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Melancholic depression. A hermeneutic phenomenological account

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Abstract The overarching aim of this paper is to provide a comprehensive account of melancholic depression from the perspective of hermeneutic phenomenology. More specifically, we propose that this condition should be interpreted as an alteration in the intentional arc that affects corporeality, temporality, and spatiality, rather than as a mood disorder. In fact, classifying melancholic depression as a mood disorder seems a particularly poor choice; the mood disorder is not a cause but a consequence of a primary disturbance in operative intentionality. Our paper comprises four sections: (1) We provide a methodological and conceptual framework for our theoretical work, adopting a hermeneutic phenomenological perspective on melancholic depression, and underlining the main differences between melancholia and depression. (2) We offer a detailed reconstruction of the different interpretations of melancholic depression and their relationships to the issue of temporality. (3) We analyze the disruption of intentionality in melancholic depression and how it affects corporeality and directionality. (4) We focus on the disruption of moods and affects in melancholic depression, observing how they shape subjective experience. The goal of this theoretical contribution is to underscore the role of operative intentionality and its disruptions in melancholic depression. We argue that taking elements such as intentionality, embodiment, and spatiality into consideration could help to direct therapies along more promising paths.
KEYWORDS: Melancholic Depression; Operative Intentionality; Corporeality; Directionality; Temporality; Mood Disorders

Riassunto *La depressione melancolica. Un'interpretazione fenomenologico-ermeneutica* - L'intento generale di questo contributo è di fornire un'interpretazione della depressione melancolica attraverso la fenomenologia ermeneutica. Più specificatamente, la nostra ipotesi è che questa condizione potrebbe essere interpretata come un'alterazione dell'arco intenzionale la quale impatta la corporeità, la temporalità e la spazialità, e non come un disordine dell'umore. Infatti, classificare la depressione melancolica come un disordine dell'umore ci sembra una scelta particolarmente limitata; il disordine dell'umore non è la causa ma la conseguenza di un disturbo a livello primario dell'intenzionalità operativa. Il nostro contributo si articola in quattro sezioni: nella prima, forniamo una cornice metodologica e concettuale finalizzata a chiarificare le fondamenta teoretiche del nostro lavoro, ad illustrare l'utilizzo della fenomenologia ermeneutica in riferimento alla depressione melancolica, e a sottolineare le differenze principali tra melancolia e depressione. Nella seconda sezione, ricostruiamo in modo dettagliato le diverse interpretazioni della depressione melancolica e la loro relazione con la temporalità. Nella terza sezione, analizziamo l'alterazione dell'intenzionalità nella depressione melancolica e come essa impatti sia la corporeità che la direzionalità. Infine, nell'ultima sezione ci concentriamo sull'alterazione degli stati umorali e della componente affettiva, osservando come questi elementi vadano a caratterizzare l'esperienza soggettiva. Il fine di questo contributo teoretico è di evidenziare il ruolo dell'intenzionalità operativa e delle sue alterazioni nella depressione melancolica. La nostra tesi è che prendere in considerazione alcuni elementi, come l'intenzionalità, l'embodiment e la spazialità, possa contribuire a delineare interventi terapeutici in modo più promettente.
PAROLE CHIAVE: Depressione melancolica; Intenzionalità operativa; Corporeità; Direzionalità; Temporalità; Disturbi dell'umore

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1 Methodological clarifications

IN THIS THEORETICAL PAPER, WE aim to provide a hermeneutic phenomenological perspective on melancholic depression. Before doing so, we offer some preliminary clarifications on both the topic of our work and the method we follow.

Melancholic depression is regarded as a severe form of depression with specific characteristics:[1] it lacks any apparent cause or origin; involves the inhibition or interruption of mental life and motricity (non-reactive mood), that is, is *the feeling of having no feelings*; and entails a substantial modification of the perception of temporality. Melancholic depression also involves a specific *affective* state: detachment from the social domain, accompanied by a sense of grief, an atmospheric sense of loneliness and a lack of capacity to engage with others and the world. The severity of this condition appears to be even more pronounced when compared to other types of depression, such as major depression. In major depression, a sense of continuity between the depressive state and one's life remains; in melancholic depression there is a break in the continuity of one's lived experience, such that the subject cannot construct a narrative around the depressive episode. On the contrary, the depressive narrative becomes fixed and there is no longer any attunement to others or the world itself. A first-person account of this type of depression is captured by the words of Sally Brambton: «It was all so normal, yet everything was different. Perhaps that was why I could make no connection. It looked, to me, like a scene from a play that I was witnessing. I could not say that I was even engaged enough to be watching it. Any focus was absent. I felt a sudden, claustrophobic grip of terror and of grief. Terrible grief».[2] We share an interest in this form of depression because of its peculiar nature: the centrality of phenomenological and pre-reflective structures, such as corporeality, spatiality and temporality. This makes the condition of particular theoretical interest; and any theoretical elucidation promises, in turn, to lead to new approaches in therapeutic contexts.

The method we follow is hermeneutic phenomenology. The relationship between phenomenology and hermeneutics is fairly complex; in fact, this very complexity makes it so rich. The task of hermeneutic phenomenology is to show the interplay between experience and its interpretations: we not only have experiences and describe them, but also need to ensure that they have significance. In the twentieth century, hermeneutic phenomenology developed as «an attempt to complement the phenomenological analysis of the experiential structures of subjectivity with an account of the reflective character (i.e., affective, cultural, historical, ethical) of selfhood».[3] Since human experience is a product of interpretation, hermeneutic phenomenology is interested in scrutinizing those accounts of selfhood that also encompass self-reflection, culture, and history. While phenomenological research is primarily descriptive and focuses on those structures which make experience possible, and on the organizational principles that are involved in consciousness, hermeneutic phenomenology is interpretive and particularly interested in the historical meanings of experience and their developmental and cumulative effects on the individual and social levels:[4] «Hermeneutical phenomenology explores how the person reflectively relates herself to, and tries to make sense of, this basic experiential fact that she is a self whose self-awareness is constantly challenged by that which is not herself».[5]

Hermeneutic phenomenology tends to scrutinize the a-theoretical domain of each lived experience, providing meaning to this foundational moment.[6] When we deal with mental health, «the task of reconstructing the "causes" of human behavior in all cases is based on and must therefore be preceded by that of reconstructing its meaning which is encoded in the brain and motivates behavior. Thus, this task is first and foremost hermeneutical in nature».[7] Stressing the role of personhood, hermeneutic phenomenology explores the sense of identity underlying the intertwinement of the ontological and normative aspects of selfhood and otherness; as such, it is an important resource that can complement any therapeutic approach. A hermeneutic phenomenological account of melancholic depression elucidates the structure of the subject's experience and the meanings that this condition assumes in her life, by understanding her symptoms through their mutual connections in a *Gestalt*.

2 Melancholia and melancholic depression: Similarities and differences

When we refer to melancholic depression, we are referring to a condition that was described long before the birth of psychiatry as we know it today. Prior to modern psychiatry, this condition was known by a constellation of terms, but mostly as *acedia* and *melancholy*: «Whereas at the beginning of its history acedia would fare side by side with melancholy as the distinctive humors of phlegm and black bile, respectively, or as the mortal sins of acedia and *tristitia*, at a certain moment, perhaps due to their phenomenological concurrence and similarity, acedia and melancholy were fused. Subsequently the hybrid condition would be indiscriminately referred to as acedia or melancholy, and today as depression».[8] Melancholic depression has been a subject of interest not only in psychopathology but also philosophy.

Throughout the centuries, philosophers have shown interest in understanding melancholy,

spleen, melancholia, and depression. The philosophical interest in describing and understanding the concept of melancholy is well known. However, by considering the dialogue between metaphysical approaches and contemporary literature on the topic, we gain a more comprehensive view. The Romantic period was perhaps the most significant and fruitful period in this dialogue. Melancholy occupies a pivotal role in both German idealism and the philosophy of life (*Lebensphilosophie*). Many philosophers published influential works on the subject of melancholy during the 'Sturm und Drang' period and the era of Romanticism.[9] During the 19th century, very few philosophers attempted to describe melancholy as a disorder; they used philosophical descriptions rather than clinical definitions, and shifted the emphasis from melancholy to melancholia. Hegel talks about melancholy in his anthropology: melancholy is the painful experience of a soul enduring the transformation from immediacy and total union with Nature to freedom. Greatly simplifying a rich and complex philosophical explanation, we can say that if, in this process of transformation, the soul falls and sinks back into itself as immediate subjectivity, it can go mad: «The main point in derangement is the contradiction which a feeling with a fixed corporeal embodiment sets up against the whole mass of adjustments forming the concrete consciousness. The mind which is in a condition of mere being, and where such being is not rendered fluid in its consciousness, is diseased».[10]

Hegel himself had a personal experience of melancholia, which he defined as "the nocturnal point of the contraction".[11] He struggled with depression for a certain period of his life[12] and in a letter dated 1810, sent to his friend Karl Joseph Hieronymus Windischmann, he recounts his experience: «From my own experience I know this mood of the soul, or rather of reason, which arises when it has finally made its way [...] into a chaos of phenomena. [...] For a few years I suffered from this hypochondria to the point of exhaustion. Everybody probably has such a turning point in his life, *the nocturnal point of the contraction of his essence* in which he is forced through a narrow passage by which his confidence in himself and everyday life grows in strength and assurance».[13]

Melancholy and melancholia are similar but different. Melancholy is a typical human feeling, settled in the depth of our constitution, linked to our finitude. It reflects our vulnerability, the instability, the fragility of being human. Melancholy is not a mere emotion, but rather an ontological feature of our existence, a fundamental mood. As such, we find it appropriate to stress the distinction between the clinical condition of melancholia and human feelings, such as the capacity to feel sorrow and nostalgia.[14] Melancholia can be defined as *a death that never comes*, because of the "double face of desire" (which for Freud is the "death instinct"). It distances death from the subject. It is a window on the desert of time, a time that has lost its meaning and seems to be empty. Freud already noticed the peculiarity of melancholic depression and, differentiating it from the phenomenon of mourning, claimed that the sufferer experienced «an extraordinary diminution in his self-regard, an impoverishment of his ego on grand scale. In mourning it is the world which has become poor and empty; in melancholia *it is the ego itself*».[15] More specifically, «the distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feeling to a degree that finds utterance in self-reproaches and self-reveilings, and culminates in a delusional expectation of punishment».[16]

3 Melancholic depression and the psychopathology of temporality

The first generation of psychiatrists interested in the use of the phenomenological method aimed to understand melancholic depression in connection with the perception of time. Among the seminal figures of this phase, we can count Binswanger, Minkowski, Strauss, and Tellenbach. The central and common focus of their works was to describe and interpret melancholic symptoms in terms of the temporal distortions provoked by the depressive event, and to classify alterations in personalities. The clinical literature and the phenomenological approach to psychopathological phenomena agreed in outlining different forms of consciousness related to the perception of time.[17] This contributed to talk about a "psychopathology of temporality", largely based on describing and understanding radical changes in the subjective experience of temporality.

This important tradition acknowledges its cardinal philosophical spokespersons to be Bergson, Husserl, Heidegger, and Merleau-Ponty. As highlighted by Thomas Fuchs, the tradition of the psychopathology of temporality is still vital nowadays and may be considered from two perspectives. On the one hand, we find an approach rooted in *Lebensphilosophie* and existential analysis, which makes no distinction between different levels of time experience, in particular «the difference between the basic or micro-level of "internal time-consciousness" (Husserl) and the extended or "life-history" level of personal temporality».[18] But eschewing such distinctions makes it difficult to differentiate between disturbances of temporality in psychotic and neurotic conditions. On the other hand, we find an approach which considers psychopathological variations of temporality from an individual perspective, «for example as a slow-

down of lived time in melancholia».[19] According to this approach, depression can be considered inhibition of "vital becoming".

When we talk about temporality, we need to make a distinction between *being aware of time* and *being aware of lived time*, a difference that relates to the distinction between implicit and explicit temporality as basic structures of subjective temporality.[20] Implicit temporality can be defined as pre-reflectively lived temporality and is grounded in two cardinal elements: the basic continuity of consciousness conceived by Husserl as a transcendental synthesis of "inner time consciousness",[21] and the affective conative momentum,[22] the basic energetic vital striving which guides affective directedness, attention and spontaneity. Both elements are characteristic of living beings in general, and also lend the "intentional arc" the tension and energy it needs.[23] Explicit temporality, however, can be defined as a kind of negation of implicit temporality through the intervention of a "rift in being", and an interruption of the smooth continuity[24] which generates an appetitive tension expressed by the "not yet" mode. In other words, the tripartite structure of internal time consciousness described by Husserl is disrupted and, accordingly, the intentional arc also becomes profoundly imbalanced with reference to the functions of passive syntheses.

3.1 Ludwig Binswanger on melancholic depression

If we look back at the interest that psychiatry has reserved for melancholia, we must first consider Ludwig Binswanger. He was the first to investigate melancholic depression from the perspective of the dissolution of the connections that constitute the transcendental structural order of *Dasein*. In his study entitled *Melancholie und Manie,*[25] he clarifies that pathological melancholy and existential anxiety are two different conditions. He was against the use of the terms "depression" – which he saw as too vague and having too many different meanings – and "black humor". Binswanger considered melancholic depression to be a specific condition characterized by a particular relationship with temporality, namely, lived temporality.

The overarching aim of his book was to examine the dissolution of the connections that constitute the transcendental structural order in the experience of melancholic depression. Appealing to the Husserlian tripartite structure of internal time consciousness (whose functions are "retentional", "presentational" and "protentional"), Binswanger stresses that in melancholic depression we observe a sort of deficit in all three domains and their mutual interactions. Under ordinary conditions, the "retentional", "presentational" and "protentional" domains function interdependently, but in melancholic depression, retention disturbs the other two temporal dimensions. These alterations in the intentional structure of temporality are scrutinized in terms of their transcendental constitution. This leads the author to affirm the a priori structure of temporal intentionality. He argues that there is a kind of failure in the intentional operations at the core of temporal objectivity, a failure that has the consequence of loosening the temporal sense and allowing for the emergence of defective regions. As a result of this disruption, we find the empty intentions, lamentations, and pervasive sense of loss independent of specific content that characterizes the melancholic style.

For example, melancholic dysthymia, as a kind of uncontextualised suffering which accompanies the person in her daily life, may be interpreted as the dissolution of the fundamental structures of experience. The inability of melancholics to access or enjoy consolation and comfort is interpreted as a consequence of these alterations, which compromise the intersubjective structure of *Dasein* as *Miteinandersein*. The collapse of intentional acts as constitutive of temporal synthesis displays itself in three specific modes which are typical of melancholic delirium: a sense of ruin, illness, and guilt. Conceived in his "Husserlian phase", Binswanger's interpretation of melancholia is grounded on Husserl's theory of the three egos: the empirical, transcendental, and pure ego, with the latter understood as the unity of the previous two. According to the German psychiatrist, in melancholic depression the function of pure ego is jeopardized and impacts the functioning of the transcendental and empirical ego. Binswanger supports this analysis by comparing melancholic with non-melancholic experience. While in non-melancholic experience the pure ego performs a constitutive and unifying function, in melancholic experience, the pure ego is disturbed and this affects its primordial function.

Binswanger talks about the weakness of the pure ego, but never about a complete dissolution. The relationship between the three egos is never grounded in a monolinear causality, but instead seems to be informed by a certain circular causality, since the transcendental and empirical egos have an impact on the regulatory function of the pure ego. This means the psychiatrist cannot define melancholic depression as resulting from personal history, or as an existential condition, but rather as an ontological characterization of *Dasein* – as such, it ontologically structures the perception of lived time. Temporality is intertwined with retrospection and prospection, which results in a defective restructuring of the connections between retention and protention that merge the past and the future. What occurs in melancholic depression is a collapse of the intentional acts that constitute temporal synthesis, a collapse that limits the transcendental possibilities of the self. The horizon

falls in line, the sense of perspective which generally characterizes future is lost and the melancholiac remains attached to subjective presentations and unfulfillable wishes that are at odds with reality and contribute to the disruption of what we usually consider familiar.

3.2 Eugen Minkowski and Erwin Straus on melancholic depression

Eugen Minkowski is another author central to any understanding of melancholic depression. His works were deeply influenced by both Bergson and Husserl. His main research focus was temporality, as a key element around which existence is organized. Time is normally experienced as a continuous, fluid, and intertwined phenomenon, which is able to guarantee the ordinary becoming of lived experience and health. When this temporal fluidity is disrupted, becoming is blocked and shattered into a sort of rigidity that blocks future possibilities: the "*élan vitale*" is obstructed and the striving which guides attention and directedness is blocked by the episode which caused this *impasse*.

This deadlock impacts the perception of temporality at its core. In depressive disorders, and especially in melancholic depression, symptoms must be understood as grounded in this experience of disturbed temporality. The melancholic patient not only loses vital contact with reality, but this loss is expressed in terms of his experience of time: «The melancholic deprives himself even of this ultimate resource».[26] Melancholic depression is understood as a disorganization of existential structure which is grounded on a *morbid subduction in time*. Minkowski makes a distinction between melancholic delirium and the delirium of Clerambault syndrome.[27] While melancholic delirium can be understood as a mental *subduction of time*, Clerambault syndrome can be interpreted as a mental *subduction of space*: «In melancholic delirium, depression seems to constitute the link which unites all the elements of which the syndrome is composed into a synthetic whole; delusions of ruin, guilt, indignity, and imminent torture fit perfectly with this emotional foundation. One is tempted to believe that these represent only an attempt on the part of the patient to explain the depression that inexplicably overcomes him».[28] The phenomenon of time undergoes profound modifications disturbing the structure of existence: «When the flow of time is only slowed down, it is the obsessive phenomena that intrude. They all seem to express the impossibility of advancing and, at the same time, of "dealing with"».[29] The ordinary orientation of our life (towards the future) is inhibited. Our original "feeling of blooming", a spontaneous and natural manifestation of this orientation, completely vanishes and our becoming is altered in terms of our relationship with the environment and its challenges: «The march of time is profoundly modified; it is inverted»,[30] it no longer moves in the direction of what is to come, but rather towards that which blocks the fluidity of temporality.

Erwin Straus also devoted his attention to understanding temporality, conceived as an immanent part of the content of perceiving and sensing.[31] In our becoming, temporality plays a pivotal role as the meaningful framework in which our life is embedded and receives meaning. According to Straus, our ability to understand the ordinary experience of time is the first step in describing and understanding temporality in psychopathological phenomena. In his analysis of temporality in depression,[32] Straus describes the relationship between subjective and objective time: The subjective time of "becoming" slows down to a point of standstill, leading to «a decoupling from world time and conditions the superiority of the past in the depressive experience of guilt».[33]

3.3 Hubertus Tellenbach and the Typus Melancholicus

Hubertus Tellenbach was a pivotal figure in the first generation of psychiatrists who used the phenomenological method to understand melancholic depression. He made a fundamental distinction between symptoms and psychopathological manifestations, which according to him were not symptoms, but essential characteristics: «The feeling of a lack of feeling cannot be conceived as a symptom of depression; it is rather a primal manifestation of the disturbance, that is, an essential characteristic (*Merkmal*) of the phenomenon as such».[34] One of the main goals of Tellenbach's work was to overcome the dualistic paradigm of mind and body, which makes it impossible to capture the complexity of psychopathological phenomena. He introduced the notion of endogeneity precisely for the purpose of exploring subjective life in its totality, also taking conditions which involve an alteration of the fundamental structures of experience into account. Endogeneity has two fundamental features: on the one hand, it is referred to as the global configuration of each stage (or phase) of human becoming; on the other hand, it has a kinetic component, a kind of inner motion which inhibits the *élan vital*. Through endogeneity, «the rhythm of life tends to be suspended. The self is just a witness to a frozen life. The melancholic patient is not able to feel anything, not even sadness. He is also incapable of entering in relation to his own inner death».[35] The suffering of a melancholic depressed patient «is endogenously inflected, is strange, incomprehensible, monstrous, deformed, even perverted suffering, a pathic apathy as it were».[36]

Tellenbach devoted his time to conducting an in-depth study of 119 melancholic subjects who

were receiving treatment at the psychiatric clinic at the University of Heidelberg. On the basis of this study, he developed his definition of the Typus Melancholicus (TM), which was incompatible with the statistic diagnostic manuals of his time. In this study, based on kinetic typology,[37] he elucidated the clinical condition through an empirical-phenomenological method. He hoped to clarify the relationship between premorbid personality (understood as a pre-condition for psychotic decompensation) and endogenous depression. Influenced directly by Martin Heidegger, who was his teacher during his university years in Freiburg, Tellenbach argued that the TM is a personality structure with two fundamental features: a constellation of stable characteristics, which form a vulnerable nucleus around which the disease organizes itself. In analyzing these fundamental features, Tellenbach highlighted the role of values, and how they give meaning to existence by providing significant horizons for acting and involving emotions and relations.[38] In Tellenbach's words, the «melancholic shows us a phenomenon [...] as a modification of existence. We question which existential determination of existence in melancholy has been modified and whether the appearance of these modifications can be shown to exist in all phenomena of melancholy».[39] The first characteristic of the TM is orderliness, accompanied by a certain obsessive denotation. The TM exhibits a «lack of elasticity when performing duties because, for the melancholic, the key is in the activity itself and not in the action. People with this type of personality tend to be culturally valued, but suffer unduly for functioning this way».[40] A second characteristic is the need for defined limits, which characterizes relationships both with others and with oneself, accompanied by a high level of moral consciousness. For Tellenbach, melancholy is an endogenous psychosis in which «the vital movements happen more slowly as opposed to states of happiness, which occur much faster. Vital sadness that permeates the melancholic is so long that it borders on stagnation of being, inhibiting their basic vital movement».[41] The manifestation of psychosis may be a specific consequence of the melancholic condition.

3.4 Karl Jaspers on creativity and psychic pathos in melancholic depression

Karl Jaspers, an author who we decided to mention due to the central importance of his work in the field of phenomenological psychopathology, took a different position. One of his main assumptions was that psychic life is an «infinite whole, a totality that resists any consistent attempt to systematize it; much like the sea, we may coast along the shore, go far out into the deeps but still only traverse the surface waters. If we try to reduce psychic life to a few universal principles and seek comprehensive laws, we beg a question that cannot be answered».[42] In contrast to his contemporaries who attempted to rigorously classify melancholy as a pathology, he characterized it, in *General Psychopathology*, as a fundamentally distorted experience of time and self that manifested as temporal stagnation and emptiness, inner vacuity and non-existence. He described melancholia as a symptom-complex: «In this state the over-valued or compulsive depressive ideas become delusion like. They are fantastically elaborated (the patients are the cause of all the misfortune in the world; they are thought to be beheaded by the devil, etc.). The ideas are believed even though the patient seems relatively sensible. Underlying the experiences there are a host of body sensations (which soon lead to hypochondriacal delusions: the patients are filled up to the neck with excreta; the food falls through the empty body right to the bottom); then there are the most severe forms of depersonalization and derealization: the world is no more, they themselves no longer exist, but still since they seem to exist they will have to live forever (nihilistic delusions); finally there is extreme anxiety, the patients seek relief from this by keeping constantly on the move and indulging in a monotonous pressure of talk which almost becomes verbigeration: "God, God, what will come of it all, everything is gone, everything is gone, what will come of it?" etc. Even when the anxiety and melancholy have lifted, the patterns of movement, the facial expression and pressure of talk seem to maintain an ossified state until – often after a considerable time – the phase finally abates and recovery commences».[43] In part 5, section 4 of his *General Psychopathology*, Jaspers considers the relation between creativity and psychic pathos, especially in the cases of melancholy and schizophrenia. This is a theme that he expands on in his pathographies of Strindberg and van Gogh.[44]

4 Melancholic depression as an alteration of the intentional arc

Following this methodological tradition, we argue that melancholic depression should mainly be regarded as a disturbance in the operative intentionality of the intentional arc, which impacts the immediate engagement that the subject feels towards the space around herself. This can be described as a disruption of directionality, or, as suggested by Kaplan and Sadock,[45] as a pervasive loss of attunement, *an ineffable quality* of melancholic experience.

The subject loses both the capability to engage with others and to grasp the shared meanings involved in everyday experience.[46] In the next paragraphs, we will show how temporality, spatiality, and embodiment are intertwined to such an extent that depression can be seen as a paradigmatic loss

of their chiasmatic relationship. In other words, we claim that what is essentially lost is the *directionality* that characterizes each experience, and the relationship between the subject and the world. This is precisely the role of operative intentionality (*fungierende Intentionalität*) whose aim is to provide the subject with a practical directedness toward the world. In *Phenomenology of Perception*, Merleau-Ponty claims that operative intentionality «produces the natural and antepredicative unity of the world and of our life, being apparent in our desires, our evaluations and in the landscape we see, more clearly than in objective knowledge, and furnishing the text which our knowledge tries to translate into precise language».[47] This directionality is characterized by immediate and corporeal engagement with the world. In other words, operative intentionality makes the subject capable of perceiving and understanding the facticity and solidity of the self and the world in which he is immersed.

Being-in-the-world presupposes moving and orienting the body in space, not just through the senses (such as touch or view), but with the totality of being. Perception should not be confined to the sole elements of sensation – this would mean being confined to a form of empiricism. Rather it indicates an intentional directness, a system of meanings in which a certain phenomenon, object, or behavior is recognized. When operative intentionality is disrupted, the link between the subject and the world can be deeply compromised. This link encompasses the experience of temporality, the perception of space and the disruption of moods, which are then registered as fragmented. All of these elements involve deep alterations in the directionality of the subject, and the embodied and pre-reflective intentionality that usually allows her to live in the world in a spontaneous way.

4.1 Centripetal and centrifugal disruptions of directionality in (inter)corporeality

In melancholic depression, the first subjective level that experiences a loss in directionality is the body itself. Usually, our body is the means by which we move in the world, interact with others and find ourselves able to take advantage of various physical and affective affordances.[48] This allows us to talk about the centripetal and centrifugal disruptions of directionality in (inter)corporeality in melancholic depression. In the first case, the subject is confined to her present bodily state and feels her body becomes a centripetal presence which hinders any possibility of movement and interaction with others and the world, instead of being a medium for actions.

This condition has been defined as "hyperembodiment"[49] or "chrematization" of the body:[50] a process in which the patient's body becomes so heavy that it can block its functions. Furthermore, the sensation of being a mere material *Körper*, a sort of corpse, makes the subject fall into an "anesthetic" state. The subject does not feel herself to be part of the shared world because she has indeed lost her "embodied sense of self".[51] This is made clear in a first-person report: «Why do they call it a "mental" illness? The pain isn't just in my head; it's everywhere, but mainly at my throat and in my heart. Perhaps my heart is broken. Is this what this is? My whole chest feels like it's being crushed. It's hard to breathe».[52] And again: «Now, sitting in my pine-paneled room, I felt myself hurtling once more into the abyss. The mental pain was physical, as if the marrow of my bones were being ground into dust».[53] As a result, even the other structures of subjectivity become impaired. The loss of embodied directionality experienced by subjects with melancholic depression comprises different but intertwining dimensions.[54]

There is not only an alteration of the subject's relationship with her own body (that we can label as a disruption of *centripetal directionality*), but also a change in her relationship with the world (that we can call an impairment of *centrifugal directionality*). In other words, there is an alteration of the patient's embodied affective intentionality.[55] This disturbance can also appear as a lack of bodily resonance, for instance in the context of an intercorporeal and interaffective dialogue during the diagnostic process.

We can claim that in melancholic depression, the loss of directionality causes a form of alienation from the interpersonal and intercorporeal world. Furthermore, whereas the schizophrenic person bewails her diminished self-consciousness, the depressed person experiences excessive identification with a fixed role. She loses her eccentricity, and shifts to an existential orientation that is dangerously "centric", or egodystonic. In some cases, a person afflicted with melancholic depression may even reach the point of denying her own existence and that of others who seem like ghosts or phantoms: we find a sort of *desynchronization* with the world. The loss of bodily resonance and emotional resonance are linked to one another: in fact, intercorporeality and interaffectivity are usually mutually related in a chiasmatic relationship. While intercorporeality involves the mutual bodily synchrony that allows two subjects to experience subjective and objective qualities through their lived bodies, interaffectivity is the intertwinement of their cycles of embodied affectivity which continuously modify each other's affordances and bodily resonance.[56] Both of these processes involve intentional feelings, an openness toward the external world. But this directionality breaks down in melancholic depression. The ego and the world are emptied, and resonance is replaced by a sense of sadness which has no intentionality but is lived both psychically and physically as a burden and an oppression, even if it has no specific determina-

tion or localization. Every kind of vital dynamism is forgotten, the patient's gaze is directed internally and loses its eccentricity. The emotional quality of perception is lost, a phenomenon that has been described as *derealization* and is associated with *depersonalization.*[57]

In melancholic depression, the body loses its *emotional directionality,* and its static presence becomes an obstacle for the development of *phronesis* and *praktognosia* typical of a living body (*Leib*) that is dynamically and intersubjectively linked to the world. We can therefore define melancholic depression as a form of alienation from the interpersonal and intercorporeal world. The claim that others do not or cannot understand what one is going through features consistently in first-person accounts of depression.[58] The depressed subject not only feels that nobody can understand her, she is also unable to understand others. There is a break in her relational and intentional attunement with the world.

4.2 Desynchronization of temporality

Disruptions at the level of centrifugal and centripetal intentionality affect the temporal dimension as well. The subject's experience of temporal becoming is not projected into the future, but rather crystallizes within her present situation; she constantly faces what has just happened (*post festum),* while space is perceived as too distant. In fact, the ex-statical unity of temporality – that is, the unity of the three dimensions of time: past, present, and future – has been devastatingly disturbed. Experiences become freeze-framed in an eternal present in which she remains forever trapped, or to which she is condemned to perpetually return to through the portals supplied by life's slings and arrows. All sense of temporal duration or stretching collapses, the past becomes present, and the future loses all meaning apart from endless repetition.[59] Alongside this distorted perception of time, her sense of life is altered; not only in relation to the content of what has happened, but also as a formal alteration in which the experience of what has been determined and resolved in the past undergoes a profound change. This bears on everything in the past, leading to the falsification and fabrication of memories. Melancholic depression exposes "the unbearable embeddedness of being".[60] The world of melancholic depressed people is fundamentally incommensurable with the world of others and a deep chasm is experienced, in which their anguished sense of estrangement and solitude become persistent. The feeling of "being stuck" and being unable to move forward is often accompanied by the perception of a colorless world. Days endlessly repeat with a feeling of sameness, sometimes agonizingly, sometimes in dull emptiness; the world becomes an almost monothematic experience of loss. The precipitating event has wiped out a horizon of possibilities in which the one and only thing that matters, the one and only thing that is cared for is not there anymore. This "there", devoid of contents that matter, often gives rise to questions of "what if", where personal responsibility and feelings of guilt prevail. We can describe the experience of temporality in melancholic depression as a "loss of conation",[61] of motivation and vitality, that is associated with the slowing down of physiological processes. It is synonymous with the diminution of "the basic energetic momentum of everyday life", of the drive, appetite, and desires that make one pursue various goals, and which are inextricably linked to the basic sense of "aliveness" or fundamental self-affection.[62]

Talking about temporality means considering time as lived by people. The link between subjective and objective time is deeply disrupted in depression. While some studies argue that what changes in depression is the velocity, and not the very basic structure of time,[63] others[64] support the view that the depressed patient suffers from a real break in subjective time, and accordingly, of the intersubjective, shared, temporal dimension. Stuck in the past dimension – a past that is inexorably tainted by guilt – the subject is not able to tune in to others and her experiences suffer from desynchronization with shared time. The subject also feels that there is no hope for redemption, and she finds herself constantly focused on her past lived experiences. Intersubjectivity, temporality, and axiology show their inextricable entanglement. Usually, our perception of time and our experiences in the world are synchronized with others (what Minkowski called "lived synchronicity"). In depressed patients this "synchronicity" is lost, along with the directional drive of temporal experience. If we conceive of subjective temporal experience as organized in different layers[65] - rhythm, synchrony, and coordination - we can see that this disruption is not limited to intersubjective time, but encompasses every level. Alterations in normal physiological rhythms are a common feature of melancholic depression. These include sleep disturbances, seasonal changes, shifts in digestion and/or sexual appetite – just to name a few. Both experiential and biological rhythms (those processes, such as heartbeat, that regulate self-awareness and subjective experiences) are characterized by *deceleration:*[66] there is no future, experience is reified and the subject finds herself in a constant present deprived of any sense. This biological *and* somatic "prostration" (as Leohnard,[67] called it) is so strong that the effects are similar to a flu.[68] Accordingly, other levels become compromised. Synchrony, namely the ability to attune to others, anticipating and matching their movements and actions, will be impaired,[69] or impossible to achieve; and coordination, which involves

higher cognitive abilities such as mutual predictability, becomes difficult. It seems, therefore, that the temporal disruption leads the subject to lose directionality towards herself, the other, and the world. These three dimensions are inextricably linked to one another, to such an extent that we can understand melancholic depression only if we take their essential intertwinement into account and conceptualize this condition as a *desynchronized mode of existence.*

4.3 Disruption of directionality and space perception

Usually, there is no absolute *a priori* or positional value by which a subject ascribes meaning to her perception of space. On the contrary, each perception is grounded on the interrelation between her living body and the spatial system. Here, her embodied and practical directionality works as a mediator between herself as a corporeal subject and the external world. She seems to be ontologically open to the world, so that, as she perceives it, she also constitutes herself. In this view, in order to perceive an object, perception is formed by a series of interactions that need to be synthesized by the perceiver.

This kind of cognition is therefore incorporated and located in the environment. The role of the body is also central because our motor skills and psycho-physical being allow us to think about (and make) changes of perspective. According to this view, we can claim that we are not an “I think” but an “I move”. Through directionality a subject is linked to the world in a pre-reflexive and practical manner. We can therefore argue, in the wake of Gibson, that objects take on specific meanings depending on the potential actions of the subject, which are based on intuitions and not the result of inferential processes. If the subject loses her directionality, she will also lose the ability to perceive space in this intuitive manner, and will be unable to perceive the affordances that a space offers her. This is what happens in depression: stuck in a crystallized time, in a heavy and unmoving body which has lost its link to the world and to others, the depressed subject does not find anything in the space that surrounds her. The living space, the space around us, which is usually rich with emotional and practical connotations, becomes an empty and cold environment that offers the subject no possibilities for action or interaction.

As Sylvia Plath describes in “*Contusion*”, the bruise «crawls down the wall» of an immobile body that finds itself as opposed to having spatial exteriority. In “The Detective” she describes the undefined space of a desolate landscape where «[t]here is only the moon, embalmed in phosphorus / There is only a crow in a tree».[70] The world is deprived of its vital and affective components, and there is a dualistic separation of the subject and her surroundings. The reciprocal attunement is broken, and the melancholic person finds herself alone in a *neutral*[71] world.

5 The fragmentation of moods as a consequence of the disturbance of the operative intentionality

Our hypothesis, as stated at the beginning of this article, is that melancholic depression cannot be regarded as a mood disorder. It involves a core disturbance of operative intentionality in the intentional arc that impacts the immediate engagement of the subject with the world. The mood disorder is thus a consequence, not the main cause, of the melancholic state. The focus on affective primacy may also be considered in light of the paradigm shift which took place in the history of psychopathology. In fact, since the psychodynamic approach gained influence, we can note a paradigm shift from a predominantly cognitive to a largely affective emphasis.

Following Michael Foucault, we can talk of a shift in the episteme, conceived as a broad system of rules for knowledge formation that are immanent to a given historical period. The passage from one episteme to another happens only through a series of breaks which make new understandings and interpretations possible.[72] The passage from the primacy of cognitive to affective elements may also be related to the role played by the Philosophy of Life (*Lebensphilosophie*) from the end of the 19th to the beginning of the 20th century. It is in the wake of such philosophical and scientific influences that the affective element began to dominate our understanding of so-called moods disorders,[73] including depression and melancholic depression. The affective element addresses the capacity to perceive and be affected by perception; in melancholic depression this capacity is highly disturbed.

One of the merits of the hermeneutical shift in transcendental phenomenology has been to stress the role played by the affects and moods in our life. By their disposition,[74] as an *a priori* constitutive part of existential facticity, people are always situated into a mood which allows them to be open to the world. In this sense, a mood always illuminates a human’s ability to understand herself. Moods play a pivotal role in the feeling we have of belonging to the world. In Heidegger’s account of moods, they are not intentional states directed at something, but rather the conditions for the possibility of such states: «In having a mood, *Dasein* is always disclosed mood wise as that entity to which it has been delivered over in its Being; and in this way it has been delivered over to the Being which, in existing, it has to be. “To be disclosed” does not mean “to be known as this sort of thing”».[75] Moods are not a kind of psychological

state that we experience within a given world, but rather a «background through which it is possible to encounter things in the ways that we do, as "there", "not there", "mattering", "not mattering", "for this" or "for that"».[76] Moods have neither an "internal" nor an "external" phenomenology: «A mood assails us. It comes neither from "outside" nor from "inside", but arises out of Being-in-the-world, as a way of such Being. [...] The mood has already disclosed, in every case, Being-in-the-world as a whole and makes it possible first of all to direct oneself towards something».[77] A mood provides a «background to all specifically directed intentional states. It is part of the structure of intentionality and is presupposed by the possibility of encountering anything in experience or thought».[78]

When moods are disrupted or distorted, our affective life is altered. This is particularly evident in the case of so-called delusional atmospheres, a particular kind of affective state which precedes the development of delusions and consists of a unique combination of perceived environmental changes, such as anxiety, perplexity, and foreboding. In the frame of delusional atmospheres, we face a shift in the general structure of experience that substantially modifies our sense of reality. Derealization is certainly one such modification, which, when combined with depersonalization experiences, can significantly affects the subject's life. Delusional atmospheres entail changes to a general sense of meaningfulness and significance and may also produce alterations in the sense of continuity and predictability, for example a loss of so-called natural self-evidence.[79] The atmospheres the characterize depressive and manic worlds are described either as gloomy or, on the contrary, as abnormally bright. By contrast, schizophrenic people are often described as manifesting 'flat' moods.[80] Affective psychosis has a number of features that bear a striking resemblance to the 'atmospheric' changes often assumed to be specific to schizophrenia: paranoia, with its sense of being at the center of a threatening or insinuating world, is especially common in mania but also in depression.

6 Conclusion

In this paper, we have described melancholic depression as a condition essentially characterized by a disturbance in operative intentionality which impacts temporality, spatiality, directionality, and mood. As a consequence of these alterations, the loss of *directionality*, namely the immediate and pre-reflective linkage a person makes with others and the world, can also compromise their "common sense". A hermeneutic phenomenological approach to melancholic depression may enrich our understanding of this condition through more detailed and nuanced theoretical tools.

By analyzing factors such as intentionality, embodiment, and spatiality, which are usually not considered in diagnosing this type of depression, therapies can be directed along more promising paths. We believe that «the study of mental disorders must stop over-relying on medication and focus on a more human and person-centered approach to treatment, that puts emphasis on the lived experiences of the patients».[81] The breakdown which occurs in melancholic depression involves a human being in her totality, to such an extent that any pharmacological treatment only focused on brain disruption is reductive and, in the long term, could lead to some form of chronic condition. We consider a careful, elaborated, and complex examination and understanding of melancholic depression to be of paramount importance, and argue that «an empathic psychotherapeutic alliance coupled with careful clinical and pharmacological monitoring are the essential prerequisites for successful antidepressant treatment».[82]

Treatments should be focused on considering people's experiences of melancholic depression in their totality and aim for a recovery of meaningfulness across the broad horizon of their lived experience. For these reasons, humanities and in particular hermeneutics and phenomenology can help redesign the pathway to the process of meaning-making, recovering the thread of narrative in people's personal history and providing clinicians with different insights that are able to challenge contemporary approaches to mental health. Through this different account of health in general, and mental health in particular, practitioners and clinicians are invited to consider the structural unity of a human being, which is an essential framework for interpreting psychopathological phenomena within the context of the person's being-in-the-world, a scope barely approached in clinical disciplines. Pharmacology should work together with neurobiological analysis, without forgetting the fact that what is at stake in depression is not simply the malfunctioning brain, but lived experience in general.

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Notes

[1] Cf. M. Rossi Monti, *Depression: The melancholic truth*; J. Radden, *Moody minds distempered: Essays on melancholy and depression*.
[2] S. Brambton, *Shoot the damn dog. A memoir of depression*, p. 121.
[3] R. Rosfort, *Phenomenology and hermeneutics*, p. 237.
[4] S.M. Laverty, *Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations*, p. 27.
[5] G. Stanghellini, *Lost in dialogue*, p. 22.

[6] F. BRENCIO, *Disposition: the "pathic" dimension of existence and its relevance in affective disorders and schizophrenia*.
[7] G. STANGHELLINI, *A hermeneutic framework for psychopathology*, p. 322.
[8] A. FELD, *Melancholy and the otherness of God. A study of the hermeneutics of depression,* p. XVIII.
[9] We refer to authors such as Goethe, Hölderlin, von Kleist, Schiller, the Schlegel's brothers, Wordsworth, Coleridge, Keats, Shelley.
[10] G.W.F. HEGEL, *The philosophy of mind*, §408, p. 38.
[11] G.W.F. HEGEL, *The letters*, p. 561.
[12] Cf. F. BRENCIO, *"The nocturnal point of the contraction". Hegel and melancholia*, pp. 149-164.
[13] *Ibidem*.
[14] Unfortunately, this is not the right occasion to go deeper into the distinction between melancholy and spleen; however, it seems important to us to stress that melancholy is a bittersweet romantic mood, which arises from the painful clash between idealistic visions and the brutal realities of the world or an idealizing nostalgia for a golden past. Quite the opposite, spleen is a state of dullness and marasmus, associated with a powerful crisis in the individual, who freezes in the contemplation of existential suffering, loses the will to act and sees life as filled with emptiness.
[15] S. FREUD, *Mourning and melancholia*, p. 246.
[16] *Ibid.*, p. 244.
[17] Cf. L. BLOC, C. SOUZA, V. MOREIRA, *Phenomenology of depression: Contributions of Minkowski, Binswanger, Tellenbach and Tatossian*.
[18] T. FUCHS, *Temporality and psychopathology*, p. 76.
[19] *Ibidem.*
[20] *Ibidem*.
[21] Cf. E. HUSSERL, *On the phenomenology of the consciousness of internal time*.
[22] Cf. T. FUCHS, *Temporality and psychopathology*.
[23]*Ibid.,* p. 78.
[24]*Ibid.,* p. 79.
[25] Cf. L. BINSWANGER, *Melancholie und Manie*.
[26] E. MINKOWSKI, *Lived time. Phenomenological and psychopathological studies*, p. 167.
[27] Clerambault syndrome, first described by G.G. De Clerambault in 1885, is popularly called erotomania.
[28] E. MINKOWSKI, *Lived time*, pp. 225-226.
[29] *Ibid.*, p. 298.
[30] *Ibid.*, p. 302.
[31] Cf. E. STRAUS, *The primary world of senses. A vindication of sensory experience*.
[32] Cf. E. STRAUS, *Phenomenological psychology*.
[33] T. FUCHS, *Erwin Straus*, p. 132.
[34] S. MICALI, *Hubertus Tellenbach*, p. 142.
[35] *Ibid.*, p. 143.
[36] H. TELLENBACH, *Melancholy*, p. 26.
[37] Cf. S. MICALI, *Hubertus Tellenbach*.
[38] For a detailed explanation of the TM, we refer the reader to H. TELLENBACH, *Melancholy*.
[39] H. TELLENBACH, *Melancholy as endocosmogenic psychosis*, p. 188.
[40] L. BLOC, C. SOUZA, V. MOREIRA, *Phenomenology of depression*, p. 112.
[41] *Ibidem*.
[42] K. JASPERS, *General psychopathology*, p. 17.
[43] K. JASPERS, *General psychopathology*, p. 598. In the context of this contribution, we use depersonalization and derealization with the following meanings: Depersonalization (following A. KRAUS, *Melancholie: Eine Art von Depersonalisation?*, pp. 169-186) is the feeling of being inanimate, detached from her emotions and environment. Incapable of being moved and affected by things or persons, this depersonalization is often defined as the "feeling of not feeling". Derealization is the melancholic patient's feeling that reality and the world around her are completely distant, separate.
[44] Cf. K. JASPERS, *Strindberg und van Gogh: Versuch einer pathographischen Analyse*.
[45] Cf. J. SADOCK, V. A. SADOCK, *Kaplan and Sadock's comprehensive textbook of psychiatry*.
[46] The legacy of the first generation of psychiatrists interested in the phenomenological method is welcomed by and expanded in the contemporary tradition. Thomas Fuchs is one of the most eminent figures in contemporary philosophy to have extensively worked on depression (also melancholic depression) and temporality. In his account of melancholic depression, he says this condition may be described «as a reification or corporealization of the lived body [...]. The melancholic patient experiences a local or general oppression, anxiety and rigidity (e.g., a feeling of an armor vest or tire around the chest, lump in the throat, or pressure in the head). Sense perception and movement are weakened and finally walled in by this rigidity, which is visible [for others] in the patient's gaze, face, or gestures. To act, patients have to overcome their psychomotor inhibition and to push themselves to even minor tasks, compensating by an effort of will what the body does not have by itself any more. With growing inhibition, their sensorimotor space is restricted to the nearest environment, culminating in depressive stupor» (T. FUCHS, *Corporealized and disembodied minds: A phenomenological view of the body in melancholia and schizophrenia*, pp. 98-99). Another cardinal source for a phenomenological reading of melancholic depression is given by Giovanni Stanghellini whose works on this topic relate the TM personality to major/unipolar depressive disorders. Addressing the relationship between a given kind of personality structure, called the melancholic personality, and the concept of temperament, his works offer promising insights into the phenotypic characterization of mood-spectrum vulnerability, challenging the theoretical hiatus between the phenomenological and neo-Kraepelinian psychopathological paradigms (cf. G. STANGHELLINI, A. RABALLO, *Exploring the margins of the bipolar spectrum*; G. STANGHELLINI, M. BERTELLI, A. RABALLO, *Typus melancholicus*).
[47] M. MERLEAU-PONTY, *Phenomenology of perception*, p. XVIII.
[48] Cf. J. KRUEGER, G. COLOMBETTI, *Affective affordances and psychopathology*.
[49] T. FUCHS, *Depression, intercorporeality, and interaffectivity,* pp. 7-8.
[50] Cf. O. DOERR-ZEGERS, *El cambio de la corporalidad y su importancia para la determinación de un síndrome depresivo fundamental o nuclear*.
[51] Cf. V. BIZZARI, *Schizophrenia and common sense: A phenomenological perspective*.
[52] S. BRAMPTON, *Shoot the damn dog,* p. 34.
[53] T. THOMPSON, *The beast: A reckoning with depression,* p. 246.
[54] O. DOERR-ZEGERS, L. IRARRÁZAVAL, A. MUNDT, V. PALETTE, D*isturbances of embodiment as core phenomena of depression in clinical practice*.

[55] Bleuler has defined this disruption as "the alteration of the centrifugal functions", since they are functions that connect us to the environment.
[56] T. FUCHS, S.C. KOCH, *Embodied affectivity*.
[57] T. FUCHS, *Corporealized and disembodied minds.*
[58] Here are some examples provided by Ratcliffe (M. RATCLIFFE, *Experiences of depression* – italic added): «...they are all selfish and don't understand»; «they don't understand and so act like nothing is wrong»; «*It feels like no one else has ever experienced anything like this before, like you're all on your own*»; «I find other people irritating when depressed, especially those that have never suffered with depression, and find the "advice" often given by these is unempathetic and ridiculous»; «nobody understands or loves me»; «*However much they say they understand, I don't believe them*»; «*There is the realization that you have never connected with anybody, truly, in your life*»; «everyone seems so annoyingly normal, happy, able to cope, unaware of the turmoil that is filling my room, my head, my life, my world»; «*You feel alone and in a world that cannot be easily explained or described*».
[59] Cf. R. STOLOROW, *Trauma and existence*.
[60] Cf. R. STOLOROW, G.E. ATWOOD, *Contexts of being*.
[61] Cf. T. FUCHS, *Temporality and psychopathology*.
[62] Cf. L. SASS, E. PIENKOS, *Space, time and atmosphere. A comparative phenomenology of melancholia, mania and schizophrenia*.
[63] Cf. K. VOGELEY, C. KUPKE, *Disturbances of time consciousness from a phenomenological and a neuroscientific perspective*.
[64] Cf. T. FUCHS, *Temporality and psychopathology*; T. FUCHS, *Depression, intercorporeality, and interaffectivity*.
[65] Cf. V. BIZZARI, *La musicalità dell'essere. Corpo e tempo nella sindrome di Asperger*.
[66] On the other hand, we can claim that the schizophrenic subject also registers this temporal disruption, and that also in this case such disruption comprises every level. Nonetheless, whereas the depressed patient suffers from a deceleration of time; the schizophrenic one experiences an acceleration and fragmentation of the temporal experience. The result is the same: it becomes impossible to tune in to others and the world.
[67] Cf. K. LEOHNARD, *Classification of endogenous psychoses and their differentiated etiology*.
[68] Cf. M. RATCLIFFE, M. BROOME, B. SMITH, H. BOWDEN, *A bad case of the flu?*.
[69] This problem is emphasized by Kraus who claims that the melancholic finds herself in the peculiar situation where she strives for resonance to such an extent that she is in a state of "hypersynchrony", where synchrony remains impossible to achieve. Cf. A. KRAUS, *Rollendynamische Aspekte bei Manisch-Depressiven*.
[70] S. PLATH, *Collected poems*.
[71] In her *Diaries*, Sylvia Plath writes: «I talk to myself and look at the dark trees, blessedly neutral» (S. PLATH, *Diaries*, p. 200).
[72] Cf. M. FOUCAULT, *The archeology of knowledge*.
[73] In the DSM-V mood disorders are divided into two groups: bipolar disorder and related disorders, and depressive disorders. In general, the main types of mood disorders include major depressive disorder, bipolar I disorder, bipolar II disorder, cyclothymic disorder.
[74] Cf. F. BRENCIO, *Befindlichkeit: Disposition*.
[75] M. HEIDEGGER, *Being and time*, p. 173.
[76] M. RATCLIFFE, *The phenomenology and neurobiology of moods and emotions*, p. 128.
[77] M. HEIDEGGER, *Being and time*, p. 176.
[78] M. RATCLIFFE, *The phenomenology and neurobiology of moods and emotions*, p. 128; cf. also M. RATCLIFFE, *The phenomenology of moods and the meaning of life*; M. RATCLIFFE, *Why moods matter*.
[79] Cf. W. BLANKENBURG, *Der Verlust der natürlichen Selbstverständlichkeit*.
[80] Cf. L. SASS, E. PIENKOS, *Space, time and atmosphere. A comparative phenomenology of melancholia, mania and schizophrenia*.
[81] J.G. PEREIRA, G. GONÇALVES, V. BIZZARI, *The neurobiology - psychotherapy - pharmacology intervention triangle,* p. 5.
[82] A. GEORGOTAS, R.E. MCCUE, *Benefits and limitations of major pharmacological treatment for depression*, p. 375.

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