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## *Depression, Intercorporeality, and Interaffectivity*

**Abstract:** *According to current opinion in western psychopathology, depression is regarded as a disorder of mood and affect on the one hand, and as a distortion of cognition on the other. Disturbances of bodily experience and of social relations are regarded as secondary to the primarily 'inner' and individual disorder. However, quite different concepts can be found in cultures whose members do not experience themselves as much as separate individuals but rather as parts of social communities. Disorders of mood or well-being are then conceived less as intra-psychic, but rather as bodily, interpersonal, or atmospheric processes.*

*On this background, the paper describes depression as a disorder of intercorporeality and interaffectivity. After developing these phenomenological concepts, it analyses depression as a 'detunement' of the resonant body that mediates our participation in a shared affective space. Instead of expressing the self, the body is turned into a barrier to all impulses directed to the environment. This impairs particularly the patient's interaction with others, resulting in a general sense of detachment, separation, or even segregation. Moreover, the restriction of the lived body also corresponds to the triggering situations of depression, namely experiences of a disruption of social bonds. Thus, intercorporeality and interaffectivity are presented as crucial dimensions for an ecological and non-reductionist view of depression.*

**Keywords:** Depression; lived body; intercorporeality; interaffectivity; delusion.

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## 1. Introduction

Depression is generally classified as an affective disorder (ICD-10, DSM-IV-TR). According to current psychiatric opinion, its core is constituted by a disturbance of mood and affect, typically connected to negative cognitions, self-evaluations, and emotions such as anxiety, shame, and guilt. Optional symptoms may include bodily or vegetative disturbances such as loss of appetite, weight, or libido, insomnia, and psychomotor inhibition; then the diagnosis receives the supplement 'with somatic syndrome' (ICD-10). On the other hand, the predominant psychological and psychotherapeutic approaches to depression are based on cognitive models: here, the core of the disorder is regarded as a combination of faulty information processing and distorted thinking (Clark and Beck, 1989; Beck and Alford, 2009, pp. 224ff). Consequently, Cognitive Behaviour Therapy is the generally recommended treatment (Beck *et al.*, 1979).

Both approaches have in common that they regard depression as an 'inner', mental, and individual disorder. Despite these predominant views, however, affective or cognitive symptoms are by no means found in all patients suffering from depression. Instead they may complain of constant fatigue, sickness, numbness, various kinds of pain or dysaesthesias. In these cases, the diagnostic vocabulary resorts to notions such as 'masked' or 'somatized' depression in order to rescue the concept of a primary emotional disturbance. However, transcultural studies, in particular the large WHO comparison study from 1997 (Gureje, Simon and Üstün, 1997), have pointed out that the core syndrome of depression is rather not of a 'psychological' nature. Loss of vitality, appetite, and drive, fatigue, sleep disturbances, and various somatic complaints such as feelings of pain, burning, tension, numbness, or heaviness are overall much more frequent than depressive mood or guilt feelings. In Turkey, Greece, Nigeria, China, and India, for instance, over 85% of depressed patients consult the doctor with somatic complaints. Only in France and Italy is the rate below 60% (Kirmayer and Groleau, 2001). Already in earlier studies, somatic symptoms and psychomotor inhibition were found to be prevailing in Africa and South America (Binitie, 1975; Mezzich and Raab, 1980; Escobar, Gomez and Tuason, 1983). One may conclude that depression is primarily experienced as a *bodily disturbance* in a majority of cultures, rather than only shifted or projected to the body secondarily (Pfeiffer, 1984).

At the same time, however, the vast majority of patients are well able to consider current stressors as causes of their condition. They

will also complain about not being able to fulfil their tasks and to take part in social life any more (Kleinman and Good, 1985; Kirmayer, 2001). Thus, in various cultures the somatic and the psychosocial experience of the illness apparently constitute an integral unity, and the lived body functions as a particular medium for the expression of interpersonal states and conflicts. The split between somatic or external and mental or internal symptoms turns out to be the result of a specifically western cultural development. It presumes an inner realm of the psyche as separated from the body as well as from the social environment, or in other words, an inner mind for which the body only serves as a field of projection. ‘Somatization’ then denotes a shift of psychological content or meaning onto the body, leading to the rather Eurocentric view that members of non-western cultures have only insufficient introspective or verbal capacities to perceive and express their feelings in a mature way.

In general, western psychopathology views mental illness primarily as a process within the individual (or his brain) which only secondarily affects the bodily and the social space. Quite different concepts can be found in cultures whose members do not experience themselves as much as separate individuals but rather as parts of social communities. Disorders of mood or well-being are then conceived less as intra-psychic, but rather as bodily, expressive, interpersonal, or even atmospheric processes. Thus, in traditional Japanese or Chinese psychopathology the surrounding climate and social atmospheres such as the *ki* (or *qi*) are regarded as carriers of mental illness: *ki* means ‘air’, ‘breath’, but also ‘mood’ and ‘atmosphere’, and thus constitutes the ‘in-between’ from which mental disorders may take their origin (Kimura, 1995; Kitanaka, 2012, pp. 23ff).<sup>1</sup>

Phenomenological psychopathology has a traditional affinity for such concepts, since it regards the lived body not only as the primary domain of self-experience, of well-being or ill-being, but also as the medium of our elementary contact to the world (Merleau-Ponty, 1945; Stanghellini, 2004; Fuchs, 2002b; 2005). Background feelings of the body such as ease or unease, relaxation or tension, expansion or constriction, freshness or tiredness provide a tacit evaluation of how ‘things stand’ in our life; they colour and permeate all world-directed experience (Damasio, 1999; Ratcliffe, 2008; Fuchs, 2012). Moreover, the body is always already oriented towards other bodily beings,

[1] Lee, Kleinman and Kleinman (2007) have explored how the traditional medical ideas about *qi* are expressed through a language of embodied emotion by people who suffer from ‘depression’ in contemporary China. Preverbal pain, sleeplessness, and social distress or disharmony play a major role in the patients’ descriptions.

connected to them from early childhood on through desire, imitation, and empathy. The mutual bodily resonance in social encounters, mediated by posture, facial, gestural, and vocal expression, engenders our attunement to others and functions as a carrier of basic interpersonal atmospheres such as warmth, ease, familiarity, and belonging, or in the negative case, coldness, tension, unease, or unfamiliarity. *The body is embedded in intercorporeality, and thus becomes the medium of interaffectivity.* From this point of view, so-called mental disorders should rather be regarded as alterations of the patient's lived body, lived space, and being-with-others. 'The patient is ill; this means, *his world* is ill', as van den Berg has put it (1972, p. 46). In this sense, the illness is not in the patient, but the patient is in the illness, as it were; for mental illness is not a state in the head, but an altered way of being in the world.

On this background, I will describe depression as a disturbance of intercorporeality and interaffectivity. I will argue that depression is not an 'inner', psychological, or neurobiological disorder, as it is considered in western psychiatry, but a 'detunement' (*Verstimmung*) of the resonant body that normally mediates our attunement and participation in the shared social space. Instead of expressing and connecting the self with others, the depressive body turns into a barrier to all impulses directed to the environment, resulting in a general sense of detachment, separation, or even expulsion. Before analysing depression on this basis, I will give a short overview of the phenomenology of intercorporeality and interaffectivity.

## 2. Intercorporeality and Interaffectivity

To begin with, we should abandon the idea that emotions are only 'mental' phenomena, and the world is bare of any affective qualities. The introjection of feelings into an inner 'psyche' is a heritage of Platonic and, later on, Cartesian dualism and its invention of the soul. In fact, we do not live in a merely physical world; the experienced space around us is always charged with affective qualities. We feel something 'in the air', or we sense an interpersonal 'climate', for example, a serene, a solemn, or a threatening atmosphere. Feelings befall us; they emerge from situations, persons, and objects which have their expressive qualities and which attract or repel us. This *emotional space* is essentially felt through the medium of the *body* which widens, tightens, weakens, trembles, shakes, etc. in correspondence to the feelings and atmospheres that we experience. There is no emotion without bodily sensations, bodily resonance, and affectability. Of

course, when I am moved by an emotion, I may not even be aware of my body; yet being afraid, for instance, is not possible without feeling a bodily tension or trembling, a beating of the heart or a shortness of breath, and a tendency to withdraw. It is *through* these sensations that I am anxiously directed towards a frightening situation. The body is a ‘resonance body’, a most sensitive sounding board in which interpersonal and other ‘vibrations’ constantly reverberate (James, 1884; Fuchs, 2013).<sup>2</sup>

Kinaesthesia is an important component of this resonance. Emotions are dynamic forces that motivate and move us in our ongoing interactions with the environment, inducing us to move forwards or backwards, upwards or downwards, or to behave in more specific ways. In this view, emotions are first and foremost embodied motivations to action (Sheets-Johnstone, 1999). As such, they are not only felt from the inside, but also displayed and visible in expression and behaviour, often as bodily tokens or rudiments of action. The facial, gestural, and postural expression of a feeling is part of the bodily resonance that feeds back into the feeling itself, but also induces processes of *inter-bodily resonance* (Froese and Fuchs, 2012). Our body is affected by the other’s expression, and we experience the kinetics, intensity, and timing of his emotions through our own bodily kinaesthesia and sensation. Thus, intercorporeality is the essential basis of empathy.

This can perhaps best be studied in early childhood. Emotions primarily emerge from and are embedded in dyadic interactions of infant and caregiver. Stern (1985) has shown in detail how emotions are cross-modally expressed, shared, and regulated. Infants experience joint affective states in terms of dynamic flow patterns, intensities, shapes, and vitality affects (for example, crescendo or decrescendo, fading, bursting, pulsing, effortful or easy) in just the way that music is experienced as affective dynamics. This includes the tendency to mimic and synchronize each other’s facial expressions, vocalizations, postures, movements, and thus to converge emotionally (Condon, 1979; Hatfield, Cacioppo and Rapson, 1994). All this may be summarized by the terms *affect attunement* or *interaffectivity* (Stern, 1985, p. 132). Thus, emotions or affects are not inner states that we experience only individually or that we have to decode in others, but primarily *shared states* that we experience through mutual intercorporeal affection. Even if emotions become increasingly independent from

[2] In his well-known paper ‘What is an Emotion?’, William James referred to the inner organs of the body as ‘...a sort of soundingboard, which every change of our consciousness, however slight, may make reverberate’ (James, 1884).

another's presence, intercorporeality remains the basis of empathy: there is a bodily link which allows emotions to immediately affect the other and thus enables empathic understanding without requiring a theory of mind or verbal articulation (Fuchs and De Jaegher, 2009).

The linkage between body, self, and other also characterizes the phenomenology of moods. It is a common understanding in phenomenology that moods are not inner states, but permeate and tinge the whole field of experience. Thus, moods are atmospheric in nature, radiating through the environment like warmth or cold, and conferring corresponding expressive qualities on the whole situation. It is no coincidence that we often use words taken from weather such as 'bright', 'sunny', 'gloomy', 'clouded', or 'dark' to denote mood states as well as the atmosphere of situations. On the other hand, moods also include background feelings of the body, such as feelings of lightness and freshness in elation, or of heaviness and weariness in depression. The phenomenology of moods is well expressed in the German notion of *Stimmung* which implies metaphors of attunement, concordance, and orchestration. Moods may be said to 'tune' body, self, and environment to a common chord, similar to a tonality linking a series of notes and chords to the major or minor key. Thus they tend to establish a consonance of bodily feeling, emotion, and environmental atmosphere.<sup>3</sup>

Moreover, moods link the background feeling of the body to the potentialities of a given life situation. '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' (Heidegger, 1962, p. 176). Moods are thus both feelings of the body and ways of finding oneself in the world. They indicate 'how things stand' in our life and how we are disposed to react to the present situation. Such feelings do not only include typical moods such as elation, serenity, sadness, or melancholy, but also what Ratcliffe (2008) has termed *existential feelings*: feelings of wideness or restriction, freedom or imprisonment, vulnerability or protection, familiarity or estrangement, reality or unreality, feeling alive or feeling dead. However, it seems important to note that all these background feelings are not just related to an anonymous world, but to the world that we share with others, or to the interpersonal world. They are *existential feelings of being-with*. It is primarily in our coexistence with others that we feel close or distant, familiar or alienated, open or restricted, and even real

[3] Of course it may occur that one's mood is in contrast to the atmosphere one encounters in the environment, as when a sad person enters a cheerful party, but usually there is at least a tendency of mood and surrounding atmosphere to converge.

or unreal. Thus, interaffectivity is not merely a particular section or application of our emotional endowment. Rather, it is the encompassing sphere in which our emotional life is embedded from birth on. This sphere has its centre in the lived body: through its affectability and resonance it mediates our participation in a shared space of affective attunement.

To summarize: in contrast to the common cognitivist picture in which our mental states and emotions are located within our head, phenomenology regards feelings as residing in between individuals. Human beings do not have moods or emotions independent of their embodied relations and interactions with their fellow human beings. Emotions are ways of being in the world, emerging on the basis of a pre-reflective attunement with others, indicating the current state of our relations, interests, and conflicts, and manifesting themselves as attitudes and expressions of the body. This view appears to be quite common among cultural anthropologists as well: numerous ethnographic studies, particularly in the Pacific and Africa, have noted that emotions are a primary idiom for defining and negotiating relations of self-with-others in a moral order (see Lutz and White, 1986, and Lindholm, 2007, for an overview). In these studies, emotions emerge as socially shaped and regulated; they are less construed as inner states, as conceived by western psychology, but result from people's engagements with others. Similarly, in these cultures, the source of emotional disturbance, imbalance, or illness is assumed to lie primarily in the social world.

One might argue here that it is not possible to define emotions as well as affective disturbances *as such*, apart from their respective cultural background, thus maintaining that both psychology and psychopathology are culturally relative. If emotions, mood, or depression are then conceived as inner and rather cognitive states in western cultures, couldn't this be due to a different kind of experience in western individuals which has developed in this way over the past centuries? And shouldn't we regard depression as being a different illness in different regions of the world? Granted, the rise of dualism and individualism in western societies has also changed our subjective experience to a significant degree. The way we conceive of our emotions and of our body certainly influences our affective and bodily self-awareness, at least on the conscious level. On the other hand, conceptualization and language do not construct subjective experience *de novo* — rather, they emphasize and highlight certain of its aspects to the disadvantage of others. Thus, the embodied and extended nature of our pre-reflective emotional experience has not vanished completely in the course

of western cultural history. It still lies hidden beneath our predominant self-concept which regards emotions as inner or mental states that we should be able to control as autonomous persons. Once we change our concepts, we could well retrieve these hidden layers of our own experience. Consequently, I argue that depression is not basically different in western and non-western cultures but that it should rather be conceived as a disorder of embodiment and interaffectivity in western societies as well — what we lack in our culture is just the non-dualistic vocabulary to adequately describe it. Phenomenology precisely offers a way to regain access to this pre-reflective dimension of experience, namely through methodically ‘bracketing’ our culture-bound and science-based assumptions about the nature and causes of affective experience (Fuchs, 2002b).

### **3. Depression as a Disorder of Intercorporeality and Interaffectivity**

On the basis of the above considerations, I will now describe depression as a disorder of intercorporeality and interaffectivity. In short, the depressive state may be characterized by a general constriction or ‘congealment’ of the lived body, leading to a numbing of emotional resonance and loss of attunement. This alters the patient’s existential feelings of being-with, resulting in a general sense of detachment, segregation, or even expulsion. In this way, the lived body also expresses the experiences of loss and separation which trigger depressive episodes on a psychosocial level.

#### *a) Corporealization*

In severe depression, the lived body loses the lightness, fluidity, and mobility of a medium and turns into a heavy, solid body which puts up resistance to all intentions and impulses directed towards the world. The depressive patient experiences a local or general oppression, anxiety, and constriction (e.g. a feeling of an armour or tyre around the chest, of a pressure in the head, etc.). The materiality, density, and weight of the body, otherwise suspended and unnoticed in everyday performance, now come to the fore and are felt painfully. In this respect, depression closely resembles somatic illnesses such as infections which affect one’s overall bodily state. Corresponding reports from patients may well be elicited provided that the interviewer takes their bodily experience seriously; they will complain about feelings of fatigue, exhaustion, paralysis, aches, sickness, nausea, numbness, etc. (see Ratcliffe *et al.*, this issue). Moreover, in depression the exchange



of body and environment is blocked, drive and impulse are exhausted. Sense perception and movement are weakened and finally walled in by the general rigidity which is also visible in the patient's gaze, face, or gestures. In order to act, the patients have to overcome their psychomotor inhibition and to push themselves to even minor tasks. With growing inhibition, sensorimotor space is restricted to the nearest environment, culminating in depressive stupor. In sum, depression may be described as a reification or *corporealization* of the lived body (Fuchs, 2005).<sup>4</sup>

The constriction and encapsulation of the body corresponds to the psychosocial experiences that typically lead to depression. These are experiences of a disruption of relations and bonds, including the loss of relevant others or of important social roles, furthermore situations of a backlog in one's duties, falling short of one's aspirations, or social defeat (Tellenbach, 1980; Bjorkqvist, 2001). In terms of temporality, one may speak of a social desynchronization (Fuchs, 2001): the movement of life is blocked and the person is unable to keep pace with others. These situations of social separation or defeat are perceived as particularly threatening since the patients feel they do not have the necessary resources for coping ('learned helplessness', Seligman, 1975). Depression is the consequent psychophysiological reaction: at the biological level, it involves a pattern of neurobiological, metabolic, immunological, biorhythmic, and other organismic dysfunctions which are equivalent to a partial decoupling or separation between organism and environment.<sup>5</sup> These dysfunctions are experienced as a loss of drive and interest (anhedonia), psychomotor inhibition, bodily constriction, and depressive mood.

#### *b) Intercorporeality and Interaffectivity*

The bodily constriction results not only in felt oppression, anxiety, or heaviness, but more subtly in a loss of the inter-bodily resonance which mediates the empathic understanding in social encounters. The depressive body lacks expression and offers no clue for the other's

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- [4] This description refers to the most frequent type of severe depression which is characterized by psychomotor inhibition. There is another type with prevailing agitation and anxiety ('agitated depression') in which the patients experience the same constriction but the loss of drive is less marked, so that they try in vain to escape from their tormenting bodily state by aimless activity.
- [5] This comes about through a prolonged organismic stress reaction, affecting, above all, the CRH-ACTH-cortisol system, the sympathetic nervous system as well as the serotonin-transmitter regulation in the limbic system, and resulting in a desynchronization of diurnal hormone and sleep-wake cycles (Wehr and Goodwin, 1983; Glannon, 2002; Berger, Calker and Riemann, 2003).

empathic perception. The continuous synchronization of bodily gestures and gazes which normally accompanies interaction breaks down. The patients themselves realize this congealment of their expression; moreover, their own mimetic perception and resonance with the other's body is lacking (Persad and Polivy, 1993; Csukly *et al.*, 2009; Bourke, Douglas and Porter, 2010). Thus, they feel unable to emotionally communicate their experience and try in vain to compensate for the loss of resonance by stereotyped repetition of their complaints.

The loss of bodily resonance or affectability concerns, more generally, the experience of affective valences and atmospheres. The deeper the depression, the more the attractive qualities of the environment faint. The patients are no longer capable of being moved and affected by things, situations, or other persons. This leads to an inability to feel emotions or atmospheres at all, which is all the more painful as it is not caused by mere apathy or indifference (as for example in frontal brain injury) but by the tormenting bodily constriction and rigidity. Kurt Schneider wrote that the 'vital disturbances' of bodily feelings in severe depression are so intense that psychic or 'higher' feelings can no longer arise (Schneider, 1920). The patients then complain of a 'feeling of not feeling' and of not being able to sympathize with their relatives any more. In his autobiographical account, Solomon describes his depression as '...a loss of feeling, a numbness, [which] had infected all my human relations. I didn't care about love; about my work; about family; about friends...' (Solomon, 2001, p. 45). Hence, the patients lose the participation in the shared space of affective attunement.

Of course, there are emotions that remain despite the loss of affectability, in particular feelings of guilt, anxiety, or despair. However, these emotions show some characteristic features: (1) they do not connect, but rather separate the subject from the world and from others; (2) their felt bodily quality is characterized by constriction and rigidity, thus corresponding to the depressive state of corporealization; (3) they are embedded in the prevailing depressed mood rather than arising as independent feelings; therefore their intentional objects are just as ubiquitous as arbitrary. A depressive patient describes what may be called an elementary, bodily experience of guilt:

It comes from below, from the gut, like a terrible oppression rising to the chest; then a pressure arises, like a crime that I have committed. I feel it like a wound on my chest, that is my tortured conscience... then this

attracts my memories, and I have to think again of all that I have missed or done wrong in my life... (Fuchs, 2000, pp. 116f)

This shows that an elementary feeling of being guilty can be rooted in bodily experience itself and only secondarily materializes in corresponding yet arbitrary memories of omissions or failures.<sup>6</sup> Similarly, the bodily state of diffuse, vital anxiety finds its concrete objects in all kinds of imagined disaster (financial ruin, lethal disease, etc.) which the patient anticipates as inevitable. The simultaneity of a loss of affectability and the presence of anxiety or guilt feelings, contradictory at first sight, can thus be explained by their mood-congruent, bodily character. In severe or psychotic stages of depression, such constricting emotions turn into continuous states of agony, and it may be doubted whether they could still be called emotions at all.

### *c) Derealization and Depersonalization*

Since the affective contact to the environment is also essential for our basic sense of reality and belonging to the world, a loss of body resonance always results in a certain degree of derealization and depersonalization. Therefore affective depersonalization is a core feature of severe depressive episodes (Kraus, 2002; Stanghellini, 2004). However, there is a special kind of melancholic depression in which depersonalization is the prominent symptom; in German psychopathology it is called '*Entfremdungsdepression*' (depersonalized depression; Petrilowitsch, 1956). Here the emotional quality of perception is lost completely, objects look blunt or dead, and space seems hollowed out, as it were; in the words of a patient:

There is only emptiness around me; it fills the space between me and my husband; instead of conducting it keeps me away. I am kept away from the whole world; there is an abyss in between. (von Gebattel, 1954, p. 25)

The patient feels like an isolated object in a world without relationships; there is only an abstract space around her, not a lived, embodied space any more. Perception only shows the naked framework of objects, not their connectedness or their 'flesh'. The depersonalization in severe depression culminates in so-called nihilistic delusions or Cotard's syndrome, formerly called '*melancholia anaesthetica*' (Enoch and Trethowan, 1991). The patients no longer sense their own

[6] In general, memories are facilitated by the bodily and emotional state that corresponds to the condition in which they were acquired; *cf.* the research on state-dependent learning and mood-congruent memories (e.g. Bower, 1981; Blaney, 1986). This is particularly valid for depression (e.g. Barry, Naus and Rehm, 2004).

body; taste, smell, even the sense of warmth or pain are missing, everything seems dead. Having lost the background feeling of the body that conveys a sense of connectedness and realness to our experience, the patients may contend that the whole world is empty or does not exist any more. This lets them conclude that they have already died and ought to be buried.

A 61-year old patient felt that her inner body, her stomach and bowels had been contracted so that there was no hollow space left. The whole body, she said, was dried out and decayed, nothing inside did move any more. The body felt numb, she sensed neither heat nor cold, meals had lost their taste. Finally she was convinced that all her relatives had died, that she was alone in the world and had to live in a dead body for ever. (Fuchs, 2000, p. 112)

The experience of derealization may in some cases lead to a combination of Cotard's with Capgras' syndrome (Enoch and Trethowan, 1991; Joseph, 1986; Wright, Young and Hellawell, 1993; Young, Leafhead and Szulecka, 1994): the patients are convinced that their relatives have been replaced by impostors or phantoms. This phenomenon points to the pre-reflective nature of interpersonal trust: the perception of another's appearance as familiar and natural depends on the basic inter-bodily resonance that mediates our affective attunement to others. It is part of our pre-predicative relation to the world and to others that we take the other's identity for granted provided there is sufficient similarity in his appearance. The complete loss of affective resonance, however, may let others appear as fakes or actors who are part of an illusionary theatre. The Dutch psychiatrist Piet Kuiper, who suffered from psychotic depression, reports this experience:

Someone who resembled my wife was walking beside me, and my friends visited me... Everything was as it normally would be. The figure representing my wife constantly reminded me of what I had failed to do for her... But what looks like normal life is it not. I found myself on the other side. And now I realized what the cause of my death had been... I had died, but God had removed this event from my awareness... A harsher punishment can hardly be imagined. Without being aware of having died, you are in a hell that resembles in all details the world you had lived in, and thus God lets you see and feel that you have made nothing of your life. (Kuiper, 1991, p. 136)

What we can notice here is the inherent connection of interaffectivity, basic trust, and the sense of realness (Varga, 2012): the world is experienced as familiar and real as long as it is permeated by the affective resonance and the practical significances shared with others — in other words, as long as it remains the common life-world. Our bodily

background feelings connect us to others and lend familiarity to the world. At the same time, this normally taken-for-granted connection constitutes the horizon of our world, which in Husserl's words is always an 'open horizon of co-subjects' (Husserl, 1973, p. 497). In this sense, our experience of the world means always already a *co-experience*. However, once the interaffective basis of co-experiencing the world is lost, as in Kuiper's case, the sense of reality dissolves and gives way to a virtualization of one's being-in-the-world. Cotard's and Capgras' syndrome — though the former usually occurs in affective disorders, the latter in paranoid disorders — share the loss of basic familiarity and therefore may sometimes shade into or accompany each other (Young, Leafhead and Szulecka, 1994).

#### *d) Delusions of Guilt*

With Cotard's syndrome, we have already entered the domain of psychotic depression. In the last section, I want to look at a more typical example of depressive delusions from an interaffective point of view, namely at delusions of guilt.

As I mentioned at the beginning, feelings and ideations of guilt are, from a transcultural perspective, rather special symptoms of depression occurring in western societies. Nevertheless, as we have seen, they also have their basis in bodily and interaffective experience. Under suitable cultural conditions, primary or existential feelings of guilt may emerge from the pervasive state of bodily constriction and separation from others. For the basic experience of guilt may also be described as the fear or state of being rejected, ostracized, or expelled from the community. The various forms of sanctions which foster the development of conscience in early childhood imply, as a rule, a withdrawal of affection, a rejection or punishment. These experiences of being separated from others and thrown back upon oneself are felt as a painful bodily constriction and anxiety. They may even be related to a primeval, instinctive *fear of segregation* that was experienced when a member of a tribe got lost or was expelled from the group (Bilz, 1971, p. 356).

As we have already seen above, the depressed patient's bodily constriction, vital anxiety, and loss of interaffective attunement are particularly suited to reactivate these primary feelings of guilt.<sup>7</sup> This holds true even more for the 'Typus Melancholicus', the personality that is

[7] This is in line with recent research on the embodiment of emotions, showing that bodily postures, expressions, sensations, and interoceptive states influence one's emotional state in various ways, 'bottom-up', so to speak (Damasio, 1999; Niedenthal, 2007; Craig, 2008).

particularly prone to fall ill from depression in western society (Tellenbach, 1980; Mundt *et al.*, 1997; Kronmüller *et al.*, 2002). This personality type is characterized by excessive conscientiousness, orderliness, hypernormic adherence to social norms, and dependency on stable interpersonal relationships. For these patients, the affective ties to others are essential, even vital, and becoming guilty means to be excluded from the indispensable community with others. In depression, the patients experience bodily constriction as an elementary separation and rejection which activates an archaic, punishing, and annihilating conscience (Fuchs, 2002a).

The crucial presupposition for depressive delusions, however, concerns the intersubjective constitution of reality. Precisely, the social reality of guilt does not mean a fixed state or quantity but is negotiated through a shared process of attribution and justification which defines the omissions or faults as well as their degree of severity. Similarly, dealing with guilt (through responsibility, regret, compensation, forgiveness, rehabilitation, etc.) involves an intersubjective agreement and mutual alignment of perspectives. This in turn requires a deeper fundament which is generated by our pre-reflective affective connectedness with others, in particular by a basic sense of *mutual trust*. The depressive patient, however, loses this pre-reflective connection and becomes locked in his bodily constriction and corporealization. Thus, he is literally deprived of the free scope that is necessary for taking another's perspective and relativizing his own point of view. Others are separated by an abyss and can no longer be reached. Guilt, instead of being an intersubjective *relation* that can be dealt with, becomes *a thing* or *an object* the patient is identified with, as shown by the following case example:

Soon after his retirement, a 64 year-old patient fell ill with a severe depression. Coming from a poor background, he had achieved to become staff executive of a big company by hard work. He reported that he had only been on sick leave for 10 days in 45 years of work. In contrast, his depression was characterised by a feeling of decay. All his power had vanished, the patient complained, he had no longer command of his arms and legs. He had burnt the candle at both ends, had not taken care of his family, and now he deserved to get his comeuppance. He accused himself of being responsible for the failure of an important deal of his company two years ago which would inevitably lead to its bankruptcy. He would never be able to cancel this debt again. Moreover, he complained that he had no more feelings for others. 'I am only a burden for them, a millstone around my family's neck... for me, life is over.' He finally thought that the death sweat already appeared on his forehead, one could even see the cadaveric lividity on his face. He

should be driven in the mortuary in the basement and be abandoned there. (Case example from my own clinical work, T.F.)

The capacity of taking the perspective of others is not only a cognitive feat but depends on a common interaffective sphere that is part of the ‘bedrock of unquestioned certainties’ (Wittgenstein, 1969; Rhodes and Gipps, 2008). It provides a foundational, non-representational structure of mutual understanding that underpins our shared view of reality. In delusional depression, however, the loss of the pre-predicative relation to others makes it impossible to take their perspective and to gain distance from oneself, thus forcing the patient *to completely equate his self with his current depressed state*. This present state means being thrown back upon oneself, feeling rejected and expelled. The delusional patient, as shown in the case example, is identified with his existential feeling of guilt to the extent that he is *guilty as such*. There is no remorse, recompense, or forgiveness, for the guilt is not embedded in a common sphere which would allow for that. Delusions of guilt result from a disruption of intersubjective relations at the basic level of interaffectivity.

This is characteristic of depressive delusion in general: corporealization and loss of attunement to others prevent the patient from taking their perspective. As a result, a state of self beyond the present one becomes unimaginable. It has always been like this, and it will stay like this forever — to remember or hope for anything different is deception. The patient is inevitably identified with his present state of bodily constriction and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of feeling dead. Hypochondriacal or nihilistic delusions, delusions of guilt or impoverishment are all just different manifestations of a complete objectivation or reification of the self that can no longer be transcended. Depressive delusion is therefore rooted in the loss of the shared interaffective space and in the utter isolation of the self that results from it.

#### 4. Conclusion

Depression is not an ‘inner’, psychological, or mental disorder, but a ‘detunement’ of the lived body that normally mediates our participation in a shared space of attunement. The corporealized, constricted body loses its affectability and emotional resonance; this undermines the patient’s existential feelings of being-with, resulting in a general sense of detachment, separation, or even expulsion. The typical cognitive symptoms of depression are only a result of this basic bodily alteration.

The constriction and encapsulation of the lived body also corresponds to the typical triggering situations of depression. These are mostly experiences of a disruption of relations and bonds: a loss of relevant others or of important social roles, experiences of backlog or defeat, resulting in a desynchronization from others and in a blocked movement of life. To these situations of threatening or actual separation, the depressive patient reacts as a psychophysiological unity. For without doubt, depression is a bodily illness also in the biological sense, implying functional disturbances on different levels and a partial decoupling of organism and environment. But at the same time, the biological dysfunctions which result in the felt bodily constriction are just the meaningful expression of a disorder of intercorporeality and interaffectivity on the psychosocial level. Our participation in interaffective space is mediated by a fundamental bodily resonance. In depression, this attunement fails, and the lived body, as it were, shrinks to the boundaries of the material body.

In concluding, we may ask why psychopathology has traditionally disregarded this bodily and intersubjective basis of depression and focused on individual psychological symptoms instead. After all, a careful interview will find those complaints in most cases, and in primary care systems reporting somatic symptoms is even the predominant mode of presenting a depression (Kapfhammer, 2006). The main reason for this neglect might be seen in the fact that psychiatry still has no concept of the lived body, nor of the organic unity of the embodied person. The traditional dualism of mind and body has only been replaced by a reductionist monism which now regards the brain as the true heir of the soul — again disregarding the living unity of the organism (Fuchs, 2011). No matter whether depression is attributed to the soul or to the brain — in both cases it is disconnected from the body and put into an inner container. As a result, the embodied experience of patients is at best regarded as a secondary ‘somatization’.

In contrast to this, intercorporeality and interaffectivity are the crucial dimensions of an ecological, non-reductionist view of depression. Hence, if we still want to call it an affective disorder, we should not understand this term as an intra-individual state, localizable within the psyche or the brain, but as a detunement (*Verstimmung*) in the literal sense — a failure of bodily attunement to the shared space of interaffectivity.

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