creates groupings for an individual to contextualize oneself within and can provide a sense of meaning and place for them. Diagnosis presents a set of values to the individual who receives it. For the most part, psychiatric diagnosis presents a *negative* value – an objectifying, hard-medicalizing lens that sees aspects of one's consciousness, personality or ability to function as *bad* things to have, things to avoid.

Disorder in itself is a tricky concept as there are few coherent grouping attributes across all forms of disorder.[7] Whatever disorder is and however it manifests, it appears to be something outside of normality. Yet it's seemingly impossible to draw the lines outright as to what is or is not disordered behavior outside of a sorites paradox. When it comes to mood disorders, the main line in the sand heap is whether or not emotions are "excessive" or "delusional" when it comes to their reactions to the world outside of oneself. What all mental disorders share in general is either the distress or disability in their lives. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) tries as best as it can to define disorders in an objective and inclusive lens. The DSM-5's general definition of mental disorder is as follows, with the understanding that it cannot capture the full meaning of disorder but only tries for as best as possible:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (American Psychiatric Association, 2013, p. 20).

[7] What a disorder is or is not is not as a category is an interesting question but is not necessary for this discussion. This problem has been conceptualized rather well by other thinkers already (Cooper, 2007; Bolton, 2008; Murphy, 2006).

The World Health Organization's (WHO) International Classification for Diseases (now in its 11th iteration as the ICD-11) additionally defines mental, behavioral and neurodevelopmental in a very similar fashion, stating that they are:

> syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning. (World Health Organization, 2018).

What is more important here for this chapter's discussion in both definitions is the claim that the disturbances within disorder affect "personal, family, social, educational, occupational, or other important areas of functioning" as a "natural" aspect of disorder. While disorder itself undermines many aspects of an individual's functioning within day to day life, the individual's understanding of disorder as such also can play a role in dysfunction and distress.

No matter the root of them, whether 'natural kinds' or constructions, diagnostic categories *create* social categories. This is shown in Ian Hacking's *The Social Construction of What* (1999) in his discussion of 'looping effects'. Diagnoses according to Hacking are social constructions at the very least in the sense that they are socially-valued categories as observed by psychiatrists. Psychiatric diagnosis, whether it identifies something "real" or "objectively" rooted in the individual or not, still provides a social grouping for the individual. Hacking describes these looping effects in terms of biolooping and classificatory looping. The former is when social processes lead to physiological changes as a form of biofeedback, like how behavioral therapy can improve the serotonin levels for an individual diagnosed and suffering from depression (1999, p.

110). Meanwhile, classificatory looping is the sort of looping social effects and patterns that arise from merely drawing a classifying distinction between groups. Those put in groups, whether that group has a psychophysiological root or not, end up identifying with one another just by virtue of being grouped. Hacking notes that both forms of looping effects are often at play within the existence and classification of mental disorders, and that these effects shape the way that individuals act and react to diagnosis. As a result, some mental disorders are "interactive kinds" that is, while they may have a psychophysiological cause, they additionally may have certain features that are shaped by social forces on top of that root.

Ian Hacking's account of looping effects shows that social constructs have force. Whether or not diagnoses and classifications of mental disorders "carve nature at the joints", self-knowledge about one's condition can lead to more interpersonal problems than the condition itself would bring alone. This can both be conscious, where individuals indulge and seek excuses from their diagnosis, as well as unintentional, where one may try to resist the trope or stereotype set up against them but in that struggle end up further distressed. Irrelevant to whether or not a disorder is a natural kind, it still has an effect in the individual's relationship to themself.

The trouble of diagnosis is that it projects external and objectifying values upon the individual. Where psychiatry in itself is still unable to answer what disorder is definitively and what it means, there are many values that are already implied in the very existence of diagnoses. The current state of psychiatry is a continuous debate of the role of medicalization and technology, where an enthusiasm for either often disenfranchises patients (Charland, 2013; Phillips, 2013). There is a danger in medicalization as it

undermines patient autonomy and dignity. Further, medicalization carries with it a sense of reducing the patient down to their condition itself. To see an individual just as a medicalized subject is to see them as just their disorder – to reduce them and their behavior simply as some negative aspect that should be excised, whether we have the means to or not.

This reduction can additionally be a form of bad faith. Sarah Richmond (2010) notes that Sartre's accounts of illness and suffering "focuses exclusively on the bad-faith variant" and that "The most pressing question to consider is whether Sartre's view can accommodate the possibility of (something like) illness in good faith" (Richmond, 2010, p. 529). For Sartre, illness as one's body in pain or suffering is taken as a physical object from the point of view of the doctor. The experience of visiting a doctor (or in our case, a psychiatrist) is one of taking oneself into the perspective of others, an objectifying view of oneself no longer as a subject but an object for others. This is what Sartre sees as an "object-ness" that an individual then internalizes when understanding oneself as being seen by others (Sartre, 1943/1956, p. 340). One's subjectivity is reduced to being other, something opaque and no longer experienced just as interiority, but as something external for the other and carried within one's sense of shame.

Shame is a large theme for Sartre, since being seen by others often implies a sense of vulnerability and exposure (Sartre, 1943/1956, p. 347). For Sartre, it is as if any encounter with the other automatically and necessarily creates shame and self-realization: "I exist as *myself* for my unreflective consciousness. It is the irruption of the self which has been most often described: I see *myself* because *somebody* sees me—as it is usually expressed" (Sartre, 1943/1956, p. 349). When the other approaches the subject in Sartre's

work, their very look interrogates and objectifies the subject immediately. It is as if the encounter of the other is the first instance in which a subject discovers their ambiguity of also being an object in the world. This reduction to object is perceived as a threat and makes the Sartrean subject feel naked and exposed in shame. Only through a seemingly tumultuous and invasive encounter of being *seen* does the subject become aware of oneself. Sartre continues: "it is the *recognition* of the fact that I *am* indeed that object which the Other is looking at and judging. I can be ashamed only as my freedom escapes me in order to become a *given* object" (350). The look of the other acts as if a limit on the individual's freedom. Through the immediate shame of being-seen, a person sees oneself as if from the outside, as an object among objects alone. One becomes brutally aware of one's body in space when encountered by the other's gaze.

The Moment of Diagnosis

Being diagnosed can be a transformative experience for the patient. The psychiatrist is an expert in disorder and approaches the patient typically in an objectifying stance. For the purpose of diagnosis, the psychiatrist reduces the patient's experience down to 'symptom criteria'. Further the psychiatrist tries to assess whether the patient is telling the truth of their experience as well as whether that experience is delusional.[8] While the relationship between doctor and patient should ideally be based in trust, there are many psychiatric encounters such institutionalization (either voluntary or not) that put

[8] Psychiatric notes and forms are relatively careful in assessing patient statements in an odd way that appears as if patients cannot be trusted in their testimony. When it comes to assessment forms for particular diagnostic criteria, patients are asked yes or no questions regarding a slew of important symptoms including motivation, sleep issues, and suicidal thoughts or ideation. Yet on these forms the possible answers are either "Yes" or "Denies". There are many reasons for a patient to resist telling the truth in these cases, but in the framing of these forms and doctor's notes, there is little room for trusting the patient when they report that they do not experience any of these possible symptoms.

strain on the capacity for trust. While there are typical standards and ethics for psychiatrists to follow at different legal, cultural, and professional levels, each practitioner enters into their treatment relationship with patients in their own way just as each patient is highly individualized in their treatment and diagnostic needs. Diagnosis through the DSM-5 (and its previous iterations) is an attempt at flattening out the idiosyncratic differences from patient to patient under a more standardizing, "objective" lens. Psychologist Gary Greenberg writes:

> The diagnostician's job is to find the disease that unites the scattered symptoms and makes them manifest in precisely the way they do, to say with certainty that this distress is the result of that illness and no other. The diagnostic enterprise hinges on an optimistic notion: that disease is part of a natural world that only awaits our understanding. But even if this is true, nature gives up its secrets grudgingly, and our finite senses are in some ways ill suited to extracting them. More important, our prejudices lead us to tear nature where we want it to break. (Greenberg, 2013, p. 11).

The mental health practitioner's hope in diagnosing the patient is to find a simpler description of their experience. The individual's subjectivity is taken as if an object to be deconstructed or dissected for psychiatrically-relevant pieces of information. Psychiatry takes subjective experience as an object for study, which reduces the individual's personal experiences as a merely something for the sake of study, observation, and quantification. This can feel invasive or as if one's very personal experiences are then something distant and detached, viewed under glass; it can be jarring to have one's entire life reduced to a label for study.

What the moment of diagnosis does, presuming accuracy, is that it reveals new information to individuals about themselves. This news may be welcome or unwelcome, but the more direct factor is that it reveals information about one's facticity. The individual then is given a new perspective on who they are and what to expect about their

self. Diagnosis is a perspectival shift regarding one's capacity to be free and their determinant nature as an agent. While an individual does not presumably change as an individual from before to after diagnosis, their attitude towards themselves can change, even radically. Knowing a new truth about oneself and one's condition is a perspectival shift, and that new perspective is something that one must then react to in terms of engaging with the world. Where the Delphic motto of "know thyself" is an important moral command, there is little guidance about what one should do after that step. There are a variety of ways that one can react to knowing oneself. One can deny the effect that diagnosis has over one's life and choices, or buy into it completely and claim no freedom over their condition, or some combination between. It can be hard to tell what one should do with diagnosis in regarding oneself and evaluating one's behaviors, compulsory or not.

Diagnosis can give the individual a sense of understanding regarding their suffering. But at the same time, the diagnosis shapes and limits their experience in a form of leveling where their experience is no longer some dynamic, personal everyday-lived-and-fought-over life, but a condition out of some book. Sadler writes:

> Diagnostic characterization implies a reduction of a more complex entity into a simpler one. This facet of diagnostic action suggests that the value of simplicity is at work; characterizations are 'good' in that they simplify the phenomenon – make a complex entity into something apprehensible and manageable. A fundamental way in which this simplification or reducing process occurs is through naming the phenomena; another is collecting a range of phenomena and giving them a suitable collective name, which is when a characterization starts to resemble a 'syndrome,' 'ideal type,' 'dimension,' or 'diagnostic category' more explicitly. (Sadler, 2005, p. 423).

Diagnosis is an attempt at simplifying life. There is a lot of reduction here that brings a life into focus as something that is flat and medical. The life of an individual is brought

down to the level of diagnostic codes, possible medical, pharmacological, and talk therapy treatments. This reduction should not yet often is confused for a totalizing explanation of who the individual is and what one's limitations are.

While some more readily buy into their psychiatric diagnosis, there is still a sense of estrangement when it comes to mental disorder as opposed to bodily disorder. If one is one's mind, and a diagnosis is a medicalized and objectifying way of looking at that mind, then the individual faces an identity crisis in learning about oneself. However with the idea that one is transcendent from one's body, there is a certain attitude that one can take towards bodily illness that translates a little more easily than mental disorder does. Jaspers discusses how when it comes to somatic illness, individuals take up a certain role or attitude towards their illness. He writes:

> the individual *feels himself* to be ill, *knows or wants to know* his illness and *adopts an attitude* to his illness. It is true that, speaking broadly, the feeling that one is ill coincides by and large with some objective somatic finding. That the patient then adopts an attitude, jumps from a perception of what he has thought to be an unimportant complaint to a judgment that 'he is ill' and that this either relates to a local deficiency in an otherwise healthy individual or expresses an awareness that the whole individual is sick—all are important facts for the patient's life-history but only of incidental importance for the somatic disorder … it is only with the help of the doctor's judgment that he can reach any medical insight; or there are feelings of illness without any objective finding when people come to the doctor and feel themselves to be seriously ill but the doctor finds nothing, calls them 'nervy' and [dispatches] them to the psychiatrist. (Jaspers, 1959/1963, pp. 782-3).

Because of more dualistic attitudes towards one's body, for some it is easier to digest when an individual is diagnosed with a physical condition than with a mental condition. One denies one's body's identity as oneself to a certain extent. While one needs a certain amount of trust in a doctor to take care of one's body, it is a harder process to take up an attitude about the very being that has attitudes, that is, oneself as a dynamic person and

individual. Where one believes that one's personality and mind are oneself, it is harder to take a diagnostic or therapeutic attitude towards one's own behavior or actions.

The trouble then becomes what the patient decides to do with this new information about themselves. The psychiatrist may suggest a course of treatment, either through medication or talk therapy or some combination, taking up new activities, and so on; yet what ends up happening otherwise is that the individual patient additionally exists as an individual outside of that clinical encounter, a full person. The patient is not simply a patient but is a free individual out in the world, left to their own devices as a free agent.[9] In trying to determine what they should do regarding their diagnosis in application to their life, the individual faces a large, overwhelming force of public opinion, both scientifically-informed and not. Some advice may be helpful to the individual looking for guidance, but much of it will not be. It is up to the individual to decide for themself in the face of these often-conflicting opinionated cultural beliefs regarding mental disorder and health.

There is a pressure for the patient to see themselves only in relation to their disorder, that there is a reducibility down to being their diagnosis and understanding oneself only in relation to the world of tests, diagnostic criteria, and comorbidities. In diagnostic view of the other, one's existence becomes concrete and resolute. Only in later denial can one claim that one is otherwise than themselves. Again, diagnosis can trigger a feeling of shame in being known and categorized by others. The diagnosis may provide for a moment of shame and vulnerability for the patient. Sartre comments that the feeling

[9] Except in cases where the individual is then housed in an in-patient facility or a prison where behavior and time is regulated, but on the condition of release the individual then has to figure out how to readjust to the outside world.

of the shame is the feeling that "I am no longer master of the situation" (355). A diagnosis can be transformative in the sense that one no longer accounts for oneself as a fully free being, but sees oneself (in bad faith) being stripped of one's autonomy and being just merely a "type" of person that is seen and judged by another in a psychiatric context.

Being "no longer master of the situation" here is the sense in which one faces a possible surrender of their autonomy. There is a sense in which going to a psychiatrist is a moment of vulnerability because it betrays one's innermost thoughts and feelings to a relative stranger. The visit is more often than not anxiety-inducing in itself.[10] Psychiatrist Linda Gask, in writing on her own experience as a patient, states:

> when I feel as though I am losing control over my life, despair soon sets in. That sense of being in charge is important to me. Yet I also know that this need to retain control can prevent a person from seeking assistance when they really need I, as accepting help can also be seen as relinquishing power over one's own life, of giving in and losing personal freedom, which can feel very frightening indeed. (Gask, 2015, p. 28).

Gask here highlights a common theme in coming to a professional for help; it is relying on an expert to pass judgment or advice. There is the possibility that one does not feel fully whole or in control of their lives again when they visit a mental health professional. As a result, there are often points in which one feels that trusting a professional is a difficult relationship to build for oneself. Gask writes further that "When you are on the receiving end of a psychiatrist's questions, you find yourself subtly judging how much to give and what to leave out" (Gask, 2015, p. 11). While one goes to the psychiatrist for the

[10] There is a sense in which any doctor visit can be this moment of vulnerability – but I feel that it is even more so for psychiatric visits, once again because the object of study and treatment is the very interiority of the individual rather than the body. With our notions of mind-body dualism, examining one's mind is something even more private and can be perceived as though one's very identity is at stake.

sake of seeking help, for some there is a legitimate fear that that treatment may take the form of an invasive hospitalization or other paternalistic measures. Albeit for some, having someone take over their decisions may provide for relief.

Socially, there are several different positive and negative changes that can arise from a diagnosis. Positive ones can include a new perspective of oneself that may be legitimating in knowing more about who one is, a sense of solidarity in not being alone and the possibility of finding "fellow travelers" who have the same condition, and possible ADA protections and accommodations. Alternatively, negative social changes can include a change in legal agency and risk of institutionalization,[11] change in one's understanding of their motivations and abilities, social stigma and testimonial injustice even to the extent of gaslighting from others (even if they are well meaning), and being taken up by sciences/socio-political platforms that are not interested in the individuals' autonomy but other motives. These and other social changes can be big pressures on the individual that affect the way in which they handle receiving their diagnosis.

There are plenty of reasons (or excuses) for one to lapse into a bad faith role regarding one's diagnosis. Once again, the experience of mood disorders often presents one with a rather insecure sense of self, both in terms of agency and moral worth. Thematically, the experiences of depression and anxiety both often engage with a feeling of being lost and in need of guidance, a lack of motivation or being overwhelmed by choices, feelings of worthlessness or insecure inadequacy, etc. Treatment for depression and anxiety is inherently a long process, where one can be understood as being in

[11] If one has not already been institutionalized in the process of their diagnostic encounter.

recovery for the entire scope of one's life. Talk therapies themselves often directly engage with distressing and re-traumatizing material for the patient, often leading to a feeling of regression. Meanwhile, anti-depressants and other medications require a rather long period of adjustment – often switching between different brands or versions of medication in the process of finding a stable medication – if one adjusts or stabilizes at all. Between these longer, often arduous and trying processes of recovery, it becomes easy to succumb to a sense of defeatism that sometimes one's mental health is something that cannot be recovered from or be otherwise than depressed or anxious for life. Granted, depression and anxiety disorders are considered lifelong conditions, but they are also not *static* conditions; mood disorders have the capacity to change along with one taking up different routines and lifestyles where just as much as one's life conditions can inspire brooding dark thoughts or worrying, bettered living conditions can change one's mood as well.

The following sections describe the two poles of bad faith in reacting to one's psychiatric diagnosis: denialism and indulgence. These attitudes are at times hard to tease apart, as sometimes individuals fluctuate between one and the other. I am more looking to these as attitudes rather than hardline types because they can shift almost at any point. But these are each *serious* bad faith rationalizations that escape one's responsibility. The two attitudes can easily be interchangeable for anyone, just as Beauvoir states that any sense of "seriousness" can be interchangeable and arbitrarily chosen. She writes that "In order to justify the contradictory, absurd, and outrageous aspects of this kind of behavior, the serious man readily takes refuge in disputing the serious, but it is the serious of others which he disputes, not his own" (Beauvior, 1947/1948, p. 53). Choosing either end of this

spectrum is arbitrary, and often provides refuge for the individual, just as one can say that "any port in a storm" is safe. To be depressed or anxious is to often feel overwhelmed by choices and to deny or indulge in that storm of feelings can provide an odd sense of comfort and refuge for them. These poles are alluring and "safer" than realizing that one is always responsible for one's actions. But more on that after a breakdown of subtypes of denialism and indulgence.

Denialism

Denialism is a bad faith attitude where one believes that a disorder diagnosis does not apply to themselves for whatever reason. There are many different reasons that individuals may deny their condition. The stigma of mental disorder is a pervasive problem that prevents individuals from wanting to accept conditions at face value, and the ambiguity and uncertainty of disorder makes it more difficult for individuals to engage directly. When I write about denialism, however, I do not want to lump in anosognosia – the symptomatic mental inability to understand oneself as sick. Anosognosia may be a contributing factor in denialism for many individuals, but I do not want to criticize the actions of those who are *unable* to understand themselves as ill.

To deny is to stamp out one's facticity and claim that disorder is just a bad attitude, not a serious condition. Denialism regarding one's condition can take up several different avenues. First, one can claim rather boldly that their diagnosis does not affect their behavior at all, or that it doesn't resemble themselves. This is an outright rejection of expert authority that seeks an alternative method of describing the individual, whether it is that they are dysfunctional or some moral failure when they exhibit symptoms. This also can be a resistance of taking responsibility of oneself in the sense of not learning

about oneself. In denialism, one takes oneself as totally free and that any sense of sadness or anxiety is the fault of the individual for not being strong enough. This denialism is a detriment to the individual altogether as it tries to fault disorder as something *other* or outside of oneself. Since disorder has such a negative stigma, the individual would want to externalize it and claim that they are not ill or disordered like others.

The social experience of mental disorder is rife with comparisons. One can still admit that disorders are something that do exist and still be a denialist when it comes to oneself. That is, one compares oneself to others and says that *others are ill*, but *not* oneself. This sense of denialism is especially toxic and harmful as it divides individuals and prevents the opportunity to find solidarity and connection with others. Denialism ends up estranging an individual not only from diagnostic understanding of themselves but also from others.[12] To claim that one is not affected by depression and anxiety after diagnosis is harmful in that it prevents healing, solidarity within a community, or anything else that would allow for a positive engagement with their condition. Denialism in this form puts others at a distance and often is an attempt at putting on a brave face in stating that one is not like the others. But just because one can find others who experience a worse depression than one's own, does not mean that one is not also depressed. The

[12] There is also a more mundane set of comparisons when one goes to a therapist and sits in the waiting room among other clients. It is hard not to size up the other individuals that are in the waiting room with oneself. Furtively glancing at others and guessing why they have decided to come into therapy as well. Questions come to mind: What are you doing here? Do you have things worse or better? Are you here just for a short-term string of visits for the loss of a loved one? Are you a chronic sufferer or is this just a phase? Are you also sizing me up? Who's crazier? Are you making better progress than I am? Where talk therapy is meant to be a revelation of one's inner, more secretive life, the waiting room can inspire a sense of exposure before others, or even a sense of solidarity that one is not the only one trying to engage with one's life struggles in a meaningful and therapeutic manner.

comparisons between oneself and others can stand in the way of one seeking help, but instead to placate and deflect their feelings.

Denialism also takes up the idea that treating a condition or recognizing depression as depression is to take oneself as morally weak compared to others. The issue here is furthered by the sense that one might "lose their edge" if they accept that the disorder is something to be treated in the person. Where one might see that one's experience of depression and anxiety is a catalyst for their creativity or personality, these feelings often become entwined with one's sense of self-worth as well as self-identity. There's a romanticism around depression disorders where one is brooding, moody, or cranky as being one's very core of a personality. This dourness often becomes typified as a character trait, and so many characters are reduced to their existence as sad, melancholic figures. The fear of medication and treatment is something that suggests that one feels as though one might not be oneself if one were to lessen the intensity of their feelings.

Alternatively, there are more mild forms of denialism – where one will admit that they have a particular condition but on the other hand argue that it can be solved through simplifying "cures" or "fixes" that sidestep psychiatry and are a little more DIY. The industries surrounding alternative medicine, yoga, dietary changes, and other de-medicalizing alternatives provide for (often expensive) flights away from understanding these conditions. This as well includes the idea that simply taking medication (or self-medicating with recreational drugs) is enough to curb the full effects of depression and anxiety without confronting issues of trauma or other life situations that may be causal factors in one's condition. This is still a form of denialism in the sense that one believes

that depression or anxiety is more a question of whether or not one is "in control", that is, that there is some sort of moral failure if one feels depressed rather than seeing it as something that exists without blame or fault. This can be immediately dangerous in many diagnostic instances, as Frantz Fanon notes that "All psychiatrists know that the most difficult patients to treat, that is to say, to maintain at hospital, are those at the beginning of their illness, those who think they can get through it themselves, who have not given up" (Fanon, 2018, p. 497). Denialism in this alternative form's moral failure is the belief that one should always be in control of oneself at all times, that depression or anxiety are vices that can be blamed in the individual themself rather than a situational problem that can strike anyone. When it comes to a hospital setting, this can end up in the form of needless contempt.[13] This sort of denialism feeds into stigma directly, as well as the conditions' own sense of worthlessness and moral inadequacy. If one "fails" their regimen of strong will against depressive symptoms, then they will resort to self-blame and worsen their feelings.

Indulgence

The opposite pole in bad faith, that of indulging into disorder, is one that suspends one's freedom in claiming that one cannot be fixed and cannot be otherwise than the way that they are. This has a handful of different permutations. The main problem of indulgence is that one takes up a vulnerable position in the "sick role" where one defers all their responsibility to the expertise of others. This sort of sick role can take on different forms, but the main aspect I'm concerned with is the one that defers

[13] In the final chapter, I will discuss defiance as a virtue by way of Potter (2016), which treads a very fine yet muddled line.

responsibility and authority to another or to the disorder while shirking their own authorship of their actions. This is where disorder becomes an issue of seriousness: the point where one takes the world to have rules.

A fairly common occurrence amongst people who go to a therapist is to parrot what their therapist says to them as a voice of authority in everyday conversation. There's a theme of justification, that by having a therapist who agrees with their ideas one has a legitimacy in their opinions about themselves and others around them. Yet, where often this is a therapeutic and helpful approach on behalf of the therapist to affirm their patients, it has a negative effect when it comes to the patient's autonomy when they are more simply looking for any direction or guidance for themselves. Often individuals will report what their therapist says to others as an attempt at scoring points in an argument with an appeal to authority or to project out their therapist's advice onto other people without taking it critically for themselves. Psychiatrist Irvin Yalom writes: "Patients, often with the silent collusion of the therapist, may settle comfortably, passively, and permanently into therapy, expecting little to happen or, if anything is to happen, that it will come from the therapist" (Yalom, 1980, p. 236). While talk therapy does require some deference to expert authority, the aim of therapy is most often geared towards the promotion of the patient's autonomy and dignity. To defer to the therapist's expertise as a crutch or leverage against others in conversations is to avoid one's own sense of autonomy in bad faith.

There's also the theme of indulgence being a form of resignation, that one cannot be better and cannot be otherwise than the way that they are. Understanding that mental illness is something that cannot be "fixed", some folks take that as an excuse to never get

better. Depression and anxiety can be seen as immutable forces that undermine one's ability to be a good person, and that one may as well indulge in the worst habits and behaviors in a self-destructive spiral. This is a form of defeatism, taking one's diagnosis as their destiny – where one insists that they are unable to be anything other than depressed or anxious. This can, as Yalom notes, exhibit itself in a "feigned helplessness" that one believes that they cannot engage with anything without explicit or implicit instructions from their therapist (Yalom, 1980, p. 236). While many depressive conditions *do* exist as rather continual and recurring conditions that pull individuals back into dark moods, this does not mean that one must give up hope for better days. Depression is not a monolith; one should not resign to be miserable outright.

Another form of indulgence is a sort of pride or one-upping compared to others. Not only is this a sense of defeatism at times but it also suggests that depression and anxiety have certain "milestones" that others "must" take up in case they want to really see themselves as depressed or anxious. This can appear in the form of challenging others/egging them on to come with them on some of their worst lows, much like journalist Andrew Solomon's memoir/investigation of depression in *The Noonday Demon* (2001). Solomon writes:

> If my depressions had been either worse or longer, I can imagine that I would have become more actively suicidal, but I don't think I could have killed myself without hard evidence that my situation was irreversible … I took foolish risks when they presented themselves to me. I was game to eat poison; I just was not particularly inclined to find or brew it. One of my interviewees, who has survived multiple suicide attempts, told me that if I'd never even slit my wrists, I'd never *really* been depressed. I chose not to enter that particular competition, but I have certainly met people who have suffered enormously but have never made attempts on themselves. (Solomon A. , 2001, pp. 260-261).

There are two things at play here regarding the encounter with Solomon's interviewee. First is that the interviewee themself is *indulging* in the idea that there is some *true* or *pure* depression that they have experienced but Solomon has not; that the only way in which an individual can experience depression is through an actual suicidal attempt, not "mere" suicidality or parasuicidal behavior.[14] This is a "no true Scotsman" style fallacy, believing that there is only *one* way to be depressed despite all the evidence that depressions are just as idiosyncratic as depressives. The other issue here is that this interviewee, through their indulgence, encourages *denialism* in Solomon. This interviewee could have made Solomon doubt his own experiences of depression through this comparison and bragging about their own suicide attempts, excluding the experiences of those who may feel suicidal and yet never attempt for themselves. While Solomon doesn't take the bait, this form of indulgence excludes those who are trying to make sense of their depression but don't experience the same things.

Diagnosis-as-Destiny and the Serious Man

I have been describing this experience of facing different social and expert expectations of how to live with disorder as being epistemically adrift. The moment of receiving a diagnosis is illustrative of being adrift in this way where one does at least find some direction or orientation for themselves. The question then is how they react to this moment of direction. A psychiatrist or therapist can give one a helpful direction in terms of where to go or how to react, but this guidance is neither absolute nor is it immediate in its effects. When epistemically adrift, many individuals will cling to whatever makes

[14] Parasuicidal behavior is the sort that Solomon describes here, where one engages in deliberately risky behavior because one does not feel as though they care whether they live or die. This lack of caring can either be conscious or not.

sense for themselves. Not everything clung to is a viable life raft, but with so much information present one has to choose some plan for themselves in response to learning about oneself in diagnosis. There is a temptation to treat one's diagnosis as a form or destiny, that one's options are limited to the existence of a hyper-medicalized, deterministic, and objectifying lens.

At the tail-end of *Being and Nothingness*, Sartre identifies that the end result of existential psychoanalysis (and thus his book) is to "make us repudiate the *spirit of seriousness*" which "has two characteristics: it considers values as transcendent givens independent of human subjectivity, and it transfers the quality of 'desirable' from the ontological structure of things to their simple material constitution" (Sartre, 1943/1956, p. 796). This is to say that individuals often take the world to mean something transcendent of what it is in itself, and that objects' values exist in the real world. One takes the world outside as something that has *rules*, hardline order and meaning that is from outside of human experience that shapes and limits our experience. This sense of seriousness is to be repudiated for Sartre as it is a form of bad faith in which one no longer takes oneself as a subject but determined by the external world. In the context of psychiatry, the spirit of seriousness is the belief that disorder is something that exists with rules and stipulations of what it looks like and what it ought to be. The belief here further is that there is some right way to be depressed or anxious, that one should stick to being depressed or anxious as something that is part of their *identity* that cannot be changed or addressed in any way but accepted as a brute and immutable fact that one *is* their symptoms.

Extrapolating on Sartre's spirit of seriousness, Simone de Beauvoir describes this attitude in the character of the "serious man". This attitude archetype is one who lies to oneself about the extent of their freedom by "losing oneself into" rules and stipulations of what the world *must* be. Beauvoir sees this as dishonesty where one chooses against their freedom for seriousness as an infantile and simplistic world. She writes:

> The serious man's dishonesty issues from his being obliged ceaselessly to renew the denial of this freedom. He chooses to live in an infantile world … the man who has the necessary instruments to escape this lie and who does not want to use them consumes this freedom in denying them. He makes himself serious. He dissimulates his subjectivity under the shield of rights which emanate from the ethical universe recognized by him; he is no longer a man, but a father, a boss, a member of the Christian Church or the Communist Party. (Beauvior, 1947/1948, pp. 51-52).

Seriousness in its rule-boundedness is a black and white world. One either follows the rules or does not. The serious man reduces one's understanding of the world to a very strict sense of rules. When Beauvoir discusses being "no longer a man, but a father, a boss, a member of the Christian Church or the Communist Party," she means the sense in which one no longer understands or conceives of oneself as a full person, but reduces oneself to a very simplistic role. It is not that one can only be inauthentic while being a father, a boss, Christian, or Communist, but rather one is not and cannot singularly define oneself as one aspect alone. Being depressed or anxious is a way of relating to the world, but it is not the only way in which one does. There are identity concerns in being depressed or anxious or otherwise "mad", but that identity does not totalize one's existence as the only thing that they are.

The sense of seriousness in diagnosis and treatment is when an individual takes this new information about themselves as being the grand-totalizing narrative for who they are. Where there are other aspects of who one is, taking up and radically changing

oneself altogether for the sake of dealing with a new diagnosis can go too far if one claims that this one new key to who one is then undermines and changes all the other elements of who one is. A person is never just one thing, and even though learning a brand-new truth or way to take care of oneself can be revolutionary for them, it is dangerous to believe that that new truth is an altogether new version of themselves. It is just something new that has been revealed and a new way to travel in life rather than a radically new self.

But this sense of seriousness is very fragile. Where one's sense of order or stability is forged on a contingent or unclear foundation of rules and stipulations, the chance for losing one's sense of purpose is immense. If one puts their faith seriously into their diagnosis as an identity, then there is a contingency in that diagnosis being correct and accurate – both in the sense that the diagnosis is a real/natural kind as well as that the diagnosis is an accurate description of one's symptoms. Both of these factors are contingent on several issues, including the possibility of changes in psychiatric patterns and the opening of new breakthroughs. Different diagnostic and treatment paradigms have come and gone, and staking one's a sense of worth and agency in one over another is a precarious position that can fall apart not due to the individual's own (often self-perceived) failure but instead changes in scientific patterns and research paradigms.[15]

[15] For example, the appearance of Asperger's Syndrome in the DSM led to a sort of looping effect for individuals identifying together socially with the label. The disappearance of the diagnosis in the DSM-5 has led to questions of hermeneutical injustice and the erasure of a social community that is based on an out-of-fashion diagnosis. This change raises problems in terms of the question of legitimacy of this condition and a loss of grounding for many of those who joined together in this community (Solomon M. , 2017). While depression and anxiety are perhaps more static categories, the shift in understanding these conditions may still change and develop over time, in ways that change the social understanding and patterning that our society takes up.

Disorder-as-identity is contingent upon several different factors and if any of them fall apart, there is the risk of the individual losing what flimsy grounding they have. Seriousness can set a person up for failure. Beauvoir writes:

> It is in a state of fear that the serious man feels this dependence upon the object; and the first of virtues, in his eyes, is prudence. He escapes the anguish of freedom only to fall into a state of preoccupation, of worry. Everything is a threat to him, since the thing which he has set up as an idol is an externality and is thus in relationship with the whole universe and consequently threatened by the whole universe; and since, despite all precautions, he will never be the master of this exterior world to which he has consented to submit, he will be constantly upset by the uncontrollable course of events. (Beauvior, 1947/1948, p. 55).

One cannot readily control oneself in their moods, and in confronting a diagnosis one often discovers that they have a long road ahead of them in figuring out how to recover or take care of themselves in a way that their moods become more manageable. In discussing the attitude of seriousness, de Beauvoir argues that many individuals cling to whatever sense of meaning that they can find in rules and regulations to preoccupy themselves and worry less about their contingency.

The danger of seriousness and diagnosis-as-destiny is that not only does this bad faith limit one's understanding for who they can be and what their behavior is in scope, but that its fragile status can fall into an even worse attitude. For Beauvoir, to fall out of serious is to fall into nihilism. The fragile hope that one projects is often to hold out against a fear of one's contingency. There is a sense that one's rules and stipulations for oneself can anytime give way to the realization that perhaps nothing is holding us and there are no rules, chaos reigns. Beauvoir writes:

> This failure of the serious sometimes brings about a radical disorder. Conscious of being unable to be anything, man then decides to be nothing.

> We shall call this attitude nihilistic. The nihilist is close to the spirit of seriousness, for instead of realizing his negativity as a living moment, he conceives his annihilation in a substantial way. He wants to *be* nothing, and this nothing that he dreams of is still another sort of being … Nihilism is disappointed seriousness which has turned back on itself. (Beauvior, 1947/1948, p. 56).

This seriousness can at any time collapse into destructive tendencies. The danger of seriousness is that it easily falls into nihilism as soon as it is disappointed. Nihilism in this case is most readily expressed in self-destructive behaviors and suicidal tendencies. The disappointment of seriousness can lead to destruction and harm. If one tries to live by strict rules regarding their condition, the loss of the sense of meaning that those rules may provide can undermine one's very sense of self-preservation and self-worth as they blame themselves for not doing well enough. To hold out and believe that one's depression is a reprieve from their actions may work contingently and sparingly to cope in the short term, but can lead to a greater upset and all the worse harms for an individual who recklessly and arbitrarily puts belief in a higher sense of order and defers their own growth or progress.

Breaking from Bad Faith, Responsibility without Blame

In this final section, I will attempt to carve out an alternative to these bad faith poles. In carving an authentic or genuine and responsible reaction to one's disorder, one must avoid taking one's condition as an absolute or totalizing. Beauvoir writes that "The first implication of such an attitude is that the genuine man will not agree to recognize any foreign absolute" (Beauvoir, 1949/2011, p. 13). This is to say that one does not take diagnostic stipulations and discussions as hardline rules for one's life. These are things about oneself, yes, but they do not determine who the person is throughout.

Hanna Pickard's work offers what I believe can be constructed into this third, authentic way of engaging with one's psychiatric diagnosis. Her projects on "responsibility without blame" look to different psychiatric and addiction-related disorders and argue that the best anti-stigma work for these conditions is not to blame an individual for their behaviors that are related to disorder but instead to still hold them as *responsible*. "Responsibility" in this way is a question of understanding that one is still the author of one's actions and choices, even in the case of compulsion. Pickard writes that "the idea of 'holding responsible' means more than judging others to be responsible, but actually treating them thus: treating them as accountable or answerable for their behavior" (Pickard, 2013, p. 1141). The question of being responsible here is that of holding individuals accountable for their actions. They are "answerable for their behavior" in the sense that they are still accountable for their actions, even if they are behaviors motivated by one's mental disorder.

Within Pickard's responsibility without blame model, the idea is to avoid the sort of stigmatizing and destructive viewpoints of mental disorder that only worsen the condition for individuals. Removing the individual from the context of blame is something that allows for the person with mental illness to understand themself in a positive way that allows for personal growth. The alternative, blaming an individual for their behaviors that are compelled by disorder more likely leads to worsening behavior and symptomology. Pickard writes:

> Blaming service users may trigger feelings of rejection, anger, and self-blame, which bring heightened risk of disengagement from treatment, distrust and breach of the therapeutic alliance, relapse, and, with service users with personality disorder, potentially even self-harm or attempts at

> suicide: it is essential that compassion and empathy be maintained. (Pickard, 2013, p. 1135).

While the responsibility without blame model is meant as an external attitude towards mental health service users, there are elements that are helpful here for individuals with depression and anxiety. This model is meant to foster patient autonomy and allow for them to understand themselves not as merely a collection of their symptoms, but to understand that they are still responsible for their actions.

Pickard goes further to divorce the conception of responsibility from the conception of blameworthiness that often stigmatizes and worsens one's feelings around their actions. One still has to be responsible in the sense that one must deal with the consequences of one's actions, however that responsibility is not rooted in the idea that one has done wrong or is unforgivable in their disordered behavior. To blame someone for actions that came from a depressive episode does not alleviate that feeling of worthlessness but rather can easily worsen it. Responsibility without blame is an attempt at harm reduction; the individual understands that they are responsible for themself but at the same time does not hold oneself in contempt when one slips back into depressive feelings or behaviors. Pickard argues that a healthier way to engage with individuals is to hold them accountable but not blame them when things go awry. Try as one might, a person who has depression cannot always stave off an episode from coming. It is unhealthy to take this as something to blame them for experiencing. But it is a healthier way to engage with one's disorder to understand that sometimes these things happen, one is thrown into the midst of a depressive episode, feel suicidal or otherwise self-destructive, and that what one can only do is strive to react better. Falling into bad faith

happens, but to hold oneself accountable rather than blameworthy prevents the individual from continuously doubling-down into their bad faith patterns.

To some extent, the responsibility without blame model can be seen in context with Camus' analysis of the Myth of Sisyphus at the end of his eponymous essay (Camus, 1955/1983). Sisyphus' attempt at rolling the boulder up the hill can be seen as trying to live a good life. But repeatedly, the rock slips and he loses control. But as in the responsibility without blame literature, the point is not to blame Sisyphus or chastise him for failing when the rock rolls back down, but instead to start again when he can. He is not a wretch or blameworthy when he falls, but he just has more work to do. In the same sense, when one gives into addiction or depression or other behavioral-compromising actions, one is not wretched, but will have to continue on again. Depression may return, but that does not mean that it is inevitable as an individual's only recourse.

In parallel to this discussion, Sartre writes about the experience of being fatigued and its relation to one's freedom. Doing something out of or to alleviate one's fatigue is still a free choice, albeit constrained by the state of being fatigued. In midst of his section on freedom in *Being and Nothingness*, he describes going on a hike with friends and becoming fatigued. He writes

> A choice is said to be free if it is such that it could have been other than what it is. I start out on a hike with friends. At the end of several hours of walking my fatigue increases and finally becomes very painful. At first I resist and then suddenly I let myself go, I give up, I throw my knapsack down on the side of the road and let myself fall down beside it. Someone will reproach me for my act and will mean thereby that I was free—that is, not only was my act not determined by any thing or person, but also I could have succeeded in resisting my fatigue longer, I could have done as my companions did and reached the resting place before relaxing. I shall defend myself that I was *too tired*. (Sartre, 1943/1956, pp. 584-585).

Fatigue here is something that inspires one's decisions and is often used as a 'crutch' or a blameworthy element of one's behavior. To be fatigued, to be *too tired*, is something that undermines one's feeling of being free. The hike makes him weary and he gives into the weariness. But this is not bad faith in itself, since he is recognizing the weariness as being a part of himself, as his state of being.

There is a more nuanced understanding for Sartre here, that one's fatigue is not something that is given as an excuse for one's behavior, but instead that one's fatigue shapes and limits one's facticity:

> Let us note first that the fatigue by itself could not provoke my decision. As we saw with respect to physical pain, fatigue is only the way in which I exist in my body. It is not at first the object of a positional consciousness, but it is the very facticity of my consciousness. (Sartre, 1943/1956, p. 585).

Fatigue here is then a part of who Sartre is in this moment. His example of fatigue is not that he is trying to play it off as an excuse, but that he states that it is part of who he is at that moment. Just as well, one's depression or anxiety becomes oneself in the sense that one enters into a mood and views the world through it. Moods become their own facticity that affect the way in which one engages with all their tasks and projects. It affects who they are and how they interact with other individuals.

Closing by returning to Gask's memoir, there is a sense in which one can take up one's depression as a real part of one's life but not identify with it directly. She writes "This is who I am. I cope most of the time; I am well for months, sometimes even for more than a year, but there are recurring periods of my life when the world seems a darker, more hostile and unforgiving place. I am a person who gets depressed" (Gask, 2015, p. 14). Understanding that depression or anxiety is not the thing that altogether

defines who one is yet still can return at any point to affect one's engagement with the world. Despite its inherent experienced feelings of inadequacy and desperation, depression isn't all there is to the person. There is a need to recognize that one is not only defined by their mental disorder or abnormality. To live authentically with depression and anxiety is to engage with one's feelings as they come, not to take them as immutable or doomed to repeat indefinitely. In the final chapter, I propose a set of virtues for living with mood disorders where one takes responsibility for their condition in the form of *responding* to these feelings directly rather than getting hung up on indulging or denying one's condition as seen by others in diagnosis.

CHAPTER 4

MOODY RESPONSIBILITY: AN EXISTENTIALIST VIRTUE THEORY OF SORTS

This chapter seeks to build something relatively new: an ethics specifically written around the experience of depression and anxiety disorders. Where mood disorders are typically excluded – either implicitly or even sometimes explicitly – from most of philosophy's ethical discourse, I aim specifically to build something that is geared towards this experience. This chapter orients itself around the question of what it means to be "responsible" for one's mood disorder. For our purposes, being responsible is not the sense of seeing oneself as the fault or cause of one's disorder or mood, but rather a reaction to one's moods that seeks neither to deny nor indulge in the worst of them. Any attempt at faulting the individual for the state of their emotional life is an exercise in gaslighting and/or victim-blaming. One is not at fault or blame for one's depressive moods, or mania, or anxiety, but rather there are environmental and biopsychosocial causes.[1] For the purposes of this chapter, I will detach emotional experience from its causes, as they can be so idiosyncratic and while searching for the root of the problem for the individual may be helpful in a therapeutic setting, such an exercise is not pragmatically necessary in the day-to-day decision-making for individuals. Responsibility rather instead is the question of how does the individual *respond* to their emotional state? While there are steps that one can take in terms of therapies, activities,

[1] There are of course cases of wallowing in or somewhat-intentionally exacerbating one's feelings in order to play a sick role and garner pity – which I discuss in chapter 3 – but this is not originally created by the individual. For instance, resisting change and therapy or taking on one's suffering as a normative punishment are ways in which one can cause one's own suffering all the worse. Underneath, there are still the patterns of disorder that come from elsewhere that harm the individual outside of their control.

and diets that may help ameliorate or change one's mood regulation and one may be responsible for adopting these, some of the emotional experience of mood disorders appear as if a brute fact.

One's mood appears not fully authored by oneself, yet still they must react with it in some way and be accountable for the actions that come in that response. Where moods often motivate one's actions in some way, in being responsible for one's mood disorder one must figure out how to take clear and deliberate steps to be accountable for oneself, despite having one's own feelings often sabotage oneself. This desire for self-sabotage competes with one's desire for being a good moral agent and can often stem directly from the sorts of feelings of worthlessness or overwhelming guilt that one can feel within depression and anxiety. One can often feel as though one does not "deserve" good things, and therefore choose against one's happiness in ways that not only harm oneself, but others.

This chapter is an existentialist's attempt at virtue theory. The benefit of virtue theory is that it does not require a correct action in all cases, but the development and practice of that action. This means that one can slip, one can fail to do the right thing, but one can still aim towards being better in the future. Similarly, existentialism is helpful much like virtue theory in its commitments to seeing an individual not as some finalized project, but one who is continuously trying new things and taking up new projects in the process of becoming. The problem with virtue theory however in this case is that traditional or mainstream virtue theory is concerned with a conception of human flourishing (*eudaimonia*) that most people conflate with happiness. Flourishing is not the same as happiness per se, yet still carries with it a lot of "happiness baggage". Where

mood disorders rather clearly impede one's ability to live a "happy" life, this ethic then must aim for something else as one's telos or end. Or, at the very least, this theory aims at "flourishing-enough" where one understands that one's feelings of inadequacy will likely remain throughout their life at different times in ebb and flow. Where many individuals with depression and anxiety may struggle their whole lives in search of happiness and contentment, only to find it inadequately fleeing as if just mere pleasure, this ethics has to look to a sense of grim realism. That is, it understands and gives space to the fact that sometimes happiness is unobtainable for the individual and that is okay; one is not inadequate or "broken" if their emotional state does not allow for the stability that permits happiness.[2] As a result, I have a few rather preliminary remarks before I outline the sort of virtues that I mean in order to flesh out what a "flourishing-enough" type model would look like. For this I will be working from philosophers Lisa Tessman's theory within *Burdened Virtues* (2005) and Nancy Nyquist Potter's *The Virtue of Defiance and Psychiatric Engagement* (2016), which both argue that virtue theory is still possible for oppressed and marginalized agents even when flourishing or happiness do not seem attainable. I believe that a virtue theory framework can become existentialist by uprooting the sort of essentialist or teleological goals of flourishing. While this makes it an incomplete form of virtue theory, it still centers around cultivating virtues toward other ends.

[2] Further, I want to avoid a notion of flourishing that is entirely based on the existence of material goods or social currency that allows for one to engage with the world as a full moral agent. In a society rife with racism, sexism, homophobia, transphobia, classism, and other hateful systemic practices that exclude individuals from living "the good life" besides one's emotional state, there are many factors that prevent flourishing as such.

As an alternative to traditional accounts of flourishing as happiness, I want to focus on two sometimes contradictory, sometimes complementary ends: authenticity and caring for oneself. Authenticity is a tricky concept for mental disorder, let alone for anyone. To be authentic in this sense I do not want to argue that it is the highest end, but that it is a vital end to strive towards. To be authentic is to live openly and honestly, knowing as best as one can of one's desires and goals and the projects that they put out into the world. Authenticity is important in alleviating some of the suffering by way of opening up and creating accountability through an honest engagement with one's feelings. Keeping quiet and to oneself seems to be a way to bottle in one's feelings and worsen their condition or day-to-day state. Yet, telling the truth about one's condition can all too easily put oneself in a vulnerable position before others with very real dangers and costs. It is too easy to speak too boldly and endanger one's reputation, career, friendships, etc. and it is additionally easy to be taken advantage of when one bares all to another. In terms of caring for oneself, one must continue to survive and make life-affirming decisions in order to continue to be a good person before others and themselves. One must continue to exist in order to be a moral agent, and additionally one must not wear oneself down in order to continue to be there for others. On the other hand, one needs to be wary of closing off from others' concerns and being too selfish in caring for oneself.

When it comes to the existentialist commitments of this chapter, I believe that existentialism already has a built-in conceptual framework that can apply to anxiety and depressive disorders. Existentialism grapples directly with the feelings of anguish, meaninglessness, and other mood disorder-adjacent themes, and builds ethical engagements through arguing that without direct answers, it is up to the individual to

make meaning for oneself. While the existentialists write for an intended general audience, they are at the same time often dismissed for being too dramatic or melancholic in their commitments and tone. The sense of urgency in decision-making inherent to existentialists appears as if directly speaking to those who suffer from mood disorders. By urgency, I mean the sort of anxiety that exists and shapes every decision according to existentialists such as Heidegger, Sartre, or Camus. These writers suggest that there is anxiety in every choice just as there is anxiety in not choosing. The world for them is hinged and framed within anxiety and one's existence. This can be a compelling account but at the same time this is where existentialism is often dismissed; not everyone is suffering from anxiety and not every choice is warped or mired by an attunement to the absurd.

This chapter sketches an existentialist virtue theory that engages with the experience of depression and anxiety directly in order to build a space for ethical theory specific to those who live with those conditions. This is an attempt to create something new that provides for these individuals to help make meaning within their lives that sometimes otherwise feel meaningless. I believe that this approach as a side effect can still help provide ethical insight for those who do not experience these conditions or experience similar "abnormal" mental conditions.[3] While this theory may not be universally-applicable, the sudden universal-yet-existentially-unique COVID-19 crisis has brought with it so many new members into the fold of depression and anxiety as so

[3] I hope in future work to add to this theory to make it even more inclusive. There are certain aspects of related mental disorders that I hope to approach in the future, including mania and depersonalization/dissociation.

many individuals not only worry for their own lives and those of loved ones, but grieve the sense of normalcy that has been lost.

This chapter begins with an examination of depression and anxiety as a "call to action" as it were that makes individuals feel compelled to do *something* – even if it is unclear as to what. Then I discuss burdened virtues and their practicality for this call to action. From there I list the virtues in brief. This chapter ends with a sketch of these virtues for being responsible when one may feel adrift and overwhelmed, unable to navigate themselves and their emotions in an often hostile and seemingly-meaningless-and-indifferent world. This final chapter attempts to help individuals project meaning into their life-worlds in order to live authentically with themselves and others.

Depression and Anxiety as a Call to Action

At the end of the section on "Existential Psychoanalysis" in *Being and Nothingness*, Sartre laments that "Man is a useless passion" (Sartre, Being and Nothingness, 1943/1956, p. 784). While he may have recanted this later for being too "literary" and not technical enough (Sartre, 2013), there is a legitimate fear here for those within mood disorders. Within mental disorder, one often feels "useless" in one's emotional life – that one has not done enough and ultimately cannot do enough to be a good person. Sartre's lament is hyperbolic, perhaps, yet matches with the often-dramatic feelings within mood disorder. There's a fear that disorder discredits the individual's capacity for moral judgment or general usefulness. At the same time, passion – whether couched within mood disorders or not – feels as though it is a call to action; individuals feel as though they must act in some way even if their feelings themselves arrest their motivations as well. Mood disorders can provide both inspiration to do something as well

as a fear of doing the wrong thing. Being a “useless passion”, individuals with mood disorders often feel as though there must be something that they are doing wrong.

Where several ethical theories exclude mental disorder in some way or another, there should not be anything about disorder in and of itself that undermines one’s ability to contribute to society. One’s emotional experience is entangled not just within a vacuum, but also in context of one’s day to day accomplishments. In a capitalist society that actively measures one’s worth based on productivity, having a mood disorder undermines one’s self-esteem beyond just the natural state within the possibly symptomatic feelings of worthlessness but also in terms of social expectations and pressure. Feeling “useful” then is something that can worry an individual to a large extent. Cultural myths around meritocracy and success end up making those who feel inadequate about the material conditions of their lives feel further inadequate about who they are as persons. The feeling of inadequacy that often besieges individuals in the experience of depression and anxiety is exacerbated by outside pressures and the lives of others who seem to have it more together.

The purpose of this chapter is to discuss strategies that individuals with mood disorders can take in order to (re)act responsibly in context of their conditions. In terms of action and reaction I will write rather loosely, as our actions are typically reactions to our situations in some way. However, I am not going to present some prescriptive account of what actions one must take in any given situation; deontological commands seem to evoke too powerful a sense of shame in those who feel that they are unable to do enough. Many of these overlap with principled tenets of different established therapeutic practices. But further there is a need to understand that just as mood disorders are

dynamic and often caused by and experienced in radically idiosyncratic ways, this chapter pushes for a pluralistic engagement with mood disorders. There does not seem to be any one definitive or panacea way to respond or not respond to one's disordered moods, and thus there is a need to allow for individuals with mood disorders to find "whatever works" for them as a means of coping with their condition, so long as it doesn't cause for further harm to themselves or others.

Where I am otherwise critical of the fast and loose and chaotic everyday advice-giving surrounding mental disorder, this "whatever works" understanding of taking care of one's mental condition may sound hypocritical. It is hard to deliberate what the best course of treatment or action may be when one feels/is in crisis. Yet, the trouble is that in the absence of clear consensus regarding the status or treatment of mental disorder, along with the lack of mental health infrastructure resources, individuals with mood disorders *must* by necessity figure out their own coping strategies in order to care for themselves in a society that has left them adrift. Instead of finding a single way of coping with one's mental disorder, one needs to recognize for themself that there may be multiple approaches to cope with one's condition, some of which may be helpful in certain contexts, while unhelpful in others. Further, what helps one individual cope additionally might be utterly useless or harmful for another.[4]

[4] This inefficacy of certain strategies appears in the lyrics of the song "Charity" by singer/songwriter Courtney Barnett: "Meditation just makes you more strung out" and later "Medication just makes you more upset" (Barnett, 2018). Where both meditation and psychiatric medication have efficacy in some patients, neither approach is universal. As I've discussed in the first chapter, the frustration over treatments not being effective immediately/varying efficacy puts many off from committing to long-term therapies and methods to curb depression and anxiety.

Moods "color" and affect an individual's worldview. In this way, moods can be understood metaphorically as a landscape. Some landscapes are pleasant and cheery, others tumultuous. One's mood is a way of shifting one's perspective on the world, where "normal" landscapes can change in meaning. Much like the weather, the outlook on the world can change easily. Where being in a pleasant mood can allow for one to not focus or notice negative aspects of the world, a depressed or anxious mood leads to focusing on the grim and/or dangerous aspects of the world. Anxiety can make the world seem too overwhelming and full of dangers and unnerving sights, like a Hieronymus Bosch painting. Depression can create a landscape that is without value to its beholder. The world of depression can be bleak and muted, without any guiding light. One's feelings within a mood disorder can be messy – sometimes tumultuous and stormy, other times dull and boring and without any sense of purpose or motivation.

While sometimes mood disorders are unpredictable, there are also a lot of times that one's feelings are very predictable, boring, and unable to provide for anything other than the numbing, self-defeating knowledge that one is going to die and that one feels as though nothing is worth doing. Depression at times is very boring in this way. One can look out at their future and predict that they will not be able to do anything interesting for themselves. This can then often become a self-fulfilling prophecy; if I feel that I won't get my work done, that I won't finish this chapter, then I can ensure that I won't by avoiding work altogether while feeling sorry for myself.

While there are chaotic elements within depression and other mood disorders as well, there is also a sense that one will only ever do or be the same agent and feels utterly immobilized by one's sadness or anhedonia. When asked what one plans to do for one's

weekend, one can predict that they will do nothing of interest, and as a result condemn themselves to it. As much as depression shapes and alters one's engagement with the world and it should be taken seriously as part of who one is, it additionally must be pushed back against. There's a bind here – a hard line to toe in which one must both at the same time recognize and subvert the danger inherent within one's own mind but also give it space to understand it for oneself. Depression saps an individual's energy and motivation to do anything for themselves and while one cannot "just get over it", one must also do one's best to overcome their darkest moods if they hope to survive and be a moral agent. The repetition of depression can be altogether oppressive against one's sense of self-esteem and sense of worth. Entire spans of time within depressive episodes can feel the same again and again. This is something that has become a little too familiar and perhaps to some extent universal in the COVID-19 crisis of 2020; every day has become so oppressively the same and yet fresh and new and terrible. The changeover to working from home for many has been this sort of loss of productivity, loss of meaning, loss of hope is almost totalizing, communally shared across cultures in ways never before experienced.

Being a moral agent in this sense is something that is messy and often compromised as a result of fluctuating, dulled, or destructive moods. As a result, I am sketching out an ethics that is messy – or muddled – through this chapter. I suspect that any ethics that takes on the experience of mood disorder is inherently messy, much like Camus' understanding of the absurd or Beauvoir's ambiguity. There are elements to the experience of mood disorder that are inherently messy, imperfect, and insecure. Depressed and/or anxious individuals are those who often feel uncomfortable in their

own skin and unable to experience life as fully as those around them. To a certain extent, they are what Sara Ahmed (2010) calls "affect aliens" – individuals who understand what others may feel and experience but feel alienated and unable to live fully "good" or happy lives as a result of the conditions in which they live. The alienation of anxiety and depression undermines an individual's sense of moral agency in because they are oftentimes not able to feel comfortable or in community with others around them. In addition to the exclusion of mental disorder within ethical theories, there is additionally a sense in which individuals with mood disorders may not recognize themselves in mainstream ethical theory. Discussions around stoicism, rule-bound deontologies, or rational deliberative projects present ethics as something that oftentimes should not be emotional, yet emotional experience guides much of an individual's feelings of whether they have done the right thing or not.

Mood disorders can give individuals a sense of inadequacy when it comes to moral action. Anxiety imposes a sense of urgency, that one *must* act and do so in the right way – otherwise they fail themselves, others, or the world. Depressive moods on the other hand suggest to the person that their actions are already too late. One often believes that there is something that they should have done but that they have already failed and there is no redemption possible. Depression in this way is a morally-compromising factor for many individuals – or at the very least it *feels* this way. The combination of anxiety and depression can be especially hard; one may feel that everything is both extremely urgent and must be taken care of immediately, but at the same time it is much too late and the actor is too "worthless" or feels too compromised to do anything about it. This state is one of agony. The virtues or guidelines that I want to outline in this chapter are meant to

combat these feelings of immediacy and inadequacy, to work against self-destructive and other destructive patterns in order to build something instead.

Ultimately, the hope of any such ethics of mood disorder is that the individual finds a sense of home, of comfort, of being amongst others in a community that is receptive and mutually-beneficial. A sense of home of course is not simply a building, but a sense of belonging somewhere. This is a difficult feeling to attain when one is undergoing an episode that makes them feel at odds and alienated from the world. Especially in the case of paranoia, there is often the need to push back on the feelings of emotional alienation as much as possible in order to help the individual feel welcome and at home with others. This requires not only the individual to fight back but to find a supportive community that constructively hears yet challenges the worst or lowest feelings. Much of this chapter argues not just that an individual cultivates the right habits for oneself, but that one finds beneficial and mutually-enriching friendships and relationships. One helpful strategy is to find those who I call "fellow travelers" – other individuals who experience the same or similar mental disorders – so that one can share coping methods and keep each other accountable. In the next section, I outline what these sorts of virtues would look like.

A Virtue Framework for Disordered Moods

With this chapter I intend to outline some important virtues for someone experiencing a mood disorder. Altogether this is not a standard sort of virtue theory. Unlike Aristotle and traditional virtue theory in general, I do not see these as virtues that

are readily applicable to all individuals.[5] My interests here are to carve out what virtues look like in response to what are rather 'typical' features (or symptoms) of mood disorder. These sorts of typical features of mood disorder that I refer to are low or sad mood, anhedonia and lack of interest, feelings of guilt, feelings of worthlessness, suicidality, and alienation. As a result, this virtue theory is perhaps a "negative" one – a virtue theory that operates based on counteracting difficult feelings, rather than cultivating more "acceptable" desires.

The following are general guiding virtues or principles for engaging responsibly with one's mood disorder. Where this is relatively fresh ground, I will be developing a positive account of these virtues rather than a critique of existing ethical systems. Some of these following principles are not considered "ethical" or even noticeable problems for those who do not have personal experience with mood disorders. In effect, these may not be universalizable virtues, but they may have surprising applications for those who are unaffected by disorder. I am not ruling out this possibility, but my focus must remain regarding the responsibility of those undergoing mood disorders. Further, some of these virtues have several caveats that I will have to explicate. Many of these caveats have to do with the question of accessibility and affordability along class, gender, and racial intersections.

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[5] Another contra-Aristotelian point is that mental disorder, at least to some extent, appears to be what Aristotle would refer to as incontinence. There are many aspects to mental disorder that present as behaviors that block "virtuous" action, or at least the actions that one believes or knows are the right things to do. Aristotle identifies incontinence as not morally reprehensible, but rather as a condition that prevents an individual from being able to act virtuously. If incontinence for Aristotle resembles some of our contemporary conceptions of mental disorder, then Aristotle does believe that it is impossible for the individual acting (or not acting) out of compulsion of mental disorder cannot be a virtuous or flourishing person. My attempt at building an ethics for mood disorder runs directly counter to this with the belief that mental disorder should not preclude one from being a good person, even when that disorder contains compulsive behaviors.

Further, I am a bit wary of the language of virtue and vice, which is a fairly odd disclaimer to put up before establishing a list of virtues. However, some of these virtues resemble what some typically denigrate as "vices". The discussion of virtue and vice often creates a rather dualistic view of the world, which rather naturally excludes alternative ways of existence or being. Perhaps the discussion of virtue itself is not the best language to use in this case, but a term more like guidelines or principles. I evaluate each of these guidelines in the sort of Aristotelian "golden mean", as I believe that they lie between extremes of deficiency and excess (Aristotle, 1999).

This chapter engages with a form of virtue theory that is "burdened". Following the work of Lisa Tessman (2005), I argue that there is a form of "moral failure" for "compromised" moral agents who are shaped by oppression and situational inability to do the right thing. Aristotle more classically argues that following virtue necessarily leads to a good life outside of misfortunes. But this ignores the fact that many individuals are kept down due to oppressive hegemonic structures that harm them due to race, gender, sexuality, class and other identity markers.[6] There is an inherent estrangement where individuals who otherwise would act with virtue are inherently downtrodden and overcome with harms to their health and stature due to the shape of society. Aristotle

[6] There is perhaps a small compatibility trouble with Tessman's work that I want to address at least briefly here: Tessman is specifically tracking the burdened virtues that come directly from oppression. The trouble here is that individuals with mental illness are not necessarily openly or explicitly oppressed by virtue of their mental illness but rather often times mental illness is exacerbated by other identity-related oppressive structures that an individual might share in addition. While oppression is often a causal factor of individuals' depressions or anxieties, but these mental conditions do not in themselves lead to one's oppression. Instead, depression and anxiety can be an inhibiting factor that leads to an individual not resisting oppression as they may feel worn down or not worthy of recognition or respect. Much of Tessman's example work draws on hierarchical oppression that confers from more visually obvious identity hierarchies such as race, gender, class, sexuality, and so on. Where mental illness and mood disorder can affect people of all walks of life and different stratifications of privilege, there are some stopgaps where one is not necessarily oppressed per se, but may *feel* as if they are oppressed or limited in their chances at flourishing due to their condition alone.

never considered, due to his cultural milieu, the harms and degradation of those who do not have the prerequisite access to flourishing that he establishes in the *Nicomachean Ethics*. Instead, he concerns himself with the moral development of an aristocracy that aims towards its own ends. Tessman on the other hand is concerned with the chance of flourishing for those who have been otherwise morally compromised by social conditions. The individual who acts virtuously out of "burdened" virtues is one who may feel as though they are not worthy of acting well or living a good life. While not everyone who has a mood disorder is compromised by social conditions that oppress them, many are and others may feel as if they are, which allows for Tessman's work to create for some fruitful support for this project.[7]

Tessman looks to create a form of ethics that understands wholly that individual actors can be compromised from living "the good life" but that does not mean that they are completely disqualified from acting virtuously. Flourishing itself may be impossible for some individuals due to the conditions under which they live in, but this does not mean that they are incapable of doing good things for themselves or others. While certain virtues are compromised by oppression or one's identity, there are plenty of aspects to life in exclusion that still can access community-building and creating new starts for oneself. Tessman writes on what she calls "burdened virtues", the sort of virtues that are constrained by certain material conditions that oppress or limit one's ability to engage in "the good life" but nevertheless are still constitutive of what a good life could be. Tessman looks to ameliorate these sorts of fears, although outside the context of mental

[7] One aspect that appears within depression and anxiety narratives is the feeling of being incarcerated or trapped in one's moods or in one's body, as Ratcliffe (2015) points out. This however really is merely a metaphor unless one is actually incarcerated, but the mindset is hard to escape from and these existential feelings may return again and again.

illness. Tessman's burdened virtues looks to the state of those living under oppressive conditions and how they may be able to overcome that although they already may suffer from "dirty hands". The idea of burdened virtues is that while they might not lead to living "the good life", they at least lead to a "good enough life".

In the end of her 2005 book *Burdened Virtues,* Tessman describes different trait assessments for these sorts of virtues. When writing on unburdened or typical virtues, Tessman identifies Trait v1 which: "tends to enable its bearer to make the right decisions and to perform good actions (given the assumption that these are available); and, having trait v_1 is conducive to or partly constitutes living a good life" (Tessman, 2005, p. 162). These aren't burdened virtues but are instead the sorts of virtues that are unconstrained by an individual's material conditions. That is, these are typical virtues that most virtue theories cover. Good actions are both available and the agent is willing and able to complete them.

The more burdened virtues are those in which there is some sort of block on one's ability to flourish. That is, there are conditions that prevent one from being able to live by most accounts what is considered a "happy" or "good" life, but instead they are mired in unhappiness or feeling inadequate. More typically Tessman believes that these are the result of oppressive hierarchies, but I believe that additionally these are operant within mood disorders and other conditions that prevent a general sense of happiness. Further of course, there is the grim reality that social oppression can cause or exacerbate disorder, meaning that those who are in compromised positions are already dealing with disorder in some way Tessman describes trait v_2 for virtues:

> When good actions are unavailable, trait v_2 tends to enable its bearer to choose as well as possible, with the appropriate feelings, such as regret or anguish, toward what cannot be done. Furthermore, trait v_2 is a trait that would be good—in the straightforward sense of conducive to or conducive of flourishing—if conditions were better and presented a truly good option, for in such a case trait v_2 would operate without the encumberance of a moral remainder, and thus without the negative feelings that attach to it. (Tessman, 2005, p. 163).

In this case, one is choosing as best as one can in the case of having a compromised feelings of happiness for oneself. One can easily see the good in these types of virtues and feel compelled to do the right thing, but don't necessarily feel that this will be the best for their own well-being. By and large, virtues that correspond to trait v_2 are good virtues that one should follow in general, even though one's feelings about following them might be skewed or negative given one's circumstances. The compromised feelings of happiness are clearly applicable for depressive moods, where the individual may feel as though they cannot fully attain happiness.

But things can get even more complicated for an agent whose happiness is compromised by oppression (or in our case depression). Tessman describes that a virtue that exhibits trait v_3:

> …is chosen because it is judged to be the best trait to cultivate in the circumstances, even though it is not conducive to or constitutive of anyone's flourishing at present; it does, however, tend to enable its bearer to perform actions with the aim of eventually making flourishing lives more possible overall (for the bearer of trait v_3 and/or for others). (Tessman, 2005, p. 165).

This sort of virtue is one that is investing in a possible future, even if it doesn't seem like it has any positive consequence in the current stage. In a mental health context, this is a virtue that does not provide any sort of immediate relief (such as the beginning stages of

investigating one's trauma) but may provide the conditions of the possibility of flourishing for oneself or others down the line.

Even more compromised is trait $v_{4,}$ which:

> tends to enable its bearer to make the best possible decisions and to perform the best possible actions; and, having trait v_4 is conducive to or party constitutes living as well as possible, though because trait v_4 carries a cost to its bearer (and perhaps to others), it is only choiceworthy when bad conditions are present and a good life is unattainable. (Tessman, 2005, p. 166).

Trait v_4 is oriented around "living as well as possible" but still might carry a cost to the individual and others and is only the best action in the case of bad conditions. Tessman's analysis of burdened virtues is helpful in building a virtue theory of mental disorder in the sense that one is not necessarily living an ideal life, but is instead trying to build something as best as one can from compromised feelings. In engaging with virtues of mental disorder, I am seeking to build something that leaves open for imperfection in this way. The feeling of mood disorder is a feeling of burden, often that one cannot be otherwise and cannot fix oneself.

Burdened virtues are to a certain extent provisionary and if one "graduates" in a sense to better available virtues, they can to a certain extent be dispensed with. That is to say that burdened virtues are meant specifically for life situations in which more traditional virtues and flourishing are unavailable. In adapting Tessman's work for her own ethics for mental disorder, Nancy Nyquist Potter (2016) notes that a realistic account of eudaimonia within mental disorder would require the following "elements":

> (1) giving and receiving attentiveness, sensitivity, and positive concern for great suffering without destroying the self;
> (2) an adequate recognition of interdependence that entails mutuality;

(3) a reduction in moral damage;
(4) a decrease in the existence of burdened virtues;
(5) access to the expression of basic capabilities. (Potter, 2016, p. 66).

Here Potter argues that flourishing enough sees a decrease in the need for burdened virtues in (4). Burdened virtues are important for helping someone navigate in trying circumstances, but they do not have to be permanent. If they work well and the individual enjoys a certain amount of moral luck to get out of their compromised circumstances, then a state more resembling eudaimonia should be possible and the burdens can be dispensed with. I will explicate more on points (1) and (2), as they fit within the virtues that I outline below in that one needs to both take one's condition seriously but without indulging too far into one's moods and that building a strong interdependent community is important for one's wellbeing regardless.

Each of the virtues that I outline below are burdened in the sense that they are in reaction to one's mental health. Where others have more of a sense of unrestrained freedom when it comes to feeling happy or at least not bogged down with depression or anxiety, those who do have depression or anxiety must make choices that may not lead to happiness but nevertheless are still responsible choices. These are burdened virtues in the sense that the individual agent must continue to strive and act in ways that allow for them to continue authentically, but do not necessarily promote a sense of feeling content with one's decisions. Some of these virtues that I will discuss aim in hopes of feeling better such as with v_2 and v_3 above, but may also be those sorts of virtues as listed in v_4, where one does not feel any improvement or feel as though they are making a positive effect in the world. As a result, there may be a sense of frustration or futility despite these virtues aiming for what is right – but doing the responsible thing has often been in conflict with

one's happiness already in mainstream ethics. The point more is that depressed and anxious individuals, already as "compromised" moral subjects, should aim for authentic and interconnected lives as opposed to relying on what "feels" right even when nothing feels right. Some sense of relief may come from these virtues below, but the point is more to keep to living as best a life as one can, rather than being bogged down on flourishing as the pursuit of happiness, which makes them feel even more alienated or separate from others.

Moody Virtues, in Brief

Some of these virtues may overlap to some extent, meanwhile not all of them are applicable to all aspects or variations of mood disorders. Again it is possible as well that these virtues may apply to individuals who do not have mood disorders, but that is not my aim as I am building from the margins of emotional experience, but not directly concerned with the center or mainstream. Further, there may easily be other virtues that could apply and this should not be treated as an exhaustive list – this is merely the list that I have put together after years of research specific to depression and anxiety. The point is to understand that these virtues are piecemeal and existentially context dependent. The application of these virtues will be more fully explained later in this chapter, but the general sketch of them is as follows:

- *Understand what one can regarding one's symptoms* – While one's moral worth is not reducible to one's psychiatric symptoms, one nevertheless ought to learn as much as one can about oneself in engaging with the world. The general principle behind this guiding virtue is the Delphic Motto "Know Thyself". In order to responsibly understand one's place in the world and the effect their emotional life

has on their engagement and perspective, one must understand the realm of possible symptoms and behaviors tied to their condition. One can then do a "systems check" of sorts, being aware of one's symptoms when they arise and coming up with strategies to deal with the worst of their moods. This virtue stands between an excess of obsessing over one's diagnosis as a blueprint for their identity (as discussed in chapter 3) and the deficiency of outright ignoring treatment options and claiming that one can go it alone.

- *Moods are not objective statements on the world* – Moods may bleed out and affect one's engagement and perspective on the world in dynamic and interesting ways, emotional experience is not the same as a normative declaration. There can be a truth or insight in depressive or anxious feelings (as I've demonstrated in the chapter on depressive guilt), but that feeling is still looped in with one's own *subjective* experience. This virtue stands between the extremes of discounting or discrediting one's moods altogether by way of self-doubt or gaslighting on one end and readily believing fully that one's feelings are a full account of how the world is (such as believing that the world is worthless and that there's no hope while within a depressive episode).
- *Avoidance of taking oneself to be a perpetual victim or a "walking disaster"* – In taking on a better understanding of and articulating one's own suffering in mental disorder, there is often an urge to narrativize oneself as the constant victim or someone who is undeserving of love or a wretch. One needs to combat these positions wholesale in terms of ensuring that one does not either reprieve their actions altogether as a victim or see themselves as a destructive force of nature.

One can easily be the victim of suffering or have repetitive patterns of destructive behavior, but neither of these are deterministic for the individual's full existence. Where one may be shaped by one's history of trauma or self-destructive tendencies, this does not mean that the individual is entirely reducible to such a simplistic role. The deficiency of this is to take on one's victimhood or destructive tendencies as determinant and immutable factors of their existence, the excess is to deny one's biographical history or feelings and their effect on the individual's day-to-day experience.

- *Self-Care* – In order to act against one's more self-destructive moods, one must take care of themself. The extremes of this are self-indulgence or self-deprecation. It is hard to convince an individual who is undergoing feelings of worthlessness or feelings of extreme high esteem to back away from their feelings, but the need is to instead act in such a way that one takes care of themselves deliberately, even when one feels that one does not deserve it or deserves much more.
- *Survivalism/Perseverance* – This perhaps is an odd claim for a virtue theory as survival is seen as a precondition for even being able to live a life in general let alone an ethical one. Further it can be hard to understand how this differentiates from the self-care tenet above. However, in the case of the individual who by way of their mental health feels as though they are worthless, unlovable, wretched, or suicidal, survival becomes not only bare minimum precondition but also a moral statement. Even if this is the mere baseline, individuals who are able to take care of themselves in the face of their own feelings that they do not

deserve to live are still acting virtuously.[8] Claiming this as a virtue additionally harkens to comedian Maria Bamford's line "if you stay alive for no other reason at all, please do it for spite" (Bamford, 2013); there is a spitefulness for those who choose repeatedly to take care of themselves and hold on even on a bad day.[9] The deficiency of this is self-harm (in varied levels and forms) and the excess would be mere selfish survivalism that precludes the individual from being able to relate to others or be trustworthy.

- *Defiance* – I adopt this virtue directly from Nancy Nyquist Potter's *The Virtue of Defiance and Psychiatric Engagement* (2016). Defiance, according to Potter, is a virtue in psychiatric contexts in the sense that patients must make autonomous decisions that may run counter to social or medical expectations in order to preserve their own dignity. This falls in line with the Mad Pride movement and other movements concerned with the problems of autonomy and external authority. The deficiency of defiance for Potter is a complete deference to authority figures while the excess is almost spiteful defiance for the sake of defiance.
- *Find Confidants and Comrades* – All of these preceding virtues cannot be done alone. Where Aristotle devoted two entire books to the importance of friendship

[8] There is a general trope to call those who suffer suicidal episodes "brave" for resisting. On the face of it this seems apt, but several of those who experience suicidal ideation or feeling find it patronizing. I want to argue for a different form of virtue in calling this survival in order to move away from the odd valorization of calling living day to day "brave" for these individuals. The disgust in calling such resistance of suicidal feelings as "brave" suggests an inverse that the individual who does commit or attempt suicide is a "coward", which further undermines this individual's self-esteem and can worsen their feelings and behavior.

[9] Bamford's comic routines and other work are extensively based on her own frank and honest discussions of her own experience with mental illness including several hospitalizations over the years. She presents this line as an insider, someone giving open testimony.

in living a good life, the person besieged by mood disorder must also do what they can to overcome their sense of alienation by finding others who are willing and ready to listen, to support, and to just be there for them. Perhaps this is the hardest virtue to sketch out, as it requires fighting against social anxiety, desperation, or a general cynicism that others will fail them. However, where one can often be plagued with self-doubt there is a need to find those to affirm them instead. Again, much of this will follow along an Aristotelian-friendly line, but there is a deeper and more stringent need regarding confidants and comradery. Where Aristotle imagined that two virtuous friends would only build and engage with each other, there is a problem here. When one person does not have the same level of self-love as another, or if both individuals are "compromised" in this way, there is a fear of codependence or becoming too much of a "burden" upon the other. This is a comradery that requires checking-in. The excess of this guideline is to indulge too much into a relationship, while the deficiency is hermitage and giving into alienation.

Moody Virtues, in Detail

Understand what one can regarding their symptomology and conditions

Self-knowledge and self-awareness are important parts of becoming a responsible agent. It is hard to be authentic without a sense of knowing oneself. Without striving to know what one can about oneself, one can easily remain in bad faith where one ignores one's limitations or symptoms. As a part of healing from trauma especially, there is a need to be able to learn as much as one can about the wide array of one's symptomology in order to understand oneself further. While his 2016 work *The Healing Virtues* is more

concerned with the question of how therapists can help patients prosper, Duff Waring does devote some space to the discussion of how to be a good and responsible patient. Much of this revolves around the patient acting in good faith in terms of entering into a lasting partnership with one's therapist in order to commit to one's healing. Waring describes a sort of "healing curiosity" which "can be defined as the acknowledgement, pursuit, and intense desire to explore novel, challenging, and uncertain events and activities. It motivates persons to think and act in novel ways and to be immersed in, to investigate, and to learn about the interesting target of their attention" (Waring, 2016, p. 140). This sort of curiosity is one that looks into one's condition in the context of therapy. Waring believes that this is a virtue that supports others in order to move towards a better self-understanding for the individual.

Of course, to some extent this requires the institutional access to a level and fair diagnosis. Where mental healthcare is limited only to those who are able to afford healthcare or insurance, this virtue is limited to those of privilege and luck. One can try to learn as much as one can about one's condition through other means, but without institutional access to a therapist, one cannot get a clear expert opinion. Due to this sort of systematic exclusion, individuals often end up receiving information from less credible and often exploitive resources, such as religious groups, "life coaches" and influencers, self-help books, questionable YouTube videos, and so on. While some outreach and informational resources are well-intentioned and do provide accurate and accessible information, the problem is that bad actors remain online and elsewhere spouting off propaganda-style discussions of mental illness that portray disorder as a weakness of character. In the age of social media, anyone can end up with a wide platform and even

blatantly bad opinions and advice regarding what mental illness is and what it isn't and bogus treatment suggestions still remain within "the marketplace of ideas" even when tirelessly debunked by good epistemic agents.

Moods are not Objective Value Statements

Where Wittgenstein states in the *Tractatus* 6.43 that "The world of the happy is quite another than that of the unhappy" (1922, p. 88), there is an understanding that one's emotional experience of the world is highly subjective. Again, where one may have a happy disposition towards the world and as a result sees it as a safe place, the depressed or anxious person can fixate on the hostile or harmful parts of the world. These are not separate worlds, but the same shared world through different perspectives. No moody interpretation of the world, whether happy or dire, is an accurate one. Rather instead the truth lies somewhere in between and as many practices in cognitive behavioral therapy (CBT) have stated that "feelings are not facts".

The result then is that the person with anxiety or depression must understand that their experience and perspective of the world is not one that is totalizing or more right than anyone else. While earlier in the chapter on depressive guilt I argue that the experience of depression gives a certain depth of moral insight in being able to gauge our moral responsibility towards one another, this is still not a full moral authority. Rather, one must be careful in stating what one is feeling and understand that while these feelings are valid, they do not present a full and accurate picture of the world, especially when they are overwhelming. One must avoid taking on one's feelings as being full normative statements. Even if I feel guilty over climate change and that climate change is a pressing and terrible, horrible problem where ecosystems are collapsing and the world will change

in unimaginable ways causing destruction and death in its wake, I am not personally at fault for it for not recycling one bottle of water or letting my car idle for too long. While that guilt can affect the way in which I then make decisions and act, I must understand that I am not at fault.

Further, it is not the case that the world is then devoid of meaning. Where anhedonia would reveal a lack of positive value in the world to an individual, there is a need to remember that while one has lost pleasure in the things that used to be enjoyable, it is important to hold to oneself that their (lack of) feelings can pass, that enjoyment can come back again. Anhedonia can be especially hard. Where anxiety and guilt can be motivators for good moral action at times, anhedonia presents a rather nihilistic worldview altogether. To lose all or most pleasure is to become a bored, frustrated person. Anhedonia has the danger of turning to nihilism – the lack of feeling any pleasure in anything whatsoever means that things can suddenly lose all meaning for the person experiencing it. The experience of anhedonia is one that undermines any sense of positive connection to the world.

Further, there is the issue of temporality and feeling depressed. Very common within the experience of depression is the sense of a loss of future. Where the lives of others may seem fruitful and full of potential, the depressed person may feel as though there is no chance for themselves. The future is "blocked" – one cannot see one's future as anything other than the continuation of suffering and hardship. Much like as I stated above in the introduction, these feelings overwhelm and override one's sense of control over oneself. Feeling as though one has no future cuts off their ability to feel connected to the world and prevents them from feeling as though any action they do is meaningful.

This feeling also is draining. To feel as though one cannot do anything and that it is already too late for them is no viable way to persist. Ratcliffe (2015) describes despair as a loss of hope, where one no longer feels as though they have a future or that their projects. This often-recurrent feeling needs to be resisted; so long as an individual lives there are new days, new chances at starting new projects and holding off from this perceived loss of future.

There can be, perhaps, a "healthy" sense of realism to the realization that one will one day die and that life will likely move on without them. This instead can be interpreted as an inspiration to act. Just as Heidegger argues in *Being and Time* (1927/1962) that being-toward-death (*Sein-zum-Tode*) provides a grounding for authenticity, there are some gifts to being dour and concerned about death. Everyone dies, but as Camus says, "the point is to live" (Camus, 1955/1983, p. 65). One must engage with one's feelings in a way that acknowledges their suffering and (partial) normative claims, but also understands that these feelings are self-defeating and create a worsening state. Giving into one's depressive or anxious feelings is destructive. In reacting to one's depression one must push back on the darker end of these feelings but instead understand that one's emotional experience is only one interpretive stance towards the world.

Perhaps one effective reaction to the throes of depression or anxiety must come ahead with some foresight or planning. When one is not feeling at their worst, there is a need to plan ahead for when things feel bad – especially since difficulty planning and perceiving a future is symptomatic of depressive and anxious episodes. One possible strategy against the worst of depression and anxiety is to follow the sort of model of a

Ulysses arrangement or psychiatric advance directive (PAD). These are agreements that one can make in advance in order to maintain mental health treatment plans for when they may later be unable to make coherent decisions due to an episode. A Ulysses arrangement draws its name from the passage in the *Odyssey* when Odysseus (Ulysses) asks his crew to lash him to the mast when they pass by the Sirens' rocks. In doing this, he lets himself succumb to the madness of the Sirens' song but is unable to act upon his urges while his crew cannot hear him due to beeswax in their ears and he cannot escape from the mast. In psychiatric contexts, a Ulysses arrangement is a situation in which an individual who is prone to losing control to serious psychiatric episodes arranges with someone else (typically a psychiatrist) to prevent them from acting on their worst compulsions (Radoilska, 2012). A PAD is intended to prevent the individual from acting on their worst impulses. In cases such as schizophrenia, one may make a Ulysses arrangement to ensure that they stay on their medication even if they later insist that they do not need it or allow for themselves to be committed "involuntarily" in the future or for treatments such as ECT. In the United States, psychiatric advanced directives have different binding powers from state to state, but are written by someone when they are currently mentally competent in order to either provide instructions about specific mental health treatments for a crisis or to appoint a health care proxy in such event (National Alliance on Mental Illness, 2019). PADs take on a realistic approach to mental illness episodes; they recognize that one's cognition can become impaired at different times and instead of blaming or denigrating an individual at their worst, PADs allow for a plan to prevent terrible consequences of these episodes.

While PADs/Ulysses arrangements are meant to be legally binding, the countermeasure that I want to draw is much less formal and based in the question of devising things that one enjoys and finds worthwhile when one is not depressed or anxious. I'm not suggesting that people who are depressed or anxious are forced to do the things they enjoy by an outside force. Rather one ought to share in what one enjoys with others, and find individuals to hold one accountable for when moods get hard.[10] Where one can know that dark days are likely ahead again, someone who is not currently at their worst depression or anxiety can create a plan for when it may return. The point is to come up with a strategy for when one feels at their worst – since depression and anxiety are sometimes rather predictable patterns, it is possible to come up with some form of PAD that acts as a plan to work against one's moods directly. Outside of a depressive episode, someone can think back on what it was like during their last episode on what worked in terms of alleviating their feelings, what didn't work, etc. The point is to have resources and activities available as if emergency emotional rations.

One example of this is a video project that a dear friend's partner put together for them for their birthday, asking their closest friends to contribute their favorite memories about this friend. The partner's intentions for bringing this project together for them was that he knew they went through bouts of darker depressive episodes and that the affirming words of their loved ones would help carry them through the worst of it. When I asked this friend for permission to use this example, they stated that the video has helped especially during their 2020 COVID-19 quarantine. Keeping reminders that one is loved and worthy of love keeps the sense of dread and loneliness at bay. While this video

[10] This again necessitates a virtue in finding friends and comrades.

is not used as a Ulysses arrangement in the strict sense (since my friend is not forced to watch it), it provides for a countermeasure against their worst depressions to remember those who love them dearly.

Don't believe oneself to be a worthless or a walking disaster

Along with perceiving the *world* as being worthless or hostile, depressed and anxious people typically find *themselves* in low self-esteem. One's moral agency can be compromised when depressive or anxious feelings end up turning inward. One often feels inadequate and emotionally undermined in such a way that one cannot relate to others in a meaningful way, feeling as though one cannot be otherwise. Coupled with the diagnostic criteria of excessive or delusional guilt, MDD can carry feelings of being worthless as well (American Psychiatric Association, 2013, p. 161). Once again, these are 'delusional' feelings in that they do not accurately depict who the individual is and their moral worth. Feelings are not facts; to feel worthless is not to be worthless. Fighting against this notion is hard, however, as we have seen in the second chapter, that guilt can override one's feelings of self-worth and keep one from acting out of fear of not being worthy of doing the right thing. That is, guilt and feelings of worthlessness become a loop of who one believes one is. In believing that one is worthless or guilty, one makes oneself act worthless or guilty. These feelings may not be inherent facts of who one is but nevertheless drive one to act in such a way. As overwhelming as these feelings can be, one should not give in. Recovery requires a process of overcoming these feelings by making positive actions against them, which I will cover in the section on self-care.

Much like the discussion in the third chapter, one cannot idly accept one's diagnosis or feelings of self-worth as the be all and end all for who they are and all that

they can be. While a diagnosis does become part of one's personal narrative of who one is and is part of their existence in the world, it is not the only thing that defines them. Again, giving into one's feelings can altogether destroy oneself for no benefit to anyone. Common within narratives of depression and anxiety is the feeling of inadequacy that one will never be a good person. This sort of despairing in giving up on oneself has to be acted directly against. One's feelings do not represent who one *actually* is or their potential. The feelings of moral inadequacy are not a definitive claim, but as Sartre argues one has the potential to overcome one's cowardice and become a hero at any time (Sartre, 1945/2007). One can always try again, or even try for the first time, to fight against one's feelings of inadequacy in the face of mood disorder.

Instead the question must be that of finding worth in oneself. Again, this could presumably be done through something similar to a PAD, but additionally it requires close intimate relationships that affirm the moral and social worth of the person. As a virtue, fighting against these notions of taking oneself as inadequate needs to be built around working on self-esteem and confidence. Naturally, one should not overindulge in being overconfident as that can easily lead to a bigger defeat again – but one needs to work on oneself and allow for one to understand one's strengths and weaknesses while also understanding that one still belongs within a community of others.

Further, there's a need to avoid *normativizing* suffering. The suffering experienced within mood disorders is neither a test of merit or mettle, nor is it a carte blanche for acting terribly to others. While suffering is typically inherent to mood disorders, there is no use to valorize or fetishize this pain and often attempts at doing so end up harming others, passing suffering down the line. Abuse and trauma-related

disorders often perpetuate in such a way that a person who is the victim of childhood abuse may unreflectingly then later become abusers. Just as there is a need for self-awareness regarding symptomology, individuals with mood disorders must recognize that the suffering that they experience could pass on to others in their behavior or attitude towards others.

Self-Care

The term "self-care" has become so ubiquitous in current discussions of mental health that it has become almost superfluously meaningless. Yet, at the same time it is too important to take care of oneself to not mention it. Where one can often feel that one is a disaster or inadequate above, one must counteract this more directly through engaging with oneself as one *worthy* of care. Part of the reason that self-care has become so overused is that it can take on so many forms. Colloquially, self-care can mean a healthy diet, indulging, exercise, resting, seeing friends, spending time alone, and such a wide array of different opposites and spectrums. The issue is that different people have different needs for care and self-love at different times, making the conversation around self-care absolutely impossible to decipher as anything other than a pluralistic endeavor. The ubiquity of self-care talk has turned it into a cultural joke, where many chide that they are doing self-care if they neglect their work altogether, party, eat too much, sleep too much, or any other overindulgent action. Yet nevertheless while self-care is a bit ambiguous and overused, there is a vital need for individuals to find the things that bring joy for oneself and actively make time for them. Where one may feel as though one does not deserve happiness or to take care of oneself, a refusal to take care of oneself is a refusal to make oneself a social and moral agent.

Self-care and self-love then are in contradistinction with self-neglect. Where one wants to hold oneself as a responsible agent, one cannot allow for oneself to throw one's life away to misery but instead work to living well. Waring writes:

> self-neglect can be ethically responsible and calls for self-accountability, if not self-reproach. I would hold mentally capable persons responsible to themselves for a measure of self-care that supports degrees of physical and mental health that are better than adequate and less than supremely excellent. I would also hold them responsible for not being evasive about identity-conferring commitments that they are convinced they really ought to live by. (Waring, 2016, p. 133).

This of course is a bit tricky to hold someone in reproach for not loving oneself. In building self-care routines and self-love, one has to build up a sense of self-accountability. One has to hold on for oneself and maintain practices that allow for one to flourish, even when one does not feel that one "deserves" flourishing. To hold oneself in this form of self-reproach or self-accountability requires a commitment to the believe that one does in fact deserve happiness for oneself, even when it is something that is often out of reach.

Where one can feel anhedonia or despair, the most important thing one can do is to not be hard on oneself but to allow oneself to be kind. One example of this is Hume's famous backgammon excursion in the *Treatise*. Hume writes that when he's perplexed and depressed by a particularly distressing problem, he must step away from work. He states:

> Most fortunately it happens, that since reason is incapable of dispelling these clouds, nature herself suffices to that purpose, and cures me of this philosophical melancholy and delirium, either by relaxing this bent of mind, or by some avocation, and lively impression of my senses, which obliterate all these chimeras. I dine, I play a game of backgammon, I converse, and am merry with my friends; and when after three or four hours' amusement, I would return to these speculations, they appear so

> cold, and strained, and ridiculous, that I cannot find in my heart to enter into them any farther. (Hume, 1978, p. 269).

Hume's excursion away from his problem may seem like a flight into bad faith, especially for the person who is so entrapped within a problem that they cannot escape thinking of anything else. But, to escape at least for a moment from the things that trouble oneself the most is to allow for oneself to recharge or to come back to something that gives a better perspective.

The point of self-care is to find activities that allow for one to stay able to do the things that the find that they must do. One cannot allow for oneself to self-destruct, but instead must give oneself the sense of balance in their lives for rest and escape from one's immediate stressors. This cannot be a full escape from responsibility, but without care of oneself one cannot be able to do the things that one feels is right. One has to commit to self-love and self-care as a method of being able to be a responsible agent.

Survivalism/Perseverance: Holding on Despite Suicidality

Sometimes, just staying alive is virtue enough.

When one feels utterly miserable and lost and that there is no hope in their world, then even holding onto the next day requires commitment and determination. Suicidality is a common and harmful aspect of mood disorders (and mental illnesses at large). Even if one doesn't want to die consciously, the *feeling* of wanting to die, killing or harming oneself, or acting in reckless behavior is often all-too-alluring for individuals who regularly experience depression or anxiety. Much like bouts of depression and anxiety, these feelings come and go and still bother the individual. Suicide is a nearly universally condemned action, which makes it hard to establish that these thoughts or feelings are

things that are not "wrong" with the individual. As a society, we treat suicide as anathema, curiosity, sin, fetish, and countless other things that ebb and flow and often exacerbate these feelings for those afflicted. This virtue of survivalism/perseverance takes up suicidality seriously as an experience that can come and go, but argues that surviving – staying alive for the chance of improved feelings and for remaining with others preventing them from the duress of surviving another's suicide – is *virtuous enough* because it can allow for individuals to try again.

Famously, Albert Camus argues that suicide is the "one truly serious philosophical problem" (Camus, 1955/1983, p. 3). Camus' work discusses the appeal of suicide that speaks to many individuals, but ultimately condemns suicide because it stands in the way of an individual becoming an "absurd" hero, someone who wills to build and create despite the absurdity of the world that may strike "at any streetcorner" (10). Instead of resorting to suicide, Camus believes that the point is to resist and to create things for oneself. Where absurdity is hard to deal and can wear someone down, the point is to break from the monotony and horror of life and to choose new projects as each day that one is alive one can begin again. As much as it may be helpful in the short term, Camus' idea of embracing the absurd however does not seem like a sustainable reason to keep oneself alive. There is an element within becoming the "absurd hero" for Camus that appears as if it is just to spite the world. Again, much like the comedic quote from Maria Bamford above, there is a value to spite and to living out of spite, but it does not sustain beyond spite and does not make for a constructive life. Hanging on for spite is helpful in times of crisis, but it does not necessarily prevent an individual from veering towards suicidal action again in the future.

Amongst other things, suicide in most cases necessitates an unsettling aftermath upon others. Where one's suicide is often chosen in relation to rejection of or by others, one more often than not leaves a body to be found. Where there are perhaps cases of suicide that we may excuse morally, there is still nevertheless a harm in the moment of discovery. That is, discovering the body of someone brings the capacity for trauma upon the discoverer, whether they are a close loved one, an acquaintance, or even just a stranger. Sometimes, the methods of suicide explicitly intend to harm or traumatize others who would discover them. [11] When the moment of discovery is specifically planned or aimed at harming others the individual dying by suicide is acting immorally.

[11] To give an especially brutal example: on the morning of September 9, 2019, Gregory Eells, the executive director of counseling and psychological services at University of Pennsylvania, jumped to his death from the 17th floor of the 100 block of South Broad Street where he lived. There was no note, but he had worked for UPenn for six months, long distance from his wife and children who had stayed in Ithaca. His mother claimed that he found the job harder than anticipated. Eells' wife's mother also stated that she and his family "are confused. He was the most smiling, upbeat person I have met in my life" (Snyder, Newall, & Dean, 2019). These sorts of stories of individuals who are by appearances are happy and joyful yet are suffering and self-destructive are rather ubiquitous. It is hard for someone to feel as though one can share their pain and suffering, especially within the case of being a caretaker. Where one feels responsible for the lives and ameliorating the suffering of others, caretakers often burnout and are unable to take care of themselves. It's perhaps hard to track due to mental health caretakers not wanting to let on to their suffering for fear of being a fraud, but different studies have found that the high burnout rate for practitioners in the mental healthcare field is somewhere between 21-67% (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Eells himself was seen as an expert in resilience, but he himself must have found the pressures of his work too hard to bear alone. As much as it is hard to malign someone who left no note, there are too many circumstances that project some sort of nihilism or even malice in Eells' suicide. The 100 block of South Broad Street is the dead-center of Philadelphia, within a block of City Hall and where countless individuals are within sight of at any given time. Further, there are many people who depended on his work in the counseling and psychological center, not only students but additionally his own staff who also probably struggle with burnout and compassion fatigue as well. Penn has been decried for years for poorly handling student mental health and suicides (ibid). Eells left behind the potential for a suicide cluster to form, where the suicide rate of a particular community spikes due to the "inspiration" of others. Where Eells was the head of counseling for a large university, his death may have a large influence over the mental health of others who already are in need of services. For those struggling on their own, seeing another struggle and die by suicide provides too much of a precedent or inspiration. But especially due to his position, the cluster effect of this suicide could be immense. Perhaps the most menacing fact is that Eells' suicide took place at the very start of National Suicide Prevention Week. It is hard to imagine that these elements did not cross through Eells' mind, and that even if we are to suspend judgment on any malice he may have had in dying by suicide in this way, he must have known that this was an act that would be interpreted as selfish and not only self-destructive, but destructive of his community at Penn, his family and friends, and the unwitting strangers below him on Broad Street.

In the case where one dies by suicide publicly, one is not only survived by one's loved ones but also strangers who had no interaction with the individual when they were alive. But rather, by way of bad moral luck, one can face the suicide of another out of nowhere. The death comes as a sudden traumatic event. When one throws oneself out of a building or in front of a train, one is choosing one's death with the consequences of traumatizing others. In a more passive or private suicide, the individual's body may be discovered later by loved ones in whatever state of decay. This is additionally traumatizing. The firsthand moment of discovery of a suicide is shocking and passes on one's pain to others. Public suicides pass on that pain directly and often vengefully, wreaking havoc upon whoever happens to be there, intentional or not. To die by suicide in private still more often than not involves the discovery by a loved one, neighbor, landlord, etc.

The virtue in the face of suicidal thoughts or actions is *to survive instead*. To stay. To hold on and allow for one to keep trying. This is perhaps a hard claim to make, or at least it is hard to argue to the depressed individual who wishes death upon themself. While it is hard to hold blame for those who have been overwhelmed by their feelings and end up dying by suicide, the more virtuous action is to remain, to survive. This is to be differentiated from being called "bravery", where we want to valorize but often patronize those who remain. This is a difficult line to toe, I want to both argue that people should fight against suicidal feelings, but also at the same time I don't want to chastise those who have not, or those who have attempted suicide. Suicidal ideation and feelings have a large sense of shame and stigma that has everything to do with speaking on the feelings and experience of suicide from the outside, while those struggling are too often stuck within themselves and unable to reach out to others in meaningful ways. The

argument against suicide that I ascribe to overall is argued by Jennifer Michael Hecht in her book *Stay* (2013). Hecht argues that the best claim against suicide is that individuals leave others behind. To die by suicide is to forfeit one's chances at community and being able to build and foster relationships and allow for oneself to become a better person.

In traditional virtue theory it would be assumed that before anyone can even evaluate whether they are living a flourishing life or not, one *must* be living and surviving as a precondition. But in the case of suicidality, survivalism is something that comes up as a virtue for the individual trying to manage even the most otherwise simple day to day things or events. In response to the very existence of suicidal feelings as a threat against oneself, one must then take steps to survive oneself in order to hold on and build other aspects of a flourishing life. Lisa Tessman closes out *Burdened Virtues* with a similar point: to survive and to choose life is a vital core to living a good life, even the happiness of that life is compromised. She writes:

> The choice to go on living, to insist upon life—with its sufferings and its joys—is an existential choice of great significance under oppression, and this choice captures something crucial of eudaimonism. In fact, this phenomenon of affirming life may offer insights into how one is to conceive of *any* human flourishing, for in choosing life one chooses what is at the core of a *good* life. (Tessman, 2005, p. 168)

Suicidal feelings in themselves prevent an individual's ability to flourish at least in the moment of experiencing them, but giving into the feeling and attempting suicide can altogether lead to the complete erasure and inability to ever enjoy or contribute to anything ever again. In the case of suicidal feelings, one faces one's mortality constantly as a problem. "Insisting upon life" allows for the possibility of a flourishing life later, even if it seems so overwhelmingly hopeless for the individual who experiences suicidal feelings/thoughts. Again, this does require a certain amount of moral luck that one's

conditions (or at least their perspective on their conditions) improve. Yet choosing suicide is a definitive choice that one gives up on the world, as Camus argues.

Suicidal thoughts or ideation can be obsessional for the individual. Preoccupying oneself with their own death is a rather loathsome burden and even deciding again and again *not* to kill oneself can wear one down. One feels unable to cope with themselves, unable to cope with life. One can feel it in their bodies beyond just simple cognition or urge to want to die. Some feel a pressing or tightening in their chest; some feel as though their arteries in their arms are simultaneously on fire and ice. Phenomenologically, suicidal feeling can be a discomfort with one's entire body, one's entire existence. The bodily discomfort of suicidal urges can be racing thoughts, alternating feelings of hot and cold up and down one's veins, nausea, and other anxiety-driven corporeal feelings. Suicidal feelings are inherently uncomfortable. The philosopher Jean Améry, an Auschwitz survivor, had suicidal ideation and feeling for the latter part of his life and after several attempts died by suicide in 1978. In his series of essays *On Suicide: A Discourse on Voluntary Death*, he describes suicidal feelings as "disgust with the world, claustrophobia from the four walls closing in on each other as one hammers one's head against them" that "naturally brings potential suicides distressingly close to such shadowboxing" (Améry, 1976/1999, p. 70). Suicidal ideation and feelings are inherently uncomfortable and distressing to the individual.

Even if one does not want wholly to kill oneself, the feeling or ideation can nevertheless exist and follow one around. Even if it disgusts them to think of their death enough to prevent them from acting, individuals with suicidal thoughts find themselves playing through scenarios and looking to their environment for different opportunities to

kill themselves. While feeling suicidal, individuals interpret mundane objects as tools of destruction, ledges and passing trains as opportunities, etc. Where certain moods interpret the world in new ways, suicidal thoughts perceive the world as not only dangerous, but a danger that can be embraced.

All too typical within depression and related mental disorder is the turn towards nihilism. Where one may feel worthless or guilty or alienated from others, there is a ready desire to take up the world as meaningless and empty, to destroy any chance of meaningful connections to it. This comes out in many forms, but the more drastic, final, and most obvious form of nihilism is that of suicide. Nihilism is not the only justification for suicide, and there may be morally-acceptable forms of suicide – that of protest of oppressive regimes, self-sacrifice to let others live such as Sydney Carton in *A Tale of Two Cities* (Dickens, 1999), choosing euthanasia as a relief from debilitating disease, and so on – but very often suicide is a nihilistic, destructive act. Oftentimes it is a desire to will nothingness onto the world, that there is nothing worth doing but to destroy oneself.

In writing against suicide there is always the danger of slipping into paternalism or undermining the freedom of others in choosing to kill themselves. This comes up throughout Améry's writing, where he believes that society has continuously ignored and patronized the experience of suicidality, making it all the worse. The alienation and estrangement that those who have been suicidal from the rest of society only increases when one encounters a lack of understanding or respect for one's feelings. There is a paradox of sorts here, where one feels both the need to be heard from others but also knows that being vulnerable in discussing one's feelings to others can only made it worse. Further, in *The Ethics of Ambiguity*, Simone de Beauvoir writes:

> We blame a man who helps a drug addict intoxicate himself or a desperate man commit suicide, for we think that rash behavior of this sort is an attempt of the individual against his own freedom; he must be made aware of his error and put in the presence of the real demands of his freedom. Well and good. But what if he persists? Must we then use violence? There again the serious man busies himself dodging the problem; the values of life, of health, and of moral conformism being set up, one does not hesitate to impose them on others. But we know that this pharisaism can cause the worst disasters: lacking drugs, the addict may kill himself. It is no more necessary to serve an abstract ethics obstinately than to yield without due consideration to impulses of pity or generosity; violence is justified only if it opens concrete possibilities to the freedom which I am trying to save; by practising it I am willy-nilly assuming an engagement in relation to others and to myself; a man whom I snatch from the death which he had chosen has the right to come and ask me for means and reasons for living … whatever the purity of the intention which animates me, any dictatorship is a fault for which I have to get myself pardoned. Besides, I am in no position to make decisions of this sort indiscriminately; the example of the unknown person who throws himself [into] the Seine and whom I hesitate whether or not to fish out is quite abstract; in the absence of a concrete bond with this desperate person my choice will never be anything but a contingent facticity. (Beauvior, 1947/1948, pp. 147-148).

De Beauvoir here concedes that "saving" an individual, either from using drugs or suicide, can run directly counter to their wishes, and it does not immediately fix the situation. The trouble with suicidal ideation or feeling is that it prevents the individual's sense of finding worth or connection to the world. Again, hand in hand in depressive disorders is the feeling of worthlessness. It is hard for the individual to justify their own life if they feel that they are not deserving of it or deserving of being with others. This feeling of worthlessness often concurrently "justifies" or feeds into and off of suicidal feelings. It is hard to justify to an individual with reasons that one's life is worth living or that the state of the world is going to be or remain favorable to them. Suicidality is a direct, live, and prescient problem for individuals who experience it because the feeling of hope becomes lost to them.

This spite fits in with an existentialist ethic to a certain extent, at least where the question of death appears for Sartre (1943/1956). For Sartre, death is something that acts as an endpoint in which one becomes "prey" for the living who can judge the dead for their actions and deem them a good or bad person To choose suicide is to forfeit one's ability to continue their possibilities, their projects end with a very resolute punctuation (Sartre, 1943/1956, p. 540). Living on allows for an individual to still speak for oneself rather than let others take over their narrative, often condemning their actions in the end and forgetting the good and communal actions that they may have done in the past. Staying alive for spite means that no one else can take over one's story or narrative outright.

There is a distinction to be made between suicidal ideation and suicidal actions. Suicidal ideation is the preoccupation of suicide Additionally, I am using the term suicidal actions as opposed to trying to hedge between attempts and completed suicides. There's often a sense of downplaying suicide attempts as being less serious or "faking it" or merely "doing it for the attention". However, instead I argue that all attempts are serious, even if one is seeking attention. To wish harm against one's body for the sake of crying for help from others is still a very serious cry for help, one that requires recognition and attention. But suicidal actions are also not just those that are self-conscious, open, self-transparent actions at hurting oneself. There are also "parasuicides", actions that are related to self-harm and self-destruction that might not be actively or consciously suicidal, but still partake in a low (or utter lack of) self-esteem. Parasuicidal behavior can include deliberately abusing drugs, risky sexual behavior, or other dangerous behavior that could lead to bodily harm. Parasuicides themselves are

particularly distressing because they are not necessarily recognized by the individual, but do still partake in a desire to harm oneself in some way. This is not an attempt to villainize drug use or "risky" sexual behaviors, but a recognition that the range of self-harm is beyond the conscious.

Suicide prevention efforts are difficult because they require an admonition that suicidal feelings exist and that these feelings in themselves are not evil or betray one's ability to be considered a moral agent. Once again, there is a need to be open and honest about one's experience without indulging too much into the hardship that these feelings bring upon the person. This again raises the need for the sort of responsibility without blame model that Hanna Pickard (2013) argues for that I introduced in the third chapter; it is understandable that individuals face the experience of suicidality, but this should not be blamed in the feelings themselves or even in attempts. Rather instead, we need to move towards a model of accepting the feelings of individuals as valid and perfectly human feelings outside the model of right and wrong. While the act of suicide is devastating, suicidal feelings should not be chastised in themselves. Individuals with suicidal feelings should remain and hope for the best, but the rest of us have to ensure that we do not condemn or shame them for feeling this way. While the "virtuous" action against suicidal feelings is to persist and survive, society at large must do much better to accept the individuals who have these feelings.

Defiance

Oftentimes, depression and anxiety undermine an individual's sense of autonomy and one feels that one cannot stand up for oneself. Especially where marginalization, oppression, trauma, or abuse can be a causal factor or trigger for mood disorder episodes,

it is hard for these individuals to protect their own interests and resist the control or manipulation of others. In turn, there is often a need to be defiant: to actively engage in behavior that may seem uncouth, disrespectful, or even destructive but aimed specifically towards fighting against what is wrong for the positive development of one's own autonomy. Again, this virtue is directly adapted from Potter's *The Virtue of Defiance and Psychiatric Engagement* (2016). Potter works directly from Tessman's adaptation of burdened virtues in order to establish defiance as a virtue that applies for those who are socially limited and constrained by stigma and psychiatric control. There is a need to defy or resist the being altogether complacent with psychiatric trends. This can come in many forms, including noncompliance with medical advice. While this may seem counterintuitive, defiance is a virtue according to Potter precisely because it allows for individuals to gain autonomy for themselves. Potter sees defiance as a virtue when it "speaks to norms as much as to persons, and it expresses that the oppressors' values are distorted or perverse" (Potter, 2016, p. 31). Being defiant is virtuous in that it not only stands up for oneself, but it also takes on oppressive values as a problem. Yet, Potter sees this different from civil disobedience, which typically is more organized against a state in particular.

Of course, to have defiance as a virtue is to claim that it lies between extremes. Potter writes: "The deficiency would seem to be submission, fatalism, hopeless [sic], or subservience; the excess is something like random lawlessness, continually in-your-face actions, or belligerence" (Potter, 2016, p. 41). A lack of defiance in the face of depression and anxiety is the sort of behavior that embraces one's sense of worthlessness, to readily believe in the cruel things being said either by others or one's own terrible undermining

narrative of feeling worthless. Defiance tries actively against this cycle of submission and fatalism in order to build oneself up. The excess is a sense of recklessness and needless belligerence that does not produce anything helpful for the individual. Defiance is virtuous when it allows for the individual to resist and build. It's not merely reactionary, but is resistance that can lead to building something new in the individual for their autonomy and allow for future projects.

When it comes specifically to depression, Potter believes that even a smaller act of defiance allows for individuals to experience "a basic power, and that experience is strengthening and life-affirming. It is objectively better than being submissive and crushed by circumstances and mental illness" (Potter, 2016, p. 69). Potter cites an example from therapist Lauren Slater regarding one of her patients who when hospitalized after an overdose refuses to participate in group therapy. Although this is defiant behavior against a standard therapeutic practice, Potter notes that Slater believes that this act of defiance is helpful since it taps into an anger that the patient has and allows for her to establish some dignity for herself and it even gives Slater some relief. Potter writes:

> By refusing to comply with staff expectations and by asserting herself as someone who will not submit to something she does not like and does not believe will help her, Marie [the patient] shifts away from moral damage. And perhaps, within Marie, such an act of defiance decreases her relationship to burdened virtues: by refusing, with passion and energy, to attend group activities, she reorients herself toward what she can do and not what she cannot do she chooses within constraints, but decides what she wants for herself despite the authoritative structure of the hospital (allowing that, in many other cases, the authority of psychiatrists is in the direction of what is good for the patient) and she chooses without a negative remainder of feeling. (Potter, 2016, p. 69).

Potter points out that while refusing therapies would typically be seen as counterintuitive, the intention itself of exercising what power Marie has is important for her ability to act for herself. Defiance is autonomy-building in a case like this, and where depression usually saps one's motivations altogether, it is helpful for her to tap into her anger with her condition and her situation than to be taken up into activities that she does not want to do.

Defiance is far from a traditional virtue because of its abrasiveness and its sense of spite and fighting for oneself. But when someone otherwise feels that their life is only succumbing to subjugation or self-wallowing, being defiant helps one overcome one's worst feelings by making oneself worth fighting for, whether out of spite or just self-preservation.

Find Confidants and Comrades, Seeking Fellow Travelers

One of the more unbearable themes in depression and anxiety is the feeling of being alone (Ratcliffe, 2018). Mood disorders often feel so utterly and deeply alone for the individual. The experience of these disorders is often steeped loneliness to the point that it is hard to establish which causes the other. This sense of indistinguishability of causality between loneliness and mental disorder is why Dutch psychiatrist J H van den Berg argues:

> Loneliness is the central core of his illness, no matter what his illness may be. Thus, loneliness is the nucleus of psychiatry. If loneliness did not exist, we could reasonably assume that psychiatric illnesses could not occur either, with the exception of the few disturbances caused by anatomical or physiological disorders of the brain. (Berg, 1972, pp. 105-6).

While this is likely a drastic overstatement on loneliness' etiological effect on all disorder, it does warrant some credence that loneliness worsens individuals' mental

health. To believe that one is truly and utterly alone undermines their ability to feel at home or their ability feel comfortable in their decisions without being rejected by others. Finding confidants who one can feel comfortable expressing their feelings with is vital for not only one's own continuation and survival, but their ability to take on new projects that help sustain and flourish not just oneself but others as well.

Where depression and anxiety can feel inexpressible and alienating from everyone around oneself, the virtuous action requires not only finding friends and confidants, but what I call "fellow travelers" – those who also experience the highs and lows of mood disorder. Befriending fellow travelers is especially important in the sense that it allows for an individual to find others who have not only experienced similar feelings, but may also have figured out ways to cope, can share their own failures and mistakes. There is a lot to learn in how to cope with one's depression and it is valuable to the individual to learn what to do (or often more importantly what *not* to do) in facing one's darker moods. It may often be hard to find these others, as many try not to advertise their dark feelings due to stigma, or on the other hand one may be too indulgent in them in ways that become too taxing on oneself. It is important to find those who one feels at home with.

At the outset, this virtue seems rather straightforward and in-line with virtue theories in general. After all in the beginning of book 8 of the *Nicomachean Ethics*, Aristotle states that friendship "is a virtue, or involves virtue. Further, it is most necessary for our life. For no one would choose to live without friends even if he had all the other goods" (Aristotle, 1999, p. 119). It is imperative to find friends to help through one's worst feelings. Friendships are notoriously hard for people with mood disorders. It is very

difficult to maintain friendships when one has the propensity to disappear from social life.

There are however some caveats to Aristotle's form of friendship that might stand in the way of the experience of depression and anxiety. Aristotle defines friendship as "reciprocated goodwill" (Aristotle, 1999, p. 121). This is specifically the sort of goodwill that one has towards those that one knows personally. It is hard enough for individuals with depression to cultivate enough self-love and goodwill for themselves, let alone being able to reciprocate with others. Reciprocation is an important operant distinction here – it is hard at times to be reciprocal in one's friendships when mired in depression or paranoia.[12] Reciprocated goodwill requires that one does in fact care for those other than oneself in building friendships. Where depression and anxiety often make one selfish or closed-off from others, it is important to build relationships out of trust and accountability. To be a good friend requires not just the sense of wanting others in one's life, but also to want to be there for theirs. The trouble with goodwill and depression and anxiety as well is the problem that where one does not see oneself as worthy of love or friendship, one must actively fight against this and create connections for oneself and take risks and chances.

In the past and present in parallel to other pride movements, the Mad Pride moment has tried to destigmatize and fight for the rights of those otherwise downtrodden and medicalized. (Bracken & Thomas, 2005; Rashed, 2019). They have fought specifically to reclaim "madness" and to demand recognition as a social identity that

[12] A further psychiatric condition that can affect consistency in friendships is the Capgras delusion, where one believes that their loved ones are impostors.

deserves autonomy and understanding. There is a need and calling for the Mad Pride movement today more than ever in conjunction with other solidarity movements that seek to build new systems and networks for mental healthcare that focus directly on the needs and experiences of individuals living with disorder rather continuations of the same hierarchical power structures that have harmed so many individuals and left so many others behind and adrift.

One of the better ways to combat this sense of alienation and distance between oneself and others is to openly discuss one's experience to trusted others in some way – as a result, a sub-virtue of this is to give open and honesty testimony about how one is feeling. Where one's moods may fluctuate and undermine their capacity for consistency in keeping their word or being accountable in a general sense, speaking the truth of one's experience to others allows for one to keep accountable in a different sense. In being open about one's experience with one's close peers or family, one can additionally alleviate their burdensome feelings to some extent. As such, this virtue has multiple benefits for the individual. One benefit of talk therapy, when trust is established, is the ability to air one's experience to a receptive and listening ear that does not downplay one's feelings while still helpfully redirecting them. This can be a tough tenet to take up for oneself as being vulnerable with anyone can feel exposing for someone who already has a sense of distrust in the world and others. Finding such trustworthy interlocutors can be extremely difficult, or alternatively there is the very real concern of overextending an individual's emotional labor or harming them in turn. The deficiency of this would be repressing or bottling up one's emotional experience as a secret from others, while the excess would be oversharing with an untrustworthy audience. Additionally, it is

important not to overburden others – even though this is the very same feeling this virtue needs to overcome – being vulnerable and honest about one's experience can trigger others into similar feelings as if by contagion. This sub-virtue requires a certain amount of restraint that can at times feel Sisyphean in trying to measure what is too much or too little to bear to another, whether they are ready or not. Instead, it requires a certain amount of checking in with others to ensure that one does not overload them and a sense of mutual reciprocity when one can bear hard truths from others.

Returning to survivalism against suicide, friendships are especially important for one's sense of persistence. The argument for community in Hecht's *Stay* is built around the idea that one does not know one's influence or contagion if one is to die by suicide. While one may feel as though one is entirely alone and alienated from the world outside of themselves while experiencing suicidal ideation, the fact is that they do exist within a community of others. It is important to reach out. While one cannot rely on others wholly in order to prevent oneself from taking one's life, friendships help build community and accountability in the individual to keep them from doing something drastic and self-destructive.

Finding others to be in community with is a necessary task to fight one's darker feelings. Where dread and angst are seen in the existentialist tradition as modes of engaging with one's freedom, it is tantamount to not go it alone and to additionally be there for others. Simone de Beauvoir writes: "To will oneself free is to will others free. This will is not an abstract formula. It points out to each person concrete action to be achieved. But the others are separate, even opposed…" (Beauvior, 1947/1948, p. 78).

Where freedom can be anxiety and depression inducing, one must work with others to help sort out what is the best way in which one can engage responsibly.

Concluding Remarks

This chapter is a modest attempt at sketching virtues for depressive and anxiety disorders. These are likely far from an exhaustive list, but they help at least as a toolkit that can help individuals who are grappling with not only their mental health, but a sense of purpose for themselves and loved ones. These virtues are "burdened" in the sense that they may just be at times placeholders for these individuals, as one's life may change and, to paraphrase Susan Sontag, one may no longer be traveling along the kingdom of depressive illness (Sontag, 1990). My hope is that these virtues can be further sketched out and expanded upon. The upshot of this and any other work in ethics is that human beings must still continue to take up new ethical projects and build upon what is right beyond just one's own myopic self-determination. With worsening climate conditions and violent politics, it seems very unlikely that depression and anxiety will go away and that it may instead increase to more of a human normalcy. For the existentialists, every generation must heed the call of responsibility in order to take up projects that enrich human endeavors and allow for our mutual beneficence and aid. Where depression and anxiety often stem from the feelings of inadequacy and loneliness, it is our responsibility today to take care of one another and try as our best to put these feelings at ease in the absence of magical thinking and hopes for some futurist miraculous fix to these conditions.

CONCLUSION

DRIFTING

For the past few years, whenever I spoke to anyone about this project they would often remark how timely it is. I often joke in turn that I wish it wasn't. Unfortunately, I fear that these questions will never be untimely and that we will continue to face the problems that I have outlined indefinitely. This project has argued that the lived experiences of depression and anxiety disorders confront not only disordered feelings, but disordered information. In the meantime while waiting for a coherent pluralist approach to mental health, it is up to individuals with depression and anxiety themselves to navigate the best passage for themselves. Psychiatry aims to classify and treat mental disorder through biomedical, neurological, social, and psychological means. However as this scientific pursuit shifts different paradigms and research programs, there are very few clear paths that are accessible that individuals can cross that foster their own autonomy, dignity, and authenticity. Instead, individuals remain epistemically adrift.

To be pessimistic: it is unlikely that depression and anxiety will disappear from the world. Even worse, between the COVID-19 crisis, continued racism and bigotry, a global resurgence in fascist politics, uprisings of 2020, and impending climate change disasters, it seems quite likely that the grief and trauma of the world will create for new disordered ways of living. With the universal-yet-so-particularly-existential trauma of the COVID-19 crisis – between isolation, illness, the loss of loved ones as well as the constant anticipation of the loss of loved ones – many lament the world as it was before in some sort of "normalcy grief". Whatever happens post-corona or post-quarantine will be within a radically changed life-world. The aspects of normal everyday life have been

so dramatically changed across the world, that it is hard to fathom that anyone will come out of quarantine or essential work unchanged and not marked by the pressures of this crisis. I suspect that there will be a change not only in the uptick of cases, but also that "new" mental illnesses (particularly mood disorders) will arise in its wake. I imagine that the boundary line between well and unwell will be less clear than ever before.

With these unprecedented times, psychiatry must change as well. In an interview psychiatric epidemiologist Jaimie Gradus remarks:

> With this pandemic, we're in more of a rolling disaster, where it's been bad for a long period of time. There's variation happening in how people are planning to come out of the current situation. But we are likely to go into a situation like we've been experiencing again, and it will kind of go on and on. So mental health following a situation like this is not exactly something we know a lot about. (Stix, 2020).

The uncertainties of the COVID-19 crisis bring with them many uncertainties in mental health. Gradus remarks that many individuals are now forced home in unsafe environments in quarantine which will lead to novel cases of trauma and isolation that will unhinge individuals. It may be that psychiatry will no longer be concerned with the problems of a statistical minority, but will have to ameliorate the uncertainties of the general population too. The very face of what is and what is not disorder may change in response to this pandemic as it continues to loom over us and enters into every aspect of contemporary life.

The uprisings in the past few weeks in the United States also bring with them a large sense of uncertainty. As much as the protests against police brutality and racism have brought some success with them and may bring about revolutionary changes, the emotional scars of racial violence remain for its victims, perpetrators, and bystanders all

remain changed as shown in the case studies at the end of Frantz Fanon's *The Wretched of the Earth* (1961/2004). No matter what positive changes these upheavals bring about for the United States and other nations, the violence and trauma will leave aftershocks in those who survive and witness it.

But amongst all this uncertainty both within mental conditions themselves and within the pandemic, politics, racial violence, and climate anxiety, there is still some hope to continue and resist against outright despair. This project has aimed at explicating the everyday problems of mood disorder to build a moody responsibility. My hope is that this existentialist toolkit that I have provided can be taken up by people affected by depression and anxiety to work and navigate emotional and epistemological uncertainties together in solidarity, whatever storms may come.

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