RIVISTA INTERNAZIONALE DI FILOSOFIA E PSICOLOGIA
DOI: 10.4453/rifp.2024.0014

ISSN 2039-4667; E-ISSN 2239-2629
Vol. 15 (2024), n. 2, pp. 120-128

SYMPOSIUM

Embodied injustice, socially caused illness, and depression

Michelle Maiese[α]

Ricevuto: 14 marzo 2024; accettato: 27 aprile 2024

Abstract In his discussion of "marginalized bodies," Leder maintains that members of oppressed social groups encounter not just discriminatory treatment and limited access to societal resources, but also "embodied injustice". Such injustice occurs when an "inferior group" is not only identified with the body as such, but also labeled as "having the wrong kind of body". This devaluation of certain kinds of bodies results in an alteration of people's embodied ways of feeling, perceiving, and acting in the world. Both in injury or illness and in cases of embodied injustice, there is often (a) a constriction of lived space, (b) a disruption of lived time, and (c) isolation. To illustrate how these distressing disruptions to the body-world relation are caused largely by social factors, Leder turns to incarcerated persons (Chap. 6) and elders (Chap. 7) as case studies. Building upon this discussion, I argue that depression is both an illness that involves the sorts of alterations to the body schema that Leder outlines, and also the result of various socially caused harms. Just as the restrictions imposed by illness and incarceration can become mutually reinforcing, so, too, can the restrictions imposed by depression and the social stigmatization that often accompanies it. This has some important implications for healing and treatment.

KEYWORDS: Biomedical Approach to Psychiatry; Desynchronization; Epistemic Injustice; Racism; Stigmatization; Stereotypes

Riassunto *Ingiustizia epistemica, malattie socialmente generate e depressione* – Nel discutere i "corpi emarginati" Leder sostiene che i membri dei gruppi sociali oppressi non affrontano solo trattamenti discriminatori e accesso limitato alle risorse della società, ma anche una "ingiustizia incarnata". Tale ingiustizia si verifica quando un "gruppo inferiore" viene non solo identificato con il corpo in quanto tale, ma anche etichettato come "avente il tipo sbagliato di corpo". Questa svalutazione di certi tipi di corpi porta a un'alterazione dei modi incarnati di sentire, percepire e agire nel mondo delle persone. Sia in caso di infortunio o malattia, sia in situazioni di ingiustizia incarnata, spesso si verifica (a) una restrizione dello spazio vissuto, (b) una disgregazione del tempo vissuto e (c) un isolamento. Per illustrare come questi sconvolgimenti angoscianti nel rapporto corpo-mondo siano causati in gran parte da fattori sociali, Leder si rivolge a persone incarcerate (Cap. 6) e anziani (Cap. 7) come studi di caso. Sulla base di questa discussione, sostengo che la depressione sia una malattia che comporta i tipi di alterazioni dello schema corporeo, che Leder descrive, e il risultato di vari danni causati socialmente. Proprio come le restrizioni imposte dalla malattia e dall'incarcerazione possono diventare reciprocamente rinforzanti, così possono esserlo anche le restrizioni imposte dalla depressione e dalla stigmatizzazione sociale che spesso l'accompagna. Questo ha alcune importanti implicazioni per la guarigione e il trattamento.

PAROLE CHIAVE: Approccio biomedico alla psichiatria; Desincronizzazione; Ingiustizia epistemica; Razzismo; Stigmatizzazione; Stereotipi

---

[α] Department of Philosophy, Emmanuel College, The Fenway 400 – 02115 Boston (MA) (USA)

E-mail: maiesemi@emmanuel.edu

1 Introduction

After discussing a range of body-oriented healing strategies in the first part of this interesting and important book, Leder turns his attention to "marginalized bodies" and some parallels between bodily ills and social ills. He maintains that members of oppressed social groups encounter not just discriminatory treatment and limited access to societal resources, but also "embodied injustice". Such injustice occurs when an "inferior group" is not only identified with the body as such, but also «labeled as *having the wrong kind of body*» (Leder 2024, p. 111). This devaluation of certain kinds of bodies results in an alteration of people's embodied ways of feeling, perceiving, and acting in the world. In Chapter 6, Leder argues that changes to the body-world relation that occur due to injury or illness are similar to some of the changes to this relation that occur due to embodied injustice. In both cases, there is often (a) a constriction of lived space, (b) a disruption of lived time, and (c) isolation. Thus, embodied injustice commonly results in what might be understood as "socially caused illness". Both in cases of somatic illness and instances of embodied injustice, a subject often is disempowered partly due to the way in which their body is stigmatized by existing social institutions, such as the health care system. For example, both incarcerated persons (Chap. 6) and elders (Chap. 7) commonly encounter distressing disruptions to the body-world relation, and in both cases, these disruptions are largely socially caused.

My central aim is not to critique Leder's account, but rather to build upon some of its key insights by considering the case of depression. Although depression is an illness that involves bodily distress and incapacity, its onset and symptoms cannot be understood without reference to social factors. First, alterations to the body-world relations that occur in depression result not just from neurobiological factors, but also from embodied injustice in the form of social oppression. Second, the mental health system that subjects turn to for healing and treatment often perpetuates various forms of embodied injustice by way of stigmatization and silencing. This is partly because this system operates with a biomedical model of depression that focuses primarily on the individual's "dysfunctional" brain chemistry and obscures the influence of social and political factors. What is more, those with depression are labeled as deviant from "the norm," and they may be subject to various forms of stigmatizing treatment that casts them as inferior. Such considerations lead Potter (2019) to suggest that people with mental illness are members of an oppressed group and that «this oppression is rooted in material, political, social, economic, and cultural dimensions of everyday life and results in poverty, isolation, and indignity» (p. 301).

And yet here, unlike in the case of gender or race, we may be inclined to think that there is some truth to the idea that there is a genuine bodily disruption (an illness) at play, aside from these social harms. To what extent, then, do those with mental illness (and depression in particular) qualify as "marginalized bodies"? I argue that depression is both (a) an illness that involves the sorts of alterations to the body schema that Leder outlines, and (b) the result of various socially caused harms. Due to both illness and embodied injustice, subjects with depression experience a constriction of lived space, a disruption of lived time, and social-relational disturbances. Just as the restrictions imposed by illness and incarceration can become "synergistically confining" (Leder 2024, p. 118), so, too, can the restrictions imposed by depression and the social stigmatization that often accompanies it. Because it is difficult to tease out whether associated limitations stem primarily from neurobiological disruption or from social causes, the case of depression (as a form of mental illness) is particularly interesting to consider. This discussion further reveals some important connections between illness and embodied injustice, and also has some interesting implications for healing and treatment.

2 Depression as illness: Disruptions to the body-world relation

Depression commonly involves the sorts of alterations to the body-world relation that Leder suggests are characteristic of illness. First, there is a constriction of lived space; those suffering from chronic pain and illness inhabit a shrunken world. Their focus of attention narrows, and due to bodily dysfunction and incapacity, they encounter a limited range of possibilities. In cases of depression, this constriction of lived space is associated with diminished bodily activity, slouched posture, and tension in the shoulders. Some subjects describe their bodies as tired, achy, heavy, and unresponsive and report that it feels like there is a weight pulling them down (Smith 2013, p. 629) or that ordinary tasks feel quite difficult. Others report feeling trapped or unable to move, which Aho (2013) describes in terms of paralysis: «the transparent and seamless bond between body and world is broken and our corporeality obtrudes in its place as something clumsy and heavy, a foreign obstacle or thing that inhabits our practical engagement with the world» (p. 754). One might say that the bodily changes experienced as part of depression articulate the orientation between the subject and world in terms of "I cannot" rather than "I can" (Smith 2013, p. 632). A sense of impossibility often becomes a consistent theme (Ratcliffe 2010, p. 610).

Second, there is a disruption of lived time. The narrowing of possibilities just described are accompanied by aberrant time experiences and a sense of being cut off from the future. Leder notes how pain and illness can fracture lived time in different ways. On the one hand, they relentlessly pull an individual to the "now" of immediate bodily events (e.g., the pain or discomfort they are currently experiencing). On the other hand, the experience of pain is also the body's way of requesting immediate action to reduce the pain; «this now from which [they] are summoned is one from which [they] wish to flee» (LEDER 2024, p. 118). Someone's thoughts may drift to a future when their symptoms will be alleviated, yet they may feel unable to realize this future or sense that the future actually is likely to bring a worsening of symptoms. As a result, the subject feels estranged from past, present, and future alike. Such alienation also occurs in cases of depression: the future lacks openness and no longer appears as a domain of possible activity; the "now" may take on a repetitive quality, leading to feelings of boredom; and alongside the loss of hopeful anticipation, there may be a deep sense of regret. Aho (2013) proposes that depression is atemporal in a sense: «in the fog of depression» the sense of anticipation that ordinarily characterizes the present may be missing, and the future may be experienced as fixed and inescapable (p. 758). In addition, if a subject's relationship to the future is distorted, there is a sense in which they also will feel uncoupled from the past. If the past cannot be understood as part of the subject's path toward the future, its significance will no longer resonate (RATCLIFFE 2012, p. 129).

These disruptions to lived time contribute to another change to the body-world relation that Leder maintains is characteristic of illness: social isolation. Because the subject has a sense of being cut off from their future, there may be a «temporal mismatch between the subjectively felt inner pulse and [the] time frames the outer world seems to follow» (JACOBS *et alii* 2014, p. 100). One subject with depression reported that it seemed as if the world was moving faster, and as if they were moving slowly while others were moving quickly (JACOBS *et alii* 2014, p. 99). Due to this "desynchronization" (FUCHS 2013), subjects commonly feel "out of tune" with other people and less able to apprehend possibilities for social interaction. They also may have a sense that others are unable to understand their psychological struggles and motivational challenges, or experience feelings of guilt (RATCLIFFE 2010) because they believe that they are disappointing others. Such dynamics can lead to social alienation and withdrawal.

3 Social causes of depression

According to the biomedical model, the changes to the body-world relation described in the previous section are caused by disruptions to neurobiological dynamics, i.e., a neurochemical imbalance. A biomedical model thereby casts depression as a self-contained ailment or personal pathology that is «largely divorced from social, economic, and political contingencies», and which can be treated through "value-free" and naturalistic methods of science and medicine (ESPOSITO & PEREZ 2014, p. 415). However, Leder's account helps us to see how the changes to the body-world relations that occur in depression result not simply from neurobiological factors, but also from embodied injustice.

While the predominance of a mechanistic disease model leads some people to overlook the significant role played by harmful social dynamics (NEITZKE 2016, p. 60), there is ample evidence that sexism, racism, heterosexism, transphobia, and other forms of social oppression increase someone's likelihood of developing a mental illness (HARBIN 2019). Research has shown that women are 70% more likely to experience depression in their lifetime (KESSLER *et alii* 2005), and studies have found that everyday experiences of racism (such as being followed around in stores, viewed as less smart than others, being insulted, or being given poorer services) are associated with increased chances of developing depressive symptoms (MOLINA & JAMES 2016). African American adults with depression in the United States also rate their symptoms as more severe, have a longer course of illness, and experience greater disability (WILLIAMS *et alii* 2007). In addition, numerous studies have shown that childhood adversity and maltreatment contribute to an increased risk for depression across the lifespan (CLARK *et alii* 2010) Examples of adverse childhood experiences include racism, abuse and neglect, witnessing domestic violence, parental separation or divorce, bullying, and community violence (CRONHOLM *et alii* 2015).

To explain why members of marginalized groups are more likely to develop depressive symptoms, Harris (2003) notes that the onset of depression often involves the experience of a severe life event that is a major stressor. The generalized feelings of helplessness or hopelessness that may result from this arguably are more likely in people who already belong to some disempowered population. In addition, «persons who are subject to diminished social influence and control because of violence and oppression are more likely to experience severe events» (NEITZKE 2016, pp. 68-69). The psychosocial stress resulting from repeated and cumulative incidents of discrimination, abuse, or unfair treatment can prompt a range of emotional and cognitive responses, such as negative affect, sadness, rumination, anxiety, and hopelessness (PARADIES 2006). These repeated social injuries can lead not only to exaggerated muscle tension and high blood pressure (LEDER 2024, p. 123), but also result in cumulative psychic trauma (HANKERSON *et alii* 2022).

Drawing from Leder's account, I argue that "embodied injustice" contributes to depression largely by exacerbating the disruptions to the body-world relation described in the previous section. Here, I focus on the way in which racism, in particular, results in the constriction of lived, space, the disruption of lived time, and social isolation. These harmful changes to the body-world relation not only contribute to the onset of depression, but also can help to sustain and exacerbate depressive symptoms.

First, being subjected to racism frequently results in constriction of lived space. Along these lines, Fanon (2008) speaks of the "imprisoning" gaze of the white man (p. 92), and Leder notes that when someone lives under the threat of hostile gazes and discriminatory treatment, they may feel as if they are continually in a chokehold or unable to breathe (LEDER 2024, p. 181). A particularly vivid description of the lived experience of such constriction comes from Yancy's (2017) account of encountering a white woman on an elevator. When she clutches her purse and conveys that she views his Black skin as indicative of something threatening and violent, he feels trapped; Yancy reports that he no longer felt his own bodily expansiveness within the elevator (p. 32), but instead felt constrained and immobilized., Such experiences of bodily immobilization and incapacity are commonly accompanied by feelings of muscle tension, gastric constriction, and elevated pulse and blood pressure (SEKIMOTO & BROWN 2020). It is not difficult to see how these sorts of bodily experiences could contribute to the feelings of anxiety, unease, and hopelessness commonly found in depression.

In addition, racism can result in a disruption to lived time. Al-Saji (2013) describes how "white" ways of imagining, thinking, and seeing become normative within racialized societies. In a social world where habitually "white" forms of being are privileged as normatively desirable (4), the subject with dark skin is positioned as "other". Al-Saji suggests that the racializing gaze of a white person identifies the Black subject with their skin color and positions them within a racialized frame of reference that is linked to a Black past. As a result, «the past is no longer lived at a distance, as past, but is experienced as a fixed and overdetermining dimension of the present» (p. 5). Building on the work of Fanon, Al-Saji proposes that a subject with dark skin has a sense of arriving "too late" to a realm of possibilities; «the field of possibilities has already been defined in relation to other (white) bodies» (p. 8). Available action possibilities don't seem to allow for variation and are not seen as being able to be worked out differently. This sense of being "too late" may very well contribute to feelings of hopelessness and a sense of being "out of sync" with the social world.

Racism also can lead to social alienation, withdrawal, or isolation. Yancy describes (2017) walking down the street and hearing the "ClickClickClick" of white drivers locking their car doors; Leder notes that this is the opposite of embodied communing. Along similar lines, Ahmed (2007) highlights how Black bodies routinely face obstacles when navigating various social spaces: "Who are you? Why are you here? What are you doing?". Such questions function as stopping devices that reinforce people's felt sense that some bodies are "out of place" and "do not belong." Such dynamics not only contribute to a lack of social connectedness, but also lead people to feel that they are not welcome in various social spaces. What is more, discrimination and other forms of demeaning treatment can convey to individuals that they are different, devalued, and not respected in society (CROCKER & QUINN 2003). This contributes to feelings of self-doubt, low self-worth, and hopelessness, which are common among subjects with depression.

Such considerations help to explain why forms of embodied injustice, such as racism, can both contribute to the onset of depression and exacerbate depressive symptoms. Given that being subjected to everyday racism and racist social structures tends to bring about harmful changes to the body-world relation, it would be a mistake to overlook the social causes of depression.

4 Post-diagnostic embodied injustice

I have argued that the changes to the body-world relation that commonly occur in depression are caused partly by oppressive social factors. Once a subject with depression has received a diagnosis, these distortions to the body-world relation can be intensified further still due to stigma and epistemic injustice. Such effects are yet another example of embodied injustice, and they occur largely due to the predominance of a biomedical approach to psychiatry.

Biomedical models hold that mental illnesses are diseases of the brain and that depression, in particular, results from a neurochemical imbalance. Although psychiatrists are well-aware that both environmental and biological factors contribute to major depression, «biopsychiatric research continues to focus on causal models emphasizing the singular role of the brain» (THACHUK 2001, p. 147). Some believe that adoption of a biomedical model can help to alleviate stigma. After all, if mental illness can be likened to other biologically based diseases, such as diabetes, it somehow becomes more concrete and tangible; it is not just "all in one's head," nor is it within someone's control. Displacing responsibility onto the organic brain undermines the idea that people with depression, for example, are simply weak-willed or have bad characters. What is more, adoption of this model may allow those with depression to distinguish between their "true self" and their biologically disordered symptoms. Stigmatizing attitudes can then be displaced from the subject with depression onto the symptoms/behavioral manifestations of their illness.

However, according to Thachuk (2011), adoption of a biomedical model may, in fact, do more to exacerbate stigma than it does to undercut it. One central drawback is that such models reinforce the notion that persons with mental illness are of a fundamentally "different kind" and that their brains function differently from those of "normal" people. In some cases, neuroimaging technologies create pictorial impressions that reinforce this idea that there are "different kinds of brains". The notion that someone has depression simply due to a neurochemical imbalance may lead to the kind of reductionism, objectification, and essentialism that Leder suggests is central to the operation of embodied injustice. On his account, embodied injustice occurs when the bodily attributes of an "inferior group" are taken to define them in some essential way, and to render them as deviant from the norm (LEDER 2024, p. p. 111). In the case of depression, subjects are identified as having a dysfunctional, non-normative brain that needs to be controlled and repaired via medication. Once they receive a diagnosis, they may be identified first and foremost via this diagnosis in health care settings. In addition, there may be a tendency to suppose that because their brain is somehow "broken", they (as a person) are broken.

This stigmatization is reinforced by a logic of oppression that depends on the sort of dualistic, oppositional, and hierarchical thinking that Leder describes: the world is viewed as split into two opposing elements, with one element deemed naturally "superior" to the other. Just as men in patriarchal cultures are thought to be superior to women, those who are "sane" are commonly deemed superior to those who are "mentally ill" or "crazy". Due to stigma, those with mental illness may find it more difficult to secure housing, education, and employment; their opportunities for professional advancement may be limited and their likelihood of being incarcerated increases (GOSSELIN 2018). Some people may not even seek treatment out of fear of being labeled "mentally ill".

The stigma surrounding mental illness in general, and depression in particular, is bound up with a range of negative stereotypes. To some extent, stereotyping is an unavoidable feature of human cognition; making generalizations based on characteristics thought to be shared among group members helps people to make quick and efficient judgments and navigate the social world. However, stereotyping also can be deeply problematic insofar as it is used to construct in-groups and out-groups. Common stereotypes present a picture of those with mental illness as violent, incompetent, deranged, weak-willed, or manipulative (POTTER 2019, 314) However, which stereotypes come into play depends significantly on which mental illness someone has. Those with depression are commonly assumed to be lazy or incompetent; they are «capable of having sufficient control over their behavior so as to be morally responsible for it and so are blameworthy when they fail to exercise or develop self-control and willpower» (GOSSELIN 2018, p. 79). What is more, because they lack willpower and self-control, it may seem justifiable to discredit them or doubt their general capacity for agency and decision-making. As a result, the legitimate complaints of those with depression may not be taken seriously (THACHUK 2011).

Indeed, negative stereotypes sometimes lead health care professionals to discount the epistemic and moral agency of their patients. Potter (2019) highlights how therapeutic settings are sometimes characterized by oppressive forms of interpersonal interaction. First, mental health professionals may exhibit microaggressions, i.e., commonplace verbal or behavioral slights which, whether intentional or unintentional, communicate hostility or insult members of marginalized groups. For example, if a clinician calls in the parent of an adult, competent patient and then talks mostly with the parent, this can be understood as a microinsult that indirectly belittles the patient. Or, in cases of *microinvalidation*, a clinician makes statements or exhibits behaviors that negate, nullify, or fail to take seriously a marginalized person's experiences or realities. For example, a therapist might say to a patient, "underneath your anger is….." and thereby deny that her anger is something that should be taken seriously and investigated (POTTER 2019, p. 315).

Second, in cases of silencing, the testimony of mentally ill persons may be discounted or dismissed. People who belong to minority groups, in particular, «are considered less credible both because they are viewed as incapable of being knowers and because their character is untrustworthy» (POTTER 2019, p. 316). Because those with mental illness tend to be more needy, dependent, or chronically suffering, and because they may be viewed as incompetent or deranged, their testimony may not get uptake (GOSSELIN 2018). "Testimonial quieting" (POTTER 2019, p. 317) occurs when a speaker's credibility as a knower is undervalued due to negative stereotypes or controlling images. Note that the biomedical model can contribute to silencing insofar as it focuses attention on individuals and their brains. Once depression is conceived as a problem located in neuropathways, people who try to attest that social oppression is a central cause of their distress may be discounted or ignored (NEITZKE 2016, p. 64). This not only further marginalizes them, but also prevents people from examining the social-structural causes of depression.

Epistemic injustice also may occur in the context of their day-to-day interpersonal interactions. This is because admitting that they have depression may lead family members and friends to doubt their agency or question their credibility. When people dismiss depressive feelings as mere sadness, attempt to romanticize symptoms of depression, or adopt a patronizing tone, they "speak over" the person with depression rather than listening to their testimony; in such cases, well-meaning people «commit epistemic injustice toward depressives through continued ignorance of feelings that they may not understand» (JACKSON 2017, p. 363).

Stigma, negative stereotypes, and epistemic injustice all contribute to the distortions to the body-world relation that commonly occur in depression. First, there is a constriction of lived space. As noted already, stigma and negative stereotypes lead to a narrowing of possibilities for subjects with depression, by limiting their opportunities to secure housing and employment, for example. What is more, being silenced or dismissed can erode a patient's sense of agency and undermine their sense of themselves as capable, efficacious, and in control (HOULDERS *et alii*, 2021). And because agents with mental illness often are viewed and treated as less worthy and competent, like members of other socially marginalized groups, they may begin to doubt their own worth as well as their ability to make appropriate choices. This can generate self-doubt, undermine their self-efficacy, and reinforce the sense of "I can't" that is common among those with depression.

In addition, encountering stigma, negative, stereotypes, and epistemic injustice can make those with depression feel as if they are even more "out of tune" with others and more cut off from the future. This may very well reinforce their sense of being "trapped", immobilized, and unable to envision their life otherwise. Lastly, these dynamics can contribute to social withdrawal and isolation. Stigma and negative stereotypes reinforce subjects' sense that their psychological struggles are incommunicable and that they are ill-equipped to participate in a shared social world. Along these lines, Jackson (2017) describes how those with depression often feel alienated from friends and family and have a sense that nobody can relate to them. Indeed, one key harm associated with epistemic injustice is a *lack of social recognition*:

> Only through epistemic and moral engagement do we have a meaningful social existence, and only then are we recognized *by others* as humans, as members of a shared community. (GOSSELIN 2018, p. 86)

When the testimony of subjects with depression is discounted or they are subjected to stigmatizing treatment, this contributes to their perceived lack of social recognition and reinforces their sense of isolation.

5 Healing from illness and embodied injustice

Once we acknowledge that depressive symptoms are caused and sustained, in part, by embodied injustice, what implications does this have for treatment? In this section, I build upon Leder's discussion of body-oriented healing strategies to examine how disruptions to the body-world relation might be repaired. I argue that devising an adequate approach to treatment will require that we move beyond medication and attend to subjects' bodily schema and social relationships.

The dominant biomedical approach to treating depression centers around the use of selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs). While medication does appear to be effective for many, its use sometimes involves an assumption that a neurochemical imbalance is "the" cause of depression. This exclusive focus on mechanistic neurological functioning may lead people to ignore or bracket-out the role played by oppressive social influences (NEITZKE 2016). However, the discussion so far has revealed that treatment often will need to include efforts to address social factors. How, then, can a focus on the psychosocial effects of oppression be included in therapeutic methods (HARRIS 2003)? Nietzke (2016) proposes that «the tools by which oppressed peoples find solidarity and unity against oppressors may also be the tools by which to protect their mindful or psychological well-being» (p. 69). This points to a need to promote social recognition, self-esteem, and self-efficacy, and suggests that empowerment is a key aspect of healing from depression and other forms of mental illness.

One healing strategy that Leder discusses is "communing", i.e., forming supportive and meaningful relationships with others. "Communing" with family members, friends, community groups, mental health professionals, or service animals all can be an important part of healing from depression insofar as they expand someone's range of possibilities and help them to overcome feelings of social isolation. However, there are aspects of psychiatric practice that can make it difficult for "communing" to occur in these settings. Leder notes how the provision of medical care frequently involves objectification of the body, which can lead to experiences of depersonalization and disempowerment (LEDER 2024, p. 121). Rather than experiencing their body as an arena for action, patients may experience it as objectified by the gaze of mental health professionals and subjected to surveillance and medical intervention. Epistemic injustice and other stigmatizing forms of treatment that sometimes in therapeutic settings are the very opposite of "communing".

To make care provision more empowering, mental health professionals should take steps to guard against discrediting or silencing those with depression. This includes efforts to de-center themselves and their own perspectives and listen to what their patients are saying without imposing their preestablished understandings. Rather than viewing those with depression «as mere embodiments of a diagnosis or a collection of symptoms» (POUNCEY & LUKENS 2010, p. 95), mental health care providers should approach them as unique persons. They also should try to gain an understanding of how various forms of social oppression operate and how their own social location (namely one of relative power and privilege) has the potential to reproduce or undermine these forms of oppression (POTTER 2019).

Another way to combat epistemic injustice and stigmatization is to actively involve patients in treatment decisions and to emphasize the value of their experiential knowledge. Constructive and empowering mental health practices, as I understand them, are those that are truly "person-centered", involve asking clients about their needs, and emphasize client involvement in treatment decisions. That is, there needs to be a kind of "communing" and a relationship of give and take between mental health professionals and those with depression. The role of the patient should not be simply to be compliant and accept that "doctor knows best", but rather to contribute to a collaborative dialogue. This requires that patients have decision-making power, access to information and resources, and a range of options from which to make choices (not just yes/no, either/or) (NELSON 2003, p. 188). When those with depression are actively involved in treatment decisions, this can help them to build a sense of self-efficacy, expand their sense of available options, and orient them toward a future with a fuller range of possibilities.

"Communing" in a mental health care setting also may involve the co-construction of an autobiographical narrative that sheds light on their condition and helps them see a way forward. For example, if someone with depression can construct a narrative that highlights how they have overcome adversity in the past, they may begin to see themselves as resilient, as capable of navigating their mental illness. Or, if the narrative reveals how various hobbies or personal relationships have contributed to their well-being, this can make action-possibilities associated with those pursuits seem more salient. In some cases, patients begin to tell a story about themselves that focuses on their future and involves them moving forward and gaining more control over their lives. This can help them gain a sense of what they want and what "getting better" means for them. Part of recognizing a wide array of options is the ability to envision a possible future that differs in important ways from the past. As Leder notes, this sort of re-envisioning is often a key component of healing.

Leder further notes how strategies of giving to, and receiving from, others can be extremely beneficial (LEDER 2024, p. 131). Indeed, giving back to one's family, friends, and broader community can be a powerful way to cultivate a sense of agency and move past feelings of shame or guilt regarding one's depression. The notion that helping others can be empowering is reflected in some of the key aims of the so-called "recovery movement". This movement envisions recovery as a process in which people find ways to lead the sort of life that they find meaningful (COULOMBE *et alii* 2016), either by recovering from mental illness entirely, or by learning how to live with it. It emphasizes that:

> [...] the primary prostheses for people with mental health conditions are social in nature and involve having access to caring, trusted, and knowledgeable people who can support them over time in pursuing their hopes and aspirations in the community contexts of their choice. (DAVIDSON 2016, p. 1093)

The provision of community-based supports commonly includes supported housing and employment and assistance in domains such as education, parenting, and socialization. In many cases, these resources are offered by people in recovery themselves, via peer support. Peer staff members instill hope through their own self-disclosures and role modeling and educate people for self-care. Research has found that peer support can reduce the rate and length-of-stay of hospital admissions, substance abuse, and depression, while increasing hope, empowerment, well-being, and quality of life (DAVIDSON 2016, p. 1094). In addition, as Leder's discussion of healing strategies highlights, the process of helping others can help to empower those providing peer support.

Another way to promote healing is by utilizing holistic treatment interventions that target both bodily dynamics and social relations. Dance-movement therapy, for example, is a powerful way to counter the disruptions to the body-world relation that commonly occur in depression insofar as it helps subjects to embrace their body, resynchronize, and connect with others. First, it can help subjects to overcome the constrictions to lived space that that they experience. Along these lines, Sheets-Johnstone (2010) maintains that one reason movement is therapeutic is that it is life-proclaiming: movement causes people to feel energized, and when a subject turns her attention to the source of this energy, she «awakens to the lively kinetic dynamics of [her] tactile-kinesthetic body» (p. 3). Over time, movement allows the subject to cultivate a sense of herself as an effective agent, which can contribute to empowerment.

In addition, DMT can help subjects with depression resynchronize with the social world and overcome social isolation. Baum (1991) describes how a group session might unfold: the group sits in a circle of chairs, and the leaders check with each member, both verbally and nonverbally, to gauge their mood. After an initial warm-up, the group stands and begins to move. At times, synchrony develops and the participants move together rhythmically; but in other cases, one patient will begin to initiate a movement sequence on her own, in response to internal stimuli. The leader might pick up this individual's movement to imitate and follow, and «replicating the patient's movement allows the therapist to share the patient's experiences in the moment» (BAUM 1991, p. 101). Individuals sometimes take turns initiating movement sequences, and other members of the group try to mimic that subject's quality of movement and to resonate with it. Moving in synchrony with others or coordinating movements in response to what others do can foster a feeling of togetherness and positive rapport, contribute to social cohesion (COLOMBETTI 2014, p. 197), and give subjects the experience of moving at the same speed as others. The group DMT setting thereby enables a form of "communing".

Finally, there is a need to shift the focus from patient-centered, individual healing to things that can only be brought about by sociopolitical change and modifications to the social world. While I agree with Leder that our culture of mass incarceration needs to be transformed, the case of depression suggests that even more far-reaching changes may be necessary. Indeed, if we wish to «create a health-supportive world» (LEDER 2024, p. 168), this may require not only significant efforts to combat various forms of social oppression, but also changes to society's economic system. Along these lines, Esposito and Perez (2014) maintain that economic policies in countries such as the United States have led to an erosion of decent paying jobs and the dismantling of social programs and public services, which in turn has contributed to increasing stress, financial insecurity, outright poverty, worker dissatisfaction, and declining levels of happiness (p. 426). When society considers competitive individualism as part of human nature, prioritizes business interests over workers' rights, encourages people to prioritize profit and self-gain, and views compassion and solidarity as optional, this results in a weakening of social bonds and increased levels of anxiety and discontent. Such observations highlight, once again, the connections between health and the social world, and the need for broadly holistic healing strategies that address "socially caused illness".

Literature

AHMED, S. (2007). *A phenomenology of whiteness*. In: «Feminist Theory», vol. VIII, n. 2, pp. 149-168.

AHO, K.A. (2013). *Depression and embodiment: Phenomenological reflections on motility, affectivity, and transcendence*. In: «Medicine, Health Care and Philosophy», vol. XVI, n. 4, pp. 751-759.

AL-SAJI, A. (2013). *Too late: Racialized time and the closure of the past*. In: «Insights», vol. VI, n. 5, pp. 1-13.

BAUM, E. (1991*). Movement therapy with multiple personality disorder patients*. In: «Dissociation», vol. IV, n. 2, pp. 99-104.

CLARK, C., CALDWELL, T., POWER, C., STANSFELD, S.A. (2010). *Does the influence of childhood adversity on psychopathology persist across the lifecourse? A 45-year prospective epidemiologic study*. In: «Annals of Epidemiology», vol. XX, n. 5, pp. 385-394.

COLOMBETTI, G. (2014). *The feeling body: Affective science meets the enactive mind*, MIT Press, Cambridge (MA).

COULOMBE, S., RADZISZEWSKI, S., MEUNIER, S., PROVENCHER, H., HUDON, C., ROBERGE, P., HOULE, J. (2016). *Profiles of recovery from mood and anxiety disorders: A person-centered exploration of people's engagement in self-management*. In: «Frontiers in Psychology», vol. VII, Art. Nr. 584 – doi: 10.3389/fpsyg.2016.00584.

CROCKER, J., QUINN, D.M. (2003). *Psychological consequences of devalued identities*. In: R. BROWN, S.L. GAERTNER (eds.), *Blackwell handbook of social psychology: Intergroup processes*, Blackwell, London/New York, pp. 238-257.

CRONHOLM, P.F., FORKE, C.M., WADE, R., BAIR-MERRITT, M.H., DAVIS, M., HARKINS-SCHWARZ, M., PACHTER, L.M., FEIN, J.A. (2015). *Adverse childhood experiences: Expanding the concept of adversity*. In: «American Journal of Preventive Medicine», vol. XLIX, n. 3, pp. 354-361.

DAVIDSON, L. (2016). *The recovery movement: Implications for mental health care and enabling people to participate fully in life*. In: «Health Affairs», vol. XXXV, n. 6, pp. 1091-1097.

ESPOSITO, L., PEREZ, F.M. (2014). *Neoliberalism and the commodification of mental health*. In: «Humanity & Society», vol. XXXVIII, n. 4, pp. 414-442.

FUCHS, T. (2013). *Temporality and psychopathology*. In: «Phenomenology and the Cognitive Sciences», vol. XII, n. 1, pp. 75-104.

GOSSELIN, A. (2018). *Mental illness stigma and epistemic credibility*. In: «Social Philosophy Today», vol. XXXIV, pp. 77-94.

HANKERSON, S.H., MOISE, N., WILSON, D., WALLER, B.Y., ARNOLD, K.T., DUARTE, C., LUGO-CANDELAS, C., WEISSMAN, M.M., WAINBERG, M., YEHUDA, R., SHIM, R. (2022). *The intergenerational impact of structural racism and cumulative trauma on depression*. In: «American Journal of Psychiatry», vol. CLXXIX, n. 6, pp. 434-440.

HARBIN, A. (2019). *Resilience and group-based harm*. In: «IJFAB: International Journal of Feminist Approaches to Bioethics», vol. XII, n. 1, pp. 24-43.

HARRIS, T. (2003). *Depression in women and its sequelae*. In: «Journal of Psychosomatic Research», vol. LIV, n. 2, pp. 103-112.

HOULDERS, J.W., BORTOLOTTI, L., BROOME, M.R. (2021). *Threats to epistemic agency in young people with unusual experiences and beliefs*. In: «Synthese», vol. CXLIX, n. 3-4, pp. 7689-7704.

JACKSON, J. (2017). *Patronizing depression: epistemic injustice, stigmatizing attitudes, and the need for empathy*. In: «Journal of Social Philosophy», vol.

XLVIII, n. 3, pp. 359-376.

Jacobs, K., Stephan, A., Paskaleva-Yankova, A., Wilutzky, W. (2014). *Existential and atmospheric feelings in depressive comportment*. In: «Philosophy, Psychiatry & Psychology», vol. XXI, n. 2, pp. 89-110.

Kessler, R.C., Chiu, W.T., Demler, O., Walters, E.E. (2005). *Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication*. In: «Archives of General Psychiatry», vol. LXII, n. 6, pp. 617-627.

Molina, K.M., James, D. (2016). *Discrimination, internalized racism, and depression: A comparative study of African American and Afro-Caribbean adults in the US*. In: «Group Processes & Intergroup Relations», vol. XIX, n. 4, pp. 439-461.

Neitzke, A.B. (2016). *An illness of power: Gender and the social causes of depression*. In: «Culture, Medicine, and Psychiatry», vol. XL, n. 1, pp. 59-73.

Paradies, Y. (2006). *A systematic review of empirical research on self-reported racism and health*. In: «International Journal of Epidemiology», vol. XXXV, n. 4, pp. 888-901.

Potter, N. (2019). *Voice, silencing, and listening well: Socially located patients, oppressive structures, and an invitation to shift the epistemic terrain*. In: N.N. Potter, S. Tekin, R. Bluhm (eds.), *Bloomsbury companion to philosophy of psychiatry*, Bloomsbury Academic, London, pp. 305-324.

Ratcliffe, M. (2010). *Depression, guilt and emotional depth*. In: «Inquiry», vol. LIII, n. 6, pp. 602-626.

Ratcliffe, M. (2012). *Varieties of temporal experience in depression*. In: «Journal of Medicine and Philosophy», vol. XXXVII, n. 2, pp. 114-138.

Sekimoto, S., Brown, C. (2020). *Race and the senses: The felt politics of racial embodiment*, Routledge, London/New York.

Sheets-Johnstone, M. (2010). *Why is movement therapeutic?*. In: «American Journal of Dance Therapy», vol. XXXII, n. 1, pp. 2-15.

Smith, B. (2013). *Depression and motivation*. In: «Phenomenology and the Cognitive Sciences», vol. XII, n. 4, pp. 615-635.

Thachuk, A.K. (2011). *Stigma and the politics of biomedical models of mental illness*. In: «IJFAB: International Journal of Feminist Approaches to Bioethics», vol. IV, n. 1, pp. 140-163.

Williams, D.R., Gonzalez, H.M., Neighbors, H., Nesse, R., Abelson, J.M., Sweetman, J., Jackson, J.S. (2007). *Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: Results from the National Survey of American Life*. In: «Archives of General Psychiatry», vol. LXIV, n. 3, pp. 305-315.

Yancy, G. (2016). *Black bodies, white gazes: The continuing significance of race in America*, Rowman and Littlefield, New York.