

## Feeling and Time: The Phenomenology of Mood Disorders, Depressive Realism, and Existential Psychotherapy

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**Phenomenological research suggests that pure manic and depressive states are less common than mixtures of the two and that the two poles of mood are characterized by opposite ways of experiencing time. In mania, the subjective experience of time is sped up and in depression it is slowed down, perhaps reflecting differences in circadian pathophysiology. The two classic mood states are also quite different in their effect on subjective awareness: manic patients lack insight into their excitation, while depressed patients are quite insightful into their unhappiness. Consequently, insight plays a major role in overdiagnosis of unipolar depression and misdiagnosis of bipolar disorder. The phenomenology of depression also is relevant to types of psychotherapies used to treat it. The depressive realism (DR) model, in contrast to the cognitive distortion model, appears to better apply to many persons with mild to moderate depressive syndromes. I suggest that existential psychotherapy is the necessary corollary of the DR model in those cases. Further, some depressive morbidities may in fact prove, after phenomenological study, to involve other mental states instead of depression. The chronic subsyndromal depression that is often the long-term consequence of treated bipolar disorder may in fact represent existential despair, rather than depression proper, again suggesting intervention with existential psychotherapeutic methods.**

*Key words:* phenomenology/depressive realism/in sight/time/mixed/existential psychotherapy/cognitive behavioral model/depression/mania/despair/demoralization

### *The Need for Phenomenology*

Psychiatry in the United States has never been phenomenologically advanced, with clinical observation in the past hampered by psychoanalytic assumptions. Today, those symptoms tend to be observed that are listed in diagnostic checklists, like *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, often leaving important aspects of psychopathology untouched, especially those related to patients' subjective experiences. These factors are combined in the United States with the impact of the managed care insurance and pharmaceutical industries, leading to 10- to 20-minute "med checks" where patients' experiences are superficially assessed and pharmacological decisions rapidly made. This state of affairs, the limits of which were long ago anticipated by eminent thinkers in psychiatry,<sup>1–3</sup> has not been sufficiently appreciated by modern psychiatry.<sup>4</sup>

A key to moving forward is for psychiatry to take phenomenology seriously. As Karl Jaspers long taught, phenomenology needs to precede diagnosis and treatment.<sup>1</sup> Without a systematically accurate description and understanding of a patient's inner and outer experience, clinicians cannot know how to diagnose and prognose a patient's condition. Ludwig Binswanger<sup>5</sup> made the same point by emphasizing four steps to the interview process in psychiatry. First, one must engage with the patient as a person (his "being-in-the-world"), a process in which one establishes affective contact and tries to experience the subjective state of the patient. (This is one kind of phenomenology, on the definition of it as an attempt to empathically appreciate a patient's subjective mental states without any attempt at cognitive structuring or explanation of those states. This concept is based on the work of Karl Jaspers<sup>1</sup> derived from philosophers interested in the nature of history and psychology but different from other uses of the term by other philosophers with more metaphysical notions, such as Edmund Husserl. If readers are interested in this philosophical background, a good review is found in the *Textbook of Philosophy and Psychiatry* of Fulford and colleagues.<sup>6</sup>) The next stage, according to Binswanger, is to use that information so obtained, along with other objective

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information observed about the patient, within the framework of psychopathology. (This is another definition of phenomenology, one where it is “a method for carefully describing and cataloguing particular mental states.”<sup>6</sup>) Once the second step of psychopathology is accomplished, one moves on to putting that information together in a diagnosis, which then provides guidance for treatment.

Yet in contemporary psychiatry, the first stage of phenomenology is often skipped over. The second stage of psychopathology is frequently addressed breezily, jumping rapidly to diagnosis with attention primarily to only *DSM-IV*-defined criteria,<sup>7</sup> followed by treatment.

To move forward, we should not be afraid to temporarily look back. Modern psychiatry would do well to rediscover the work of key Europeans (like Karl Jaspers<sup>1</sup> and Ludwig Binswanger,<sup>2</sup> among others, including the original descriptions of Emil Kraepelin<sup>8</sup>) and to augment that work with new empirical research on the phenomenology of mental illnesses.<sup>4</sup>

In relation to severe mood disorders, such research should assess how manic and depressive syndromes differ phenomenologically and then draw the relevant diagnostic, biological, and therapeutic implications. This paper will provide an overview of current knowledge regarding some aspects of the phenomenology of mood states and the clinical implications of that knowledge.

## Part I. Phenomenological Features of Mood Disorders

### Mixed States

*Phenomenological Description.* Any discussion of the phenomenology of mania and depression has to cope with the topic of mixed states. Wilhelm Weygandt first pointed out that the two poles of mania and melancholia,<sup>9</sup> which had been well described since Arateus of Cappadocia in the second century AD,<sup>10</sup> often appeared to be mixed together. Kraepelin agreed with this perspective<sup>11</sup> and in fact held the view that most mood states were of the mixed variety, with pure mania and pure depression being less common. Kraepelin described six types of mixed states based on various combinations of mood, will (volition), and thought processes<sup>12</sup>: manic stupor (elevated mood but decreased will and thought), depressive mania (depressed mood but elevated will and thought), excited depression (depressed mood and will but elevated thought), depression with flight of ideas (depressed mood and thought but elevated will), mania with poverty of thought (elevated mood and will but decreased thought), and inhibited mania (elevated mood and thought but decreased will). Over the years, the six Kraepelinian mixed states have been conflated to two varieties: dysphoric mania (when full mania is present with some depressive symptoms)<sup>13</sup> and the depressive mixed state (when full depression is present with some manic symptoms).<sup>14</sup> Other

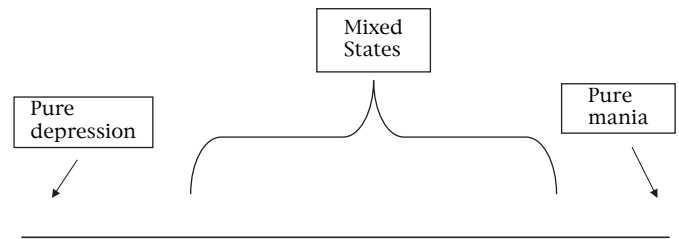


Fig. 1. The Mood Spectrum.

terms sometimes used are agitated depression (full depression with psychomotor agitation),<sup>15</sup> anxious depression (depression with marked anxiety),<sup>16</sup> irritable depression (depression with marked irritability),<sup>17,18</sup> and mixed hypomania (hypomania with some depressive symptoms).<sup>19</sup> Whether two or six or more varieties are validly enumerated is a matter for clinical research to determine.

Given this broad list of mixed states, one might conceptualize mood states on a continuum (figure 1), with pure mania and pure depression at the extremes and a variety of mixed states in between. If Kraepelin and Weygandt were right, then the majority of mood states would consist of mixed states, rather than pure depression or pure mania.

In *DSM-IV*, none of these definitions are recognized as a mixed state. Rather pure manic and depressive episodes are defined quite broadly, and the *DSM-IV* mixed episode is defined quite narrowly, requiring the presence at the same time of the full manic episode and the full depressive episode.

*Empirical Data.* Empirical studies of these different definitions suggest that the strict *DSM-IV* definition of a mixed episode only occurs in about 10% of all manic states. On the other hand, simply adding the definition of dysphoric mania would account for about 40% of manic states. Further, studies utilizing factor analytic methods indicate that the Weygandt/Kraepelin model of mixed states appears to be more valid than the *DSM-IV* narrow definition.<sup>20–23</sup> Those studies consistently identify a dysphoric or depressive component, along with a second component of irritability and aggression, to manic episodes. The pure euphoric manic episode, without any dysphoria or irritability, appears to represent perhaps only 25% of all manic episodes.

*Clinical Relevance.* The common occurrence of mixed states throws into doubt the unipolar/bipolar dichotomy. Clinically, this observation might incline one to be open to the possibility of spectrum approaches to diagnosis of manic-depressive illness.<sup>24</sup> Further, the empirical evidence above suggests that mixtures of depressive and manic conditions are quite common below the current threshold used by *DSM-IV*.

Another way of looking at the issue is that our *DSM* categories consist of “ideal types,” abstractions from re-

ality which we can use to assess empirical observations but which are not themselves empirical facts. (This concept, which is central to Jaspers' thinking in his book *General Psychopathology*,<sup>1</sup> was derived from the sociological work of Max Weber.<sup>25,26</sup> Further reading on this topic is available elsewhere.<sup>1,4</sup>) In other words, pure mania or pure depression (or for that matter unipolar depression and bipolar disorder) may be abstract formulations of classic presentations, but they are not themselves the most common empirically observed presentations seen. The ideal abstractions may help us clarify the differences between mania and depression, but there is a mistaken tendency to reify these ideal types into natural entities, thereby losing the more complex texture of the actual experience of mixed states.

Hence, in assessing the phenomenology of mania and depression, it is useful to keep in mind that these pure states are, in a way, ideal types<sup>4</sup> and that the most common presentations are mixtures of both conditions.

Therapeutically, most available evidence, though limited, suggests that antidepressants may worsen mixed states, either when defined as dysphoric mania or as the depressive mixed state.<sup>27</sup> In fact, antidepressants may cause mixed states.<sup>28</sup> Because mixed states are associated with a high risk of suicidality, perhaps a bit higher than even pure depression, they have been implicated as a factor in antidepressant-induced suicidality.<sup>29</sup> Clinicians may find such information useful therapeutically, and thus, it may be helpful to assess mixed states more carefully than at the coarse level defined by *DSM-IV*.

### Time

*Phenomenological Description.* It has been observed by phenomenologists and existential psychiatrists that the experience of time is altered in depression and in mania.<sup>30</sup> (A good discussion of time and psychiatric illness was published, along with commentaries, recently.<sup>31</sup>) Binswanger gives one of the few phenomenological descriptions of mania and time<sup>5</sup>:

... these patients live almost entirely in the present and to some degree still in the past, but no longer into the future. Where everything and everyone is 'handy' and 'present', where distance is missing, there is no future either, but everything is played off 'in the present', in the mere here and now. This also throws light on the self of such patients. A self that does not live into the future, that moves around in a merely playful way in the here and now, and, at best, still lives only from the past, is but momentarily 'attuned', not steadily advancing, developing or maturing, is not, to borrow a word, an existential self ....<sup>(pp131-132)</sup>

Yet he also sees a positive aspect to this living in the present:

Thus far ... we have characterized the manic moment of festive joy in existence in negative terms, i.e., in opposition to the problems of existence and reflection. If we wish to char-

acterize it positively, then we must describe it as a qualmsless affirmation of existence, as an attunement of existence in which 'all problems have evaporated.' Such carefree assuredness uncontradicted by life experience is termed in the everyday language which we have used so much, optimism, actually crazy optimism, or briefly, insanity ....<sup>(p137)</sup>

Leston Havens, drawing on the work of Eugene Minkowski,<sup>32</sup> provides a different but related take on the influence of the subjective experience of time on depression and mania<sup>33</sup>:

The present, standing between the past and future, is the occasion of building; in the present the past is developed into the future. Thus the present signals that one can never successfully break the past from future; the past nourishes the future. It is possible for one to lose present, past, or future. In depression the future is lost, and the past becomes fixed, immovable, bad, the place of irredeemable mistakes. In contrast, the past can be lost as one sores maniacally into an unreal future.... Anticipating becomes a disease when it merges present with future: there is nothing in the present except this futuring. In the first case, the actual present is lost to the past; in the second it has vanished into the future. In either case, there is no building. Both past and future can be lost to the present as well. One lives for the moment, afraid to look back or ahead. One surrenders to a mindless busyness which is not building, or to sensation—for example, gluttony or resistance to gluttony.<sup>(p21)</sup>

*Empirical Data.* Recent empirical studies have supported those previous phenomenological observations. For instance, in a study of 32 acutely depressed, 30 acutely manic, and 31 control subjects,<sup>34</sup> the experience of time was assessed subjectively with a visual analog scale and objectively with Chronotest software and the Trail Making Test (TMT). Both manic and depressed subjects were slow in the TMT, but the subjective experience of time was slowed in the depressed, sped up in the manic, and unchanged in the control subjects.

The speeding up of the experience of time in mania might be linked to biological research that suggests abnormal circadian rhythms in models of bipolar disorder. Research on circadian rhythms suggests that abnormalities involving the suprachiasmatic nuclei in the hypothalamus may explain many of the clinical features of recurrent mood disorders (including seasonality of episode type), perhaps through secondary effects on neurotransmitter systems. "Free-running" rhythms, cycles which are not entrained to the 24-hour day/night cycle, may desynchronize other circadian rhythms, adversely affecting mood.<sup>35</sup> This hypothesis recently has been supported by an animal model of a genetically fast biological clock in rats missing the tau gene, with behavioral characteristics roughly analogous to manic-depressive symptoms.<sup>36</sup> Lithium appears to counteract these abnormalities in circadian rhythms, perhaps partly through its effects on second messengers like glycogen synthase kinase-3.<sup>37</sup> The

slowing down of time in depression may also have a relation to the sleep disturbances inherent in this condition, which have been well characterized and involve decreased latency to rapid eye movement (REM) sleep and more time spent in REM.<sup>38</sup>

*Clinical Relevance.* The experience of time is clinically relevant in a number of potential ways. One simple aspect may relate to the importance of sleep.<sup>39</sup> If the experience of time is sped up in mania, for instance, partly due to rapid circadian pacemakers, then one can see the centrality of improving sleep in the process of controlling mania. Hence sedating antimanic agents, such as quetiapine, may benefit the mood state partly through this kind of mechanism.<sup>40</sup> Further, this concept would predict especially harmful effects of stimulating agents, such as amphetamines, in the long-term treatment of bipolar disorder.<sup>41</sup> It is known that insomnia is an early prodromal sign of a new manic episode and that sleep regulation is an important feature to maintaining stability.<sup>39</sup>

A second relevant feature of time may be in psychotherapies. Attention to the mood state of the patient may allow the psychotherapist to target interventions regarding how the past, present, and future are experienced. Thus, in depressed patients, more work may be needed to try to ground the patient in the present rather than the past as well as to show the patient the possibilities of the future. In manic patients, in contrast, psychotherapeutic efforts may need to be made to bring the past to the patient's attention, such as previous activities that were harmful in prior manic episodes which the patient might be inclined to do once again.

### Insight

*Phenomenological Description.* Another key feature of the phenomenology of mania and depression is insight, here defined as awareness of illness, predominantly, but also representing awareness of other domains, such as need for treatment or social consequences of behavior.<sup>42</sup>

Insight represents perhaps a prototypic experience that requires phenomenological research. It is a subjective experience, yet one that can be objectively assessed and even quantified. Such insight scales have now been well validated.<sup>42</sup> Impaired insight, though a subjective experience, is not necessarily purely psychological in origin. One could view insight from a purely biological perspective in some cases, such as with insults to the brain in right parietal stroke (leading to anosognosia) or in Alzheimer's dementia.<sup>43</sup> Other studies suggest a role for social factors, such as stigma, as well as belief systems regarding the nature of mental illness.<sup>44</sup> Thus, impaired insight is a complex but important subjective phenomenon that is amenable to empirical research.

*Empirical Data.* Such research has shown that insight is impaired in about 50% of manic episodes, irrespective of

the presence or absence of psychosis.<sup>45</sup> Hence, impaired insight is not necessarily an aspect of delusions. Poor insight is associated with poor outcomes in psychotic and mood disorders (partly through medication noncompliance).<sup>46,47</sup> Interestingly, in mood disorders, impaired insight appears to be limited to mania; in depressive states, insight is generally not impeded. There are exceptions; denial of depressive symptoms can occur, especially perhaps in individuals with depression secondary to medical illnesses or persons with psychotic depression. Yet, in empirical studies of primary psychiatric disorders, insight was not notably impaired in unipolar nonpsychotic depression.<sup>48</sup> This fact may be a major factor in the overdiagnosis of unipolar depression, which occurs in 40% or more of persons with bipolar disorder, a repeatedly replicated finding.<sup>49–54</sup> Patients experience depression with insight; thus they seek help for it. When interviewed, they often deny past manic symptoms, if asked. Psychiatrists then commonly diagnose unipolar depression and prescribe antidepressants, which often worsen the course of bipolar illness.<sup>55</sup>

*Clinical Relevance.* Lack of insight is key, then, to the problem of misdiagnosis and underdiagnosis of bipolar disorder. Clinicians are often insufficiently aware of this phenomenon and its impact. The best way to avoid this problem is to obtain family or third-party report because family members have been shown to report behavioral manic symptoms twice as frequently as patients.<sup>56</sup> Yet many clinicians, not paying attention to the phenomenology of insight, assume that their personal interview with the patient is sufficient for diagnostic and treatment purposes. This is a major clinical mistake in bipolar disorder.

Because better insight is associated with better prognosis, psychotherapies should also target insight in bipolar disorder. To date, only one proposed psychotherapy has done so to some extent, a group psychoeducation method, and it has demonstrated reduced relapse rates in randomized clinical trials.<sup>57,58</sup> Insight can improve, with the hard experiences of relapse and recovery as well as with psychoeducation.<sup>58</sup> It should be seen as an important target of treatment in bipolar disorder.

### Despair

*Phenomenological Description.* A fourth relevant aspect of phenomenology for mood disorders is the phenomenon of existential despair. The existential literature describes *despair* as including, though not limited to, a sense of hopelessness about the future, chronic low self-esteem, an identification of the sense of self with one's diagnosis, and a loss of meaning in life.<sup>59,60</sup> In bipolar disorder, this despair often follows in the wake of the many losses of one's previous depressive periods and also as a consequence of the havoc that flows from the exuberances of past manic episodes. This despair is also part and parcel of a sense of loss of self, or not knowing who one's self is, given the

major alterations in personality that occur during manic and depressive periods.<sup>60</sup>

Despair is related to, but not the same as, demoralization,<sup>61,62</sup> a mostly cognitive loss of hope and optimism, addressed primarily by cognitive behavioral therapy (CBT). Nor is despair a diagnosis, just as “depression” is not a diagnosis: The heterogeneous and variable phenomenon of depression needs to be analyzed into diagnostic syndromes when it can be so interpreted (eg, bipolar vs unipolar vs secondary depression); sometimes the depressive presentations we see are not diagnosable as such classic syndromes (and are somewhat uncomfortably labeled “neurotic depression” or generalized anxiety disorder or dysthymia). Sometimes, they may reflect existential states of despair. Perhaps despair should be part of our psychopathology, as demoralization is, in the course of differentiating states of apparent depression.

*Empirical Data.* No empirical studies have been conducted with operationalized assessments of despair, though such data exist with demoralization,<sup>61</sup> suggesting benefit with CBT.<sup>63</sup>

*Clinical Relevance.* The clinical phenomenon of despair may provide insight into the main long-term morbidity of bipolar disorder, which appears to be chronic subsyndromal depression, based on up to 20-year outcome data.<sup>64</sup> Yet, while these studies are often read as “natural history” studies, they are in fact treated populations because untreated outcome data are rare these days, as well as ethically dubious. Thus, we should say that in bipolar disorder today, the *treated* outcome, with antidepressants and mood stabilizers, is chronic subsyndromal depression. Hence there is no simple pharmacological answer to this problem; these patients are already receiving all our best medications, perhaps too many. Adding more antidepressants to cure their depression has already been done and has mostly failed.<sup>55</sup> It is possible that these residual depressive presentations represent demoralization or despair, rather than leftover depressive symptoms that are part and parcel of the mood episodes of bipolar disorder.

It could be that we are treating patients’ moods with medications but leaving them in a state of existential despair that we then misdiagnose with our medical and cognitive models. If indeed the phenomenology of this depressive morbidity is despair rather than clinical depression, then existential psychotherapy, as discussed below, might again provide not only a means of diagnosing the problem but also a means of treating it.

## Part II. Models of Depression and Existential Psychotherapy

Research in the phenomenology of mania and depression provides background for assessing psychotherapeutic methods for mood disorders. Whether dealing with bipo-

lar disorder or unipolar depression, psychotherapies tend to focus on treatment of depression. In bipolar disorder, this focus is relevant because it has been shown that the primary morbidity of bipolar disorder is chronic subsyndromal depression.<sup>64</sup>

### *The Cognitive-Behavioral Model*

CBT, most famously propounded by Aaron Beck, is today the predominant paradigm in psychotherapy of depression.<sup>65</sup> It holds that a major psychological mechanism behind clinical depression is the tendency of patients to distort reality through inaccurate cognitive mind-sets. In other words, what they think about the world is consistently false, and false in such a way that it makes them sad. Their moods are depressed because their thoughts are depressing. CBT aims at altering depressive cognitive styles and has proven quite effective in treating depression, often as effective as medications.<sup>66</sup> Things are not, of course, unidirectional. Moods and feelings affect cognitions, and vice versa. Yet, CBT takes as its main purpose the concept that, to the extent that cognitions affect mood, one can try to alter mood states by mainly targeting the cognitive aspect of depression. (It should be noted that most of these comments relate to the cognitive component of CBT; the more purely behavioral aspect would not be implicated in this discussion.)

### *The Depressive Realism Model*

Many clinicians are unaware of the presence of a completely opposite model of depression, “depressive realism” (DR).<sup>67</sup> This model grew out of research with normal subjects, who were given certain tests of cognitive functioning (contingency judgment of control over a green light when pushing a button), in which sometimes their errors were due to their own decisions and other times errors were introduced randomly outside the subjects’ control. Subjects were asked to describe to what extent they felt they were causing the errors produced. Those who had some depressive symptoms based on self-report rating scales were more accurate than those without depressive symptoms in correctly attributing error to themselves as opposed to random error beyond their control. Conversely, the “normal” nondepressed subjects had a sense of greater control than they really possessed. Hence, researchers suggested that these mildly, but not necessarily clinically, depressed subjects were more realistic than their completely nondepressed counterparts.

The DR model has an important implication. One might conclude that normal nondepressed persons have some lacunae of insight, some psychological blind spots, which are necessary for normal emotional functioning.

### *Reconciling the Two Models*

Beck has responded to DR<sup>68</sup> by accepting that “neither realism or cognitive distortion is an invariant characteristic

of depression or of healthy functioning; it depends.” Beck agrees that a small amount of illusion may be healthy or that illusions can be either maladaptive or adaptive depending on one’s belief structure or other circumstances: “Rather than implying that depression is uniquely associated with biased processing, leading to cognitive distortions, whereas nondepression is associated with generally realistic perceptions, a stronger formulation might include the principle that both depressed and nondepressed people construe the world in sometimes biased ways that are only partly accountable to data and that can lead to either accurate or distorted perceptions, depending on situational affordances, the content of biased beliefs, and opportunities for translating beliefs into outcomes via the actions one chooses. A salient feature of depressive biases appears to be an underappreciation of potential for improvement in current negative circumstances.”

The two explanations of depression seem contradictory. However, comprehending them in terms of the role of insight may clarify matters. Normally, everyone experiences mild depressive symptoms that follow the ups and downs of life: Shakespeare’s “slings and arrows of outrageous fortune.” In these cases, a certain lack of awareness, similar to the mild psychological denial or illusions described previously, may serve a useful purpose. The slings and arrows of life bounce off us rather than penetrate only if we fail to attend to them too closely. Where insight only incites pain, one needs to learn how to ignore, avoid, and forget. On the other hand, we might perceive them as larger and more dangerous than they truly are; they then become mortars and missiles, and we crumble under their perceived power. This may be what happens in the cognitive distortions of severe depression. In this case, we are overly aware of evils that we do not truly face.

The DR model argues that depression is associated with more insight, and the cognitive distortion model argues that it is associated with less. Is there any empirical evidence on this subject? In principle, it should be testable: Is depression associated with more or less insight? In studies conducted by our group<sup>69</sup> and others,<sup>70</sup> it appears that in milder types of depression, such as seasonal affective disorder, more depression may be associated with more insight. But severe depressions tend to be associated with some impairment of insight, though modest in comparison with other psychiatric conditions, like mania or psychosis.<sup>48,69</sup> Thus, mild to moderate depressions may better fit the DR model, while more severe depressions may fit the cognitive distortion model. These fits are due to the impact of insight, which is heightened in mild to moderate depression but lessened in severe depression. Beck<sup>70</sup> suggested a similar mechanism: “Bias can extend either in the positive direction (mania), or the negative (severe depression), and be mildly positive in euthymia, and biases may completely offset in mild depression.”

Critics may respond that CBT has been shown to be effective in “mild depression”; however, such studies still represent a more severe kind of depression than is conceived in the DR model. Another possible feature of DR is that it may apply to chronic subclinical depression, a condition often associated with notable long-term impairment.<sup>71</sup> The college students who exhibited DR could not be diagnosed with *DSM-IV* major depressive episodes, rather they had mild to moderate depressive symptoms, subthreshold for major depressive episodes. Such moderate subclinical depressive symptomatology, which might be captured in *DSM-IV* nosology using the terms “dysthymia” and “generalized anxiety disorder,” used to be called “neurotic depression” and appears clinically common.<sup>72</sup> Thus, DR may especially be relevant to such chronic mild depressive states.

These mild depressive states should not be seen as unimportant; in fact, many patients seek clinical help who do not have severe or even moderate major depressive episodes, but rather depressive symptoms that are below the major depressive episode level, and often chronically so. In the past, these patients were seen as having neurotic depression; now they are often labeled with combinations of dysthymia or generalized anxiety disorder or “residual” depression after improvement from more severe major depressive episodes. These chronic depressive states, mild to moderate in intensity, impair function notably<sup>73,74</sup> and are a major reason that patients seek clinical attention.

#### *Clinical Implications: Existential Psychotherapy*

Once we realize that DR is a viable model of depression, we might become more open to appreciating the sometimes paradoxical views of that neglected corner of psychiatry, the existential psychotherapy tradition.<sup>75–77</sup>

Existential psychotherapy may best fit the phenomenological state of persons with mild depression understood under the DR model. There are no cognitive distortions to remove, the patients are if anything overly realistic about life, thus CBT, taken literally, seems inappropriate. Psychoanalysis might advocate the stripping of all illusions, yet in the case of the mildly depressed individual with no illusions, there are no illusions left for psychoanalysis to strip away. All that is left to do is to accept the patient, to acknowledge the valid portrayal of the (depressing) realities of existence that patients experience, and to move ahead from there.<sup>77</sup> Existential psychotherapy is prepared to do this: to meet patients where they are, completely and wholeheartedly, without any further agenda, a pure encounter of two souls in the travails of life, rather than a treatment of a sick person by a healthy one. Perhaps normal individuals, or those in euthymic states, are characterized, at their most healthy, by living in the present. This present-centeredness has indeed long been a part of Buddhist/Sufi views on mental health and happiness and has also been a part of existential

philosophy in the West.<sup>4</sup> A psychotherapy that focuses on “present-centeredness” may thus be especially effective in mood disorders due to its effects on the phenomenology of time, and indeed this concept of present-centeredness is central to new psychotherapies that incorporate Eastern notions about mental health, such as mindfulness-based cognitive therapy, an approach that has shown some promise in the prevention of recurrence of depression in unipolar depression.<sup>78</sup>

If indeed mild depression is where the DR hypothesis best describes matters, then *the therapeutic corollary of the depressive realism hypothesis is existential psychotherapy*.

Another possible critique might view it as misleading to say that depressed persons either have more realism or more false cognitions. Many seem to have complex lives with complex personality development and they get depressed in the context of narratives which become fragmented and life events which they cannot endure. Here, the psychodynamic school with its longitudinal perspective and its interest in narrative and relationship may seem relevant. This may indeed be the case; the insight phenomenon is being presented here as one way, but not the only way, of viewing depressive illness. It is up to practitioners to try to identify which depressive conditions may benefit from CBT, which from existential methods, and which from psychoanalytic approaches. My concern in emphasizing the existential approach and linking it to the DR model and mild depressive states is that clinicians these days tend to monolithically think about depression only through the method of CBT, just as in the past they did so primarily with the method of psychoanalysis. Rather than such dogmatism, a pluralistic approach would limit those methods and open a scope for the use of existential psychotherapies as well.<sup>1,4</sup>

## Conclusions

While recognizing that mixed mood states are probably more common than pure manic and depressive states, there are important features that differ between mania and depression, with important clinical implications. The experience of time and the role of insight are two features that have been discussed here, as well as the relevance of the DR hypothesis for better understanding many depressive conditions. It is suggested that existential psychotherapy, highly underused and less widely understood than CBT, is the corollary to the DR model and that many apparent depressive morbidities may in fact represent existential despair.

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