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Understanding Obstacles in Psychiatric Research: An Analysis of the Structure of Mood via Merleau-Ponty

Abstract:
It is no secret that the methodology within psychiatric research has been challenged to the point of a possible paradigm shift. After decades of failed attempts to determine biological markers for the mental illnesses classified by the *Diagnostic Statistical Manual*, we are witnessing a radical transformation of the way we think about mental illness. While research seems to be on the right track by migrating from a discrete categorical approach to a dimensional matrix of the neurobiological conditions responsible for cognition, there are concerns that the neurosciences involved in the development of this dimensional framework will be unable to arrive at a diagnostic system appropriate for clinicians. Consequently, it has been suggested that researchers and clinicians should develop distinct ontologies. I argue that such an approach will not do justice to the complexity of mental illness and offer insight into the applicability of a phenomenological approach in psychiatric research.

Keywords:
philosophy of psychiatry, Merleau-Ponty, phenomenology, Diagnostic Statistical Manual, Research Domain Criteria, mood disorders

Introduction[1]

Since the American Psychiatric Association (APA) began publishing the *Diagnostic Statistical Manual* (*DSM*), psychiatry has been led astray by an inadequate symptom-based nosology. Due to the APA's inability to appropriately integrate a dimensional model into the *DSM's* fifth edition, the National Institutes for Mental Health (NIMH) began restricting funding to research centered around neural circuitry, as outlined by the Research Domain Criteria (RDoC). While the RDoC has the potential to improve psychiatry, due to its capacity to investigate the various cognitive processes involved in psychopathology, it is not clear how this research will translate into clinical practice. It is for this reason that some researchers, such as Robyn Bluhm, have refuted the NIMH's claim that the RDoC will lead psychiatry toward a complete picture of mental illness and have suggested that researchers and clinicians adopt distinct ontologies.[2] Inspired by Maurice Merleau-Ponty's *Structure of Behaviour* (1963), I maintain that the development of distinct ontologies for researchers and clinicians would produce two incomplete pictures of mental health that would not result in a complete picture if juxtaposed. Moreover, I believe that the integration of phenomenology into psychiatry provides researchers with the opportunity to develop an understanding of mental illness with explanatory and clinical relevance.

To demonstrate this, I will begin by outlining some of the obstacles that arise from research conducted within the *DSM* and the RDoC frameworks. This will be done to introduce and provide some support for Bluhm's proposition that psychiatry ought to progress by developing distinct ontologies for explanatory and clinical research. While I agree with Bluhm regarding the obstacles psychiatry faces, I am concerned that pursuing explanatory and clinical research separately will ultimately result in the reification of an already existing knowledge gap. These concerns will be made clear by referring to Merleau-Ponty's observations on the way behavior structures itself. With the recognition that one's mood is inextricable from one's behavior, it has become apparent to me that the three levels of experience revealed in Merleau-Ponty's analysis of behavior are also operative within the structure of mood. With insights established via Merleau-Ponty, I will proceed by providing a preliminary sketch of the role phenomenology can play in psychiatry's capacity to adequately demarcate and identify different forms of mood disorders – a capacity that requires not only a knowledge of the physiological changes escorting the development of mood disorders, but also an understanding of how mood disorders emerge from within an embodied subject's lived experience.

While one's mood is no doubt at issue in all forms of mental illness, I will be focusing on mood disorders because it is reasonable to think that behavioral, personality, cognitive, and learning disorders have different sets of "roots" within the totality of an individual's being. This is not to say, however, that insights developed throughout the paper are restricted in their applicability to mood disorders. Since one's mood simultaneously influences and is influenced by lived experience, it is reasonable to think of one's mood as something that is affected by the presence of any mental illness, while also affecting how an illness takes hold of one's mind. With that said, I acknowledge that the word "mood" has diverging connotations phenomenologically and psychologically. While the Heideggerian notion of *Stimmung* seems to have dominated the phenomenological discourse regarding affective experience, as that through which the world is revealed to the subject as something that matters and requires caring for, the psychological notion of "mood" can be generalized as a transient state of affectivity. For the sake of this discussion, the direct mention of "mood" will be in reference to the psychological

1) I would like to express my appreciation to the editors, dr. Jakub Tercz and dr. Mikołaj Sławkowski-Rode, for their detailed comments on an earlier version of this paper. I would also like to thank one of the anonymous reviewers for *Eidos. A Journal for Philosophy of Culture* for his/her helpful suggestions I received during the blind review process.

2) Bluhm, "The Need for New Ontologies in Psychiatry," 156–157.

notion of the word. It is my hope that we can engage with psychological and psychiatric constructs phenomenologically, without radically altering the meaning behind them – unless, of course, phenomenological insights strongly challenge their naturalistic implications. To understand a mood as a transient state of affectivity is certainly not mutually exclusive with the notion that it is through our moods that we come to grasp the significance of the situations we find ourselves in. This is especially true when we begin to see how transient states of affectivity are structured by the multiple levels of lived experience demarcated by Merleau-Ponty.

The Inadequacy of the DSM and RDoC Frameworks

There are two clear obstacles to our understanding of mood disorders when relying on the *DSM* as the grounds for our conceptual knowledge. The first issue is concerned with the assumption that mood disorders are identifiable by reducing a patient's lived experience to a unique set of symptoms that have a causal relationship with an independent diagnostic category. "Across all of the versions of *DSM*, there is one common assumption, in other words such a categorical approach to mental illnesses assumes that mental disorders are discrete entities shared by relatively homogenous populations that will display similar symptoms of any given disorder."[3] Such an assumption fails to account for forms of suffering involving symptom-sets that cannot be accounted for by a single diagnosis, ultimately resulting in a misdiagnosis or the necessity of a comorbid diagnosis. Addressing a patient as having a comorbid diagnosis assumes that the various aspects of one's mood can be arbitrarily segregated into independent diagnostic categories – an assumption that I would argue is not supported by lived experience. A patient diagnosed with both a depressive disorder and an anxiety disorder is not an individual with two moods competing for the attention of consciousness. The patient's depression and anxiety appear to the patient within the totality of a life-world scaffolded by pre-reflective and conscious manifestations of one's mood.

In addition to problems regarding comorbidity, each diagnostic category is plagued by a heterogeneity of possible symptoms sets. In a 2013 paper, Galatzer-Levy and Bryant calculated that there are 636,210 different combinations of symptoms that would warrant a diagnosis of PTSD, according to the *DSM-V*.[4] "Thus, while [comorbidity] suggests that there may be a single common biological explanation for distinct diagnostic categories, [heterogeneity within categories] suggests that there may be distinct biological processes underlying a single diagnostic category."[5] A different approach, one in which mood disorders can be framed as dimensional processes, seems necessary to overcome these dilemmas.

In contrast with the *DSM*, the RDoC motivates research with a dimensional model structured around neural circuits. The dimensional approach advanced by the RDoC recognizes the complex nature of mental illness by dissolving the clear-cut categorical boundaries established by the current classification system.[6] As a multi-level framework with neural circuits resting at its foundation, the RDoC guides research down one of two paths: toward an analysis of neural circuits in relation to physiological and behavioral changes, or toward an analysis of the intimacy between neural circuitry and their genetic, molecular, and cellular influences. While this approach is useful for developing insights into the complex dynamics of the brain, mind, and experience, the translation of a dimensional understanding of mood disorders into a clinical practice remains complicated.[7] And, herein lies the problem with dimensional approaches – its applicability is greatly restricted in clinical

3) Lupien et al., "The DSM5/RDoC Debate on the Future of Mental Health Research," 3.
4) Galatzer-Levy & Bryant, "636,120 Ways to Have Post Traumatic Stress Disorder," 656.
5) Bluhm, "The Need for New Ontologies in Psychiatry," 148.
6) First, "Current State of Psychiatric Nosology."
7) Ibid.

settings where doctor-patient interactions are brief and infrequent. The dynamic nature of a dimensional nosology makes consistent diagnoses within a clinical setting difficult.

While commenting on the *DSM* versus RDoC debate, Bluhm makes the case that neither framework can provide the ontological grounds required for the kind of nosology psychiatry aims for. Bluhm's skepticism of the RDoC is primarily rooted in two concerns. The first issue has to do with a concern over whether diagnostic categories can become objects of neuroscientific study. Referencing Jacqueline Sullivan, Bluhm argues that variations in research methods render independent studies on the same concept incompatible.

> While these differences may be subtle (e.g., variation in the experimental stimulus, or in how an effect is measured), Sullivan shows that the difference among experiments are significant enough that it is not clear whether different experiments can be assumed to be measuring the "same" phenomenon. In a [separate] paper (Sullivan 2010), she shows that in cases where a standard experimental paradigm is used, researchers may characterize the cognitive phenomenon being investigated very differently, suggesting that there is no clear and agreed-upon conceptualization of the cognitive phenomenon.[8]

Here, we see issues similar to the concerns raised over comorbidity and heterogeneity. On the one hand, similar to how the presence of a specific set of symptoms will not guarantee that a patient can be given a single diagnosis, the presence of a certain set of data does not guarantee that the neural circuity responsible for a particular cognitive dysfunction has been localized. On the other hand, similar to how the *DSM's* discrete categories contain complex variations in the way patients describe what it is like to live with their illness, the descriptions of cognitive phenomena being studied can also vary considerably amongst researchers. The second and more pressing issue that Bluhm takes up against the RDoC is its inability to produce an understanding of mental illness that is practical for clinical use. Referencing Ian Hacking, Bluhm asserts that there exists "a tension between the integrative, explanatory aims of RDoC and its ambition, at least in the long run, to improve clinical practice."[9] Bluhm's critique is primarily concerned with how neuroscientific studies on cognition enframe phenomena within a conceptual framework beyond clinical practicality. Bluhm, via Hacking, is skeptical of the degree to which clinical diagnostic practices can integrate laboratorial data and, thus, rejects the notion that the RDoC will lead to the development of reliable diagnostic categories.

Due to the *DSM's* inability to adequately incorporate a dimensional understanding of mental illness into its discrete diagnostic categories, and because of the problematic concerns raised over the RDoC's capacity to reliably develop novel diagnostic categories, Bluhm proposes that "research in psychiatry will see the most benefit if it separates its explanatory and its predictive (clinical) goals and pursues each largely separately."[10] Yet I believe that the primary knowledge gap found in psychiatric research – arguably characterized by an inability to bridge a material understanding of neurobiology with a vital understanding of symptomology – will *remain* divorced if we are to proceed by reifying this ontological fracture. Through a phenomenological investigation, however, we can begin to see how physical and vital structures co-operate, alongside existential structures, in the production of affective experience.

8) Bluhm, "The Need for New Ontologies in Psychiatry," 151–152.

9) Ibid., 154.

10) Ibid., 156.

Phenomenology as a Tool for Advancing Psychiatric Research

There is something fundamentally wrong with the assumption that we can predict how an individual will respond to treatment without having, first and foremost, a thorough understanding of the very condition being treated. How, then, can we take up an ontological view of mood that allows for a description of mood disorders with explanatory *and* clinical relevance? Phenomenology presents researchers with the resources to "take a step back" from the problem in order to evaluate what it is that we are working with in the first place. With a phenomenological perspective comes the understanding that we must first address how we are receptive to the way mood changes in our everyday experience in order to arrive at a clinically relevant explanation of distinguishable mood disorders. Merleau-Ponty's highly underrated work, *The Structure of Behaviour,* offers insight into how the natural sciences are misguided when failing to orient research around the situational whole of a phenomenon. Mental illness does not merely exist in the brain: to have a mental illness is to experience a kind of suffering that affects one's relationship with the environment and with oneself, *in addition to* alterations in neuronal activity.[11]

Much of the *Structure of Behaviour* is devoted to asserting that human behavior cannot be understood through physical conditions alone. Ultimately, Merleau-Ponty makes the case that we cannot make sense of the way we act without appealing to the way actions are influenced by perception. This insight helps makes clear an implicit aspect of our mood that remains concealed from lived experience. Mood, like behavior, cannot be reduced to physical systems because changes in mood are not the *effects* of an event – changes in mood are revealed to be constitutive *features* of an event.

Merleau-Ponty's reflections on the way behavior is revealed phenomenologically led him to the claim that "behavior is not a thing, but neither is it an idea."[12] Since behavior is neither a thing nor an idea, we must consider the way it integrates its forms into the structural whole of experience. While deeply habituated, pre-cognitive, forms of behavior are limited to supporting the immediate context of a situation, higher forms of behavior, on the other hand, are liberated from this integration and can open the individual up to the possibility of conditioning the contextual limitations of their actions.[13] Through this approach, Merleau-Ponty differentiates three forms of behavior that present themselves through the physical, vital, and symbolic structures of human life. The three structures are taken up by Merleau-Ponty as partial wholes that rely on the presence of each other for their appearance in the structural whole of an embodied experience. Each form thus depends upon each other without being reducible to each other.

The first form of behavior, which is most deeply embedded in the immediacy of a situation and is therefore referred to as *syncretic*, appears through a mechanistic cooperation between physical structures. Syncretic behavior "responds literally to a complex of stimuli rather than to certain essential traits of the situation."[14] We can think of this sort of behavior as being purely instinctual, which is to say that syncretic behavior emerges habitually, without the motivation of an intentionality. It is because this kind of behavior lacks intentionality that it takes on the appearance of being something pre-programmed by an organism's biological structure. For

11) See Fuchs, *Ecology of the Brain.*

12) Merleau-Ponty, *The Structure of Behaviour,* 127.

13) It is worth noting here that I take a "healthy" structure of behaviour to be one in which the individual's capacity to act (or refrain from acting) maintains some degree of liberation from habituated modes of being. Merleau-Ponty's example of the phantom limb provides some sense of what it would be like for behaviour to be disordered: behaviour that fails to liberate itself from maladaptive habit.

14) Merleau-Ponty, *The Structure of Behaviour,* 105.

example, we can safely predict that a moth will fly toward a light when in a dark environment. It is because this kind of instinctual behavior appears to be strictly motivated by a biological reaction that we can make such predictions.

While the second form of behavior is always grounded in its physical counterpart, *vital* behavior is guided by an internal norm that is different from, yet intimately related to, an organism's biological equilibrium. Merleau-Ponty recognized that an organism's environment is always encountered as already having a particular value, a certain significance that emerges from the relationship between the presence of physical stimuli and an organism's fixed intention. For example, while in the presence of food hanging out of reach, a chimpanzee will become fixated on it as something to be attained. With this fixed intentionality, the chimpanzee encounters objects in its environment as having a use-value that is restricted to the chimpanzee's biologically motivated intentionality. As such, a box that was previously encountered as something to play with now appears as something that can be climbed upon to reach the food. This way of actively maintaining an internal norm differs from the passivity of instinctual behavior due to the integration of an intentionality within the structural whole of perception.

The third form of behavior, which Merleau-Ponty takes up as unique to human beings, is revealed in everyday experience through the symbolic structures of our life. Like the movements performed while improvising a piece of music, symbolic behavior is encountered as spontaneous and does not appear to be conditioned by a *fixed* intention. The symbolic structures of experience attune us to the way perception is distanced from the immediate spatiotemporal context one finds oneself in. Spontaneous behavior is the result of an innate capacity to integrate into one's spatiotemporal orientation, a retention of the past and an anticipation of what has not yet come to pass as the past. The chimpanzee's fixed perception of the box as something to climb on is contingent upon the box's immediate availability for that specific use. The unavailability of the box for said use would restrict the box's significance to something that cannot be used to reach the food. It is because humans can entertain various viewpoints, by placing oneself outside of one's own immediate perspective, that we can engage with the world as a field of open possibility. The chimpanzee's perception of the box, as something to climb upon or to play with, is restricted to the immediate context of the situation. Unable to "see" beyond the imminently possible, the chimpanzee dwells within a possibility space that is determined by the givenness of direct experience. Humans are liberated from this primitive form of being through the actualization of spontaneous behavior made possible by integrating an open and indeterminate future within one's perception of what is immediately present. The inability to engage with the world as a field of open possibility – or, put differently, the inability to break free from habituated modes of being – produces a sense of the world as being somehow closed off from my interactions with it.

The difference between the three forms of behavior is contingent upon the perspective from which they crystalize. Put simply, while it is debatable whether instinctual acts emerge from any perspective at all, Merleau-Ponty has made it clear that vital forms of behavior emerge from a single, fixed, perspective and that symbolic behavior assimilates a "multiplicity of perspectives" through which spontaneous conduct can emerge as meaningful. The three forms of behavior, as we have addressed, exist as partial wholes that depend on each other for their phenomenological existence. While higher forms of behavior are ultimately rooted in the material world*, physical structures would be insignificant without the drive of a fixed intention and the possibility space for such an intention to unfold.* Merleau-Ponty's account of behavior ultimately allows us to make sense of phenomena that appear neither as a thing nor as an idea, but rather as a meaningful structural whole. It is for this reason that I believe an exploration of mood as a phenomenological structure can provide insight into how we can begin to bridge the psychiatric knowledge gap.

The Phenomenological Structure of Mood

When we pay close attention to the way mood behaves as an autonomous structure, we find a dynamic relation between bodily (physical), emotional (vital), and existential (symbolic) feelings. We have already established the varying degrees of intentionality that are found within the three structures of life. Vital structures are the only kind that makes clear, in experience, the presence of an intention. Vital structures, however, do not determine their own intentional state, for it is through the relationship between an absence of intentionality found in physical structures and the multiplicity of intentionality made possible by symbolic structures, that vital forms of phenomena unfold with an intentional arc. For Merleau-Ponty, the intentional arc is that which "projects around us our past, our future, our human milieu, our physical situation, our ideological situation, and our moral situation, or rather, that ensures that we are situated within all of these relationships."[15] In other words, the intentional arc of experience ensures that the space one is situated in is taken up contextually. Intentionality, within the mood structure, involves a sense of orientation. To intend toward something can thus be understood as being oriented by something. Moreover, it is by being situated within an intentional arc that one's mood develops meaning: Moods are meaningful insofar as they are situated against the contextual changes that occur, with time, at the junction between a subject's growing history and the fulfillment or frustration of anticipated possibilities.

Like behavior, one's mood cannot be reduced to any one form it takes. Bodily feelings, which do not reveal themselves as being oriented by anything in particular, disclose to an individual its environment as having an immediate value. One's environment is not experienced as something neutral – an environment has value insofar as it provides the conditions necessary for maintaining a preferred internal state. The internal state itself, however, is not ordinarily disclosed to awareness through one's bodily feelings. It is through changes in emotions that one typically becomes aware of one's internal state as an affective trajectory that needs to be maintained or adjusted. As Thomas Fuchs states, "when I am moved by an emotion, I do not think of my body; yet being afraid is not possible without feeling a bodily tension or trembling, a beating of the heart or a shortness of breath, and a tendency to withdraw. It is through these sensations that I am anxiously directed toward a frightening situation."[16] We can thus say that bodily feelings, on their own, lack the affective orientation that emotional feelings necessarily integrate into lived experience.

Like symbolic behavior, existential feelings can be understood to emerge from a subject's multiplicity of intentionality. Existential feelings can be understood as providing the affective backdrop against which bodily and emotional feelings are experienced meaningfully.[17] The relationship we have with the whole of our being is *meaningful* insofar as it attunes us to the possible ways of encountering a world which we are inseparable from. It is through the relationship between one's bodily and existential feelings that emotional feelings (such as feeling sad, joyous, angry, or scared) are felt as being significant. In other words, the lived significance of one's mood remains concealed at the bodily and existential levels, taken in themselves, since it is through the cooperation between these levels that the significance of an emotion is understood meaningfully. This implies, moreover, that an analysis of vital symptomology which does not address the place of

15) Merleau-Ponty, *Phenomenology of Perception,* 137.

16) Fuchs, "Corporealized and Disembodied Minds," 98.

17) While my understanding of an existential feeling differs slightly from Ratcliffe's, in that I take existential feelings to be embedded within a mood structure alongside emotional and bodily feelings, Ratcliffe has gone a long way in illustrating how existential feelings have a unique phenomenality when compared to other forms of feeling. For a detailed account see Ratcliffe, "Existential Feeling and Psychopathology."

bodily and existential feelings within the mood structure will never produce a complete picture of what it is like to have a particular mood disorder.

Interestingly, Merleau-Ponty states, "the fundamental dimensions of space and time are found, if you like, at the three levels which we have just distinguished. But they do not have the same meaning at each level."[18] In order to understand what makes symbolic forms of experience unique, grasping how time unfolds at each level of experience is helpful. At the physical level, static and discontinuous forms are perceived as discrete states which change *over* time, thus appearing as disengaged from the flow of time. However, bodily feelings also contain a second sense that accompanies the first. Bodily feelings hollow out affective experience with the sense of an enduring spatiotemporal immediacy. It is for this reason that we can associate certain events with particular affective states: While a subject's bodily feelings reveal the immediate value of an environment, emotional shifts accompanying changes in bodily feeling are free to transcend the immediacy of physical environments due to their influence on the situational whole of a subject's being.

In contrast with the immediacy of bodily feelings, emotional feelings mobilize one's affective temporality by engaging with a temporal flow through which the "now" continuously becomes a past moment. In other words, while bodily feelings are understood at the physical level to have changed *over* time, they are experienced at the emotional level as changing *with* time, thus providing the subject with an individualized narrative that is in constant development throughout the duration of the subject's personal life. The kind of temporal orientation that appears through an emotional narrative – which is to say, through an understanding of one's past from the perspective of a living present – can be characterized as having a linear flow. Here, one's perception is oriented by the accumulation of a personal past through the fulfillment and frustration of hopes, desires, and expectations.

Existential feelings disclose a unique way in which experience is temporally oriented by the future, which is to say by a possibility space that is whole and indeterminate. Noticing that the future passes through the now to become the past, we can recognize that how we remember our past corresponds with how we anticipate future possibilities. For example, it is possible for someone who has endured a challenging life to experience a shift in perception such that their past, which may have once been heavily repressed, becomes attuned to from the perspective of a future possibility as a source of purpose. I believe that this is a sentiment that could be commonly found throughout peer support, where individuals who have lived through challenging experiences support others who are facing similar situations. In this case, peer support workers become oriented toward their past through an anticipated potential to help others who are suffering. There is a feeling that accompanies this shift in perspective – one that may be characterized by a renewed sense of belonging. *At the existential level, one carries along in their perception of the world, an evolving personal narrative that affects, while being affected by, one's relationship with the whole of their being.* It is this level of lived experience that has been ignored by psychiatry, and it is this omission from research that is preventing us from closing the psychiatric knowledge gap.

How, then, can phenomenology play a role in the advancement of psychiatric research? By attending empathetically to the way in which mood disorders are expressed within a patient's individuality, we can become aware of the ways in which bodily feelings maintain or disturb an affective equilibrium conditioned by the possibility space afforded through the presence of one's existential feeling. *Understanding mood as a structure allows us to reframe mood disorders as debilitating shifts in existential feeling that close a subject off from an open possibility space*. Such an approach, which focuses on shifts occurring at the existential level, can prevent us from reducing experiences of mental suffering to physical structures or vital structures *while accounting for*

18) Merleau-Ponty, *The Structure of Behaviour*, 104.

both.[19] Such an approach would take up the dynamic interrelationship between bodily, emotional, and existential feelings as the grounds from which we can arrive at a holistic understanding of mood disorders and mental illness more broadly.

Existential feelings, as we have seen, involve a peculiar temporality that affects the subject differently than the temporality of bodily or emotional feelings. By examining the pre-reflective shifts in temporality that affect the development of an individual's self-world relationship, phenomenology can be used to undermine rigid categorical classifications, "motivate the need for a new classification, and provide new conceptual distinctions that can be used to reclassify psychopathological conditions."[20] Anthony Fernandez refers to some of these conceptual distinctions as the "basic domains and dimensions of human experience," which resonate with the Heideggerian "existentials" and can serve as the roots for a dimensional approach to a phenomenological psychopathology.[21] Some of these basic domains and dimensions of human experience include, but are not limited to, temporality, embodiment, intentionality, and self-hood.

One example of how a careful inquiry into the basic domains and dimensions of human experience challenges the current psychiatric nosology is found in Matthew Ratcliffe's study on the phenomenology of depression. In his book, *Experiences of Depression: A Study in Phenomenology,* Ratcliffe cast doubt on the presumed homogeneity between depressive experiences by studying the way patients diagnosed with depression can experience the illness differently. By attending to the temporal aspects of depressed subjects' life-worlds, Ratcliffe was able to identify three forms of altered time that have different implications on the symptomology expressed by depressed subjects. This method of situating symptom-sets within contextual shifts that occur at the existential level of experience resonates with Eugène Minkowski's approach to studying mental illness, in which the symptoms of a patient cannot be understood outside the totality of a patient's life-world. While the depressed experience is commonly understood as a "living in the past," Ratcliffe draws our attention to the fact that this presumed homogenous quality of depression is contingent on one's relationship with one's own potential future – a relationship that can take multiple forms.

Many depressed patients may feel "stuck in the past," but this existential feeling takes on a different sense when we understand it as emerging from within the entirety of a subject's being. "As stressed by Minkowski (1970, p.224), superficially similar symptom descriptions can obscure profound phenomenological differences."[22] For starters, a patient diagnosed with depression may experience, in their perception of the world, a loss of "practical significance," meaning that the significance one ordinarily attributed to the future (through phenomena such as hope, expectation, and excitement) is missing.[23] Here, the patient is "stuck" in the past because the future itself no longer carries any meaningful weight. Narratives in which a depressed patient "sees no point" in doing something that is typically engaged with meaningfully (such as, for example, playing with one's kids or visiting family for a holiday dinner) may be indicative of this form of depression. The second kind of depressed patient may be "stuck" in the past due to what is referred to as a loss of affective drive. Here, one's future maintains significance, but its significance fails to entice or motivate the patient's action.[24] This kind of depressed subject may express narratives in which they feel as though they "must do something" or "need to do something," and yet they feel as though they are inhabiting a situation in which the completion of the necessary task(s) appear out

19) Ibid., 141.

20) Fernandez, "Phenomenological Psychopathology and Psychiatric Classifications," 1027.

21) Ibid., 1025.

22) Ratcliffe, *Experiences of Depression: A Study in Phenomenology,* 188.

23) Ibid., 179–180.

24) Ibid., 186–188.

of reach. In this case, the possibility of action is there, along with its significance, and yet the motivation to act is missing. The third form of altered time demarcated by Ratcliffe is one in which the subject experiences a loss of one's life projects. Here, the patient is "stuck" in the past because of the loss of future possibilities. With a loss of future possibilities, comes a loss in present ability. It is within this form of altered time that one may encounter a depressed individual who is convinced that an actual possibility is, in reality, impossible.[25]

For example, while working at a homeless shelter, I had the opportunity to help one of the residents diagnosed with depression work toward securing housing. Over the course of nearly four months, this individual managed to get a job working at a factory, was set up with a mental health counselor, and was approaching his time-limit at the shelter. Because of this, we began looking to set up appointments with landlords and had stumbled upon a promising listing that was within the individual's budget and was in a location that he enjoyed. On the day of the appointment, the individual was overwhelmed with the feeling that he *could not* go to the interview. That he *could not/would not* be accepted as a tenant. While discussing this feeling he had, that he *could not* do it, his reasoning began and ended with the strong conviction that "I just can't." The fact that he was able to make an effort to secure work and talk to a counselor (which were not required for him for his stay at the shelter) demonstrates that this individual had not yet lost a sense of the future being significant, nor had there been a loss of affective drive since he was clearly disappointed by this perceived impossibility. Had it been the case that he had lost the sense of things being practically significant or the affective drive necessary to carry oneself toward a goal, this individual would not have been motivated enough to hold a job, nor would he have "seen the point" in talking with a counselor. Neither a loss of significance nor a loss of drive could describe his inability to act, which is characteristic of the third form of depression addressed by Ratcliffe. When faced with the problem of housing, this individual saw the point in meeting with the landlord, was motivated to move out of the shelter, and yet the possibility of becoming housed was lost prior to any attempt at actualizing this potential future.[26]

While undermining the presumed homogeneity of individuals that fit within a single diagnostic category does not, in itself, allow for the development of a new nosology, it can provide insight into how psychiatry and psychology can work with phenomenology when attempting to make sense of psychopathological experiences. Working through the affective temporal distinctions within individual diagnostic categories has "the potential to inform neurobiological studies and pharmaceutical intervention. Seemingly similar but ultimately very different forms of experience are likely to have different neural correlates and be receptive to different kinds of treatment."[27] This approach contrasts with Bluhm's proposition that psychiatry ought to develop distinct ontologies for clinicians and researchers. Rather than developing our understanding of mood disorders around the presence of physical *or* vital changes in a person's neurophysiology or psychology, we ought to begin with an understanding of the phenomena in themselves. To advance our understanding of mood disorders, it is evident that clinicians and researchers must be working toward an understanding of the same phenomenon. After all, it is from laboratorial research that medications are developed, and it is from within clinical settings that lab-based medications are prescribed and administered.

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25) Ibid., 181–187.

26) The point of this example is to demonstrate how the manifestations of one's mental illness cannot be understood in its entirety outside of the individual's personal history and projects. The *kind* of depressive experience this individual faced is different from the kinds of experiences that emerge from a loss of significance and/or drive. Phenomenology provides researchers and clinicians with an instrumental tool for teasing apart important nuances that can distinguish individual experiences assumed to belong to a homogenous population. The ability to make such distinctions may lead to different treatment methods being used to treat the different forms of depression with greater effectiveness.

27) Ibid., 188.

Conclusion

The phenomenological analysis provided by Merleau-Ponty in *The Structure of Behaviour* can provide insight regarding where psychiatry has gone wrong in the development of discrete diagnostic categories and neuro-reductionist frameworks. It is because psychiatry studies mood disorders as being divorced from their lived experiences that the *DSM* and the RDoC will continue to fail in their attempt to develop a nosological framework with explanatory *and* clinical power. As Petr Smolik states, "if medical classification is to be realistic, simple to use, and reliable, nosological systems must be based not only on established facts, but also on theoretical assumptions regarding the nature of disease."[28] This is especially true when contemplating mood disorders because what has become "disordered" is not something that exists in the world as a thing or an idea, but rather as a phenomenological structure. Mood disorders cannot be reduced to physical processes because the lived significance of a mood disorder's presence in experience is primarily concerned with how one's existential self-world relation is closed off from an open possibility space, rather than with a neurochemical imbalance, for example. When close attention is paid to the fluctuating nature of affective experience, mood is revealed as a structure that presents itself to the subject as a continuous process through which interrelated forms of affectivity stabilize the emergence of a dynamic self-world relation, thereby providing oneself with the capacity to make sense of and participate in the world.

Until recently, the *DSM* has been the golden standard for assessing patients and developing treatment strategies. However, due to its conception of mental illness as fixed mental states, the *DSM* fails to offer researchers with an appropriate framework for the discovery of the biological mechanisms "responsible" for meaningful forms of suffering. The reason current diagnostic categories cannot adequately support a psychobiological analysis of mood disorders is because a patient's vital symptomology cannot be reduced to neurobiological structures. Phenomenologically, this is made clear by noticing how changes in a patient's symptomology and neurobiology emerge from within different forms of temporality. An understanding of one's neurobiology that does not account for one's enduring situational context takes on a perspective limited to the immediate cooperation between physical structures. The problem here, however, is that mood disorders are not experienced within the objectivity of a de-contextualized, discrete, point in space or time. They emerge in the passage of time and are sedimented within the lived body as one develops habituated relationships with the situational context of various environments.

With the recognition that symptoms cannot be reduced to biological mechanisms, the NIMH released the RDoC to guide research grounded upon the assumption that neural circuits have a causal effect on the emergence of mood disorders. A more in-depth analysis of the structure of mood, I believe, will inform us that while lived experience is tethered to an individual's physiology, by way of one's bodily feelings, emotional feelings have fundamentally different qualities than bodily feelings – qualities that must be accounted for as such rather than being reduced to something quantifiable. Such an analysis will reveal the way in which these qualities are conditioned by one's relationship with the whole of one's being. In other words, a complete analysis of the structure of mood will demonstrate how emotions are grounded in the relationship between bodily feelings, which integrate into experience an absence of orientation, and existential feelings, which integrate into experience possible ways of being oriented. By understanding how a particular phenomenon emerges from the totality of lived experience, phenomenology provides us with the resources to develop overarching frameworks of mental illness within which the psychiatric "knowledge gap" can be bridged.

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28) Smolik, "Validity of Nosological Classification," 185.

Bluhm's proposition of developing distinct ontologies for clinicians and researchers would ultimately result in the reification of divergent frameworks geared toward the independent understanding of physical and vital structures. This would be ideal, *if* the mere juxtaposition of these two structures could provide a complete picture of the phenomena being studied. However, the intimacy between physical and vital – or, bodily and emotional – structures can only be understood within the context of existential structures. As Merleau-Ponty says, "Two abstractions together do not make a concrete description. There are not these impersonal forces on the one hand and, on the other, a mosaic of sensations which they would transform; there are melodic unities, significant wholes experienced in an indivisible manner."[29]

It is essential that we are receptive to the fact that all knowledge about mood disorders comes, first and foremost, from the lived experience of patients living with them. It is from this understanding – one that takes seriously that the totality of lived experience influences the development of a mood disorder and the hold it has over its subject – that we can develop a framework from within which neurobiological and psychological adaptations are understood as interrelated features, rather than causes, of an experience. Such a framework gives way to a greater potential for cooperation between the neurosciences and clinicians by dissolving an arbitrarily established distinction made between distinct abnormalities in neuronal activity (which, upon identification, assists in the differentiation and classification of different forms of mental illness) and the contextual situations within which those abnormalities are able to emerge and persist.

29) Merleau-Ponty, *Structure of Behaviour*, 165–166.

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