Association for the Advancement of Philosophy and Psychiatry

Annual Meeting
New York City, May 5 – 6, 2018

Philosophical Perspectives on Affect, Emotion, and Mood in Psychiatric Disorder

Location:
New York Sheraton
811 7th Avenue
New York, NY
10019

Program Chairs:

Gerrit Glas, MD, PhD, Professor of Philosophy of Neuroscience, VU medical centre Amsterdam; psychiatrist and director residency training Dimence Groep, VU University Amsterdam. g.glas@dimencegroep.nl

Jeffrey Bedrick, MD, Clinical Associate Professor, Department of Psychiatry, Drexel University. jeffrey.bedrick@drexelmed.edu

Peter Zachar, PhD, Professor of Psychology, Associate Dean, College of Arts and Sciences, Auburn University Montgomery. pzachar@aum.edu

Peer-reviewers for submissions:
Sanneke de Haan, PhD
Doug Heinrichs, MD
Ed Hirsch, PhD, MD
Sarah Kamens, PhD
Claire Pouncey, MD
Emma Satlof-Bedrick, PhD
Scott Waterman, MD

Jaspers Committee:
Christian Perring, PhD, Chair
Jeff Bedrick, MD
Robyn Bluhm, PhD
Brent Kious, MD, PhD
James Phillips, MD
Claire Pouncey, MD
Doug Porter, MD
John Sadler, MD
Scott Waterman, MD
Peter Zachar, PhD

Saturday, May 5, 2108
Room: New York Ballroom West

08.30: **Welcome to AAPP 2018 - Peter Zachar (President)**

Session 1
Moderator: John Sadler

08.40 : **Delusional Moods – Huw Green**
09.00: **Discussion**

Delusions are conventionally defined as beliefs, though there is considerable controversy about whether this is so. Nonetheless, most candidate accounts of the nature of delusions presuppose that they are propositional and truth apt. The distress associated with them is assumed to derive top down from their distressing content. However, the heterogeneous clinical phenomena associated with delusions extend beyond verbal mistakes about what is the case. As Jennifer Radden has pointed out, delusions seem to scope over not only statements about reality but also over the degree of investment in those statements and the attitude taken to evidence that contradicts them. This extends the category "delusion" beyond a cognitive failure of reality testing, raising a significant challenge to what we understand them to be. If affective investment in an idea can be incorporated under the appellation "delusion," can delusions include even non-propositional mental states? Can moods be delusional?

In this paper, the possibility of delusional moods (as distinct from Jaspers' notion of a "delusional mood" experienced prior to the formation of a delusion) will be examined. Moods are not propositional and they are not conventionally regarded as truth-apt; a fact which appears to place them beyond the scope of judgements about accuracy. Additionally there is, within psychiatry and psychotherapy, some suggestion that how we feel is something personal and intrinsically valid, with no need for justification or explanation. This suggests that moods cannot be delusional in the contemporary psychiatric sense. But could a mood be so inappropriate to a situation that it stops being merely idiosyncratic, and resembles a more full blown departure from consensual affective reality? Could "reality testing" also be a relevant concern for assessing the pathology of affective states? A brief clinical vignette is offered to support this possibility.

When moods are considered possible candidates for delusion, we expand the concept to more closely resemble historic formulations of psychosis (which were more likely to include descriptions of "psychotic terror" or "psychotic rage"). Delusion was originally more broadly defined than has come to be the case post DSM-III. In the years since that manual was published, a small number of "headline" phenomena of psychosis (delusional beliefs, auditory hallucinations and thought disorder) have received the majority of clinical and research attention. Considering the possibility of delusional moods has the merit of recognizing the diversity of mental states that characterize psychosis, returning them to prominence and enriching our understanding of madness.

However it also has the consequence of breaking down some of the borders between delusional and non-delusional ideation, raising problems for the concept of delusion. It is argued that contemporary definitions of delusion have become overly reductive, and somewhat arbitrary relative to the descriptions offered by Bleuler and Jaspers. Regardless of whether delusional propositions are straightforwardly believed by those who assert them (the subject of an extensive existing literature), it is unlikely that the propositional content is always the most relevant driving force of a delusion. If moods per se can be delusional, this may help to defang the problem of how people can arrive at such markedly erroneous delusional "inferences". Under one possible conception, the explanation of delusions does not lie in complicated and mistaken reasoning, but in the ways that people give language to intense affective states.

09.10: Just How Motivated Are Pathological Beliefs? – Kelso Cratsley
09.30: Discussion

The literature on delusions now includes several notable attempts to detail the role of emotion. These explanatory models all recognize that impairments to emotion processing make some kind of causal contribution, but there is limited consensus beyond this. For example, certain approaches have gone so far as to characterize psychosis itself as an emotional disorder, while others only grant emotion a secondary, supplemental place behind primary cognitive deficits. In this presentation I take up one of the most contentious points of dispute, that of the nature and extent of motivational influence on delusional beliefs. There is a long history of appealing to defensive processes in explanations of delusion, largely influenced by psychoanalytic theory. On this view, delusions are a self-protective psychological response to emotionally distressing thoughts (eg. delusions of grandeur in response to critical self-evaluation). But this general approach has suffered from a conspicuous lack of empirical support. Because of this, much of the research on emotion in delusion has focused its efforts elsewhere.

Current research programs tend to investigate the dysfunctional relations between processes that fall under the traditional headings of emotion and cognition, such as negative valence (eg. fear) and cognitive control (eg. inhibition). Frequently these behavioral constructs are correlated with variations in core neural circuitry, such as the prefrontal hypofunction and subcortical hyperfunction associated with symptoms of psychosis, and are increasingly grounded in theories of atypical neurodevelopment. However, there are notable exceptions to this kind of approach that demand increased attention, and so here I recommend that we reconsider the possibility of a motivated account. For a start, there is some evidence – though admittedly meager at this point – that delusions are indeed associated with compensatory psychological responses to negative emotion. There is also the stubborn fact that a defensive conception of certain delusion sub-types remains intuitively compelling. From a philosophical perspective, this is consistent with intentional-level explanation of the combined force of emotion and desire in driving the false beliefs attendant to self-deception. None of this is definitive, far from it, but it does raise the possibility of a minimal explanatory role for motivational factors.

In order to reassess the potential for a motivated account, I briefly review several of the leading theories of emotion in delusion. First, the standard 'delusion as defense' approach is described, including some of the most relevant empirical findings. In my view these data raise a number of questions but are at least

sufficient to require further investigation. I then evaluate a less convincing philosophical variation that builds on the psychological claim to argue for the 'epistemic innocence' of some motivated delusions (Bortolotti, 2015). While the psychological claim remains intriguing, and emotions can certainly 'skew the epistemic landscape' (in Peter Goldie's evocative phrasing), I suggest that there are good of reasons to be skeptical of any strictly epistemic claims about delusion. Finally, I describe a cognitive theory that models persecutory delusions as 'threat beliefs,' the result of the gradual interplay of fear and anxiety with various reasoning biases (Freeman, 2016). Though this theory is chiefly concerned with the direct transformation of anxiety into delusional beliefs about external threats (or neurosis into psychosis), its multifactorial approach leaves room for the possible contribution of psychological defenses. What's more, it also has the benefit of allowing for potential integration with the increasingly influential prediction error model of delusion.

09.40: The Illusory Divide Between Compulsion and Choice Models of Addiction - Zoey Lavallee

10.00: Discussion

Contemporary theories of addiction are largely divided between two camps. The first argues that, at bottom, addiction is a matter of compulsion. The characteristic behavior of addicts is compelled by some kind of pathological, irresistible desire. The upshot is that addicts lack self-control over their addiction. The second argues that addiction is ultimately a function of choice. Accordingly, addiction belongs within the realm of intentional actions. The compulsion camp identifies addiction within the sphere of affective and appetitive states, while the choice camp focuses on cognition. Typically, these two explanations are seen to be incompatible; consequently, the addiction debate is polarized. Both compulsion and choice accounts face a fundamental puzzle inherent in addiction: 1) Addicts' actions seem to be, at least in some circumstances, compelled, and 2) there is plenty of empirical evidence showing that addicts are reason, or incentive, responsive, which implies choice. Where the first prong raises trouble for a choice model, the compulsion model is undercut by the second.

I critically examine two of the most sophisticated, empirically informed versions of the opposing views: Berridge and Holton's "Compulsion and Choice in Addiction" (2017), and Hanna Pickard's "Denial in Addiction" (2016). While both articles advance the traditional addiction debate, they nonetheless maintain the dichotomy between compulsion and choice. Berridge and Holton advocate a nuanced compulsion model. However, while they do acknowledge addicts' reason responsiveness, ultimately they conclude that addiction is a matter of malfunctioning desire regulation. Unlike a wholesale choice explanation, Pickard leaves some room for desires in her account. Nevertheless, she maintains that fundamentally, addiction is a result of cognitive dysfunction. In this paper, I defend an alternate model, what I call the '*Desires as Reasons Account'* of addiction. I argue that the dichotomy between the two competing views of addiction is undermined by the observation that desires in fact fall on both sides of the divide between choice and compulsion. Beginning with this observation, I establish an account of desires as reasons. I argue that desires are not only motivating as impulses, but also, desires in and of themselves constitute motivating *reasons* in two ways. First, desires are not arbitrary feelings – they carry information; and secondly, the felt quality of a desire is itself reason giving. Expanding

on these two claims, I conclude that even when desires have overwhelming force (something like compulsion), they do not lose their role as reasons.

This applies to addiction: an addict's intense desires to use are not purely physiological; their cravings are also reasons to act. They might treat a craving with medication, meditation, having a drink, getting high, or whatever else – those are all possible solutions. And the *feeling* of the craving is itself a reason for any of those choices, not only the information that the craving carries. Accordingly, in the case of addiction, it is a mistake to relegate impulses to the realm of volition, and reasons to the cognitive domain. I use this analysis to show that the dilemma at the heart of the addiction debate is in fact illusory. When desires are understood to be both impulses and motivating reasons, the divide between compulsion and choice is obfuscated.

The upshot of the *Desires as Reasons Account* of addiction is that if desires are reasons in the twofold manner that I propose, then it is not incompatible for the actions of addicts to be compelled by desires, and also to be reason responsive. Thus, this account offers a novel hypothesis toward resolving the puzzle of addiction. The *Desires as Reasons Account* challenges the polarization of choice and compulsion models, and provides a better explanation of addiction.

10.10 – 10.20 Break

Session 2
Moderator: Christian Perring

10.20: Graded Affective Intentionality – Avraham Rot
10.40: Discussion

Anxiety and boredom appear to have little in common apart from the fact that they are both usually regarded as negative emotions. When one thinks of anxiety, boredom does not necessarily come to mind, and when boredom is under consideration, anxiety mostly does not present itself in its immediate semantic proximity. This separation accords with the common view that each of these emotions belongs to a different realm of experience and discourse such that it presents us with a correspondingly different set of practical and theoretical problems.

Emblematic of this separation is psychopathology, a field that has been traditionally characterized by a pattern of preoccupation with anxiety and relative disregard of boredom. In spite of the break of psychiatry with psychoanalysis, represented by DSM III, this and the subsequent editions of the DSM are continuous with the preceding ones, which in turn are continuous with Sigmund Freud's writings, in that anxiety is ubiquitous in them while boredom is hardly mentioned. While anxiety disorders have come to be regarded "the single largest mental health problem" in the United States (David Barlow, Anxiety and Its Disorders [New York 2002], 22), critics have long contend that what the soaring rates of anxiety disorders in fact indicate is that the definition and use of psychiatric diagnostic criteria have been "overinclusive" (Allan Horwitz and Jerome Wakefield, All We Have to Fear [Oxford 2012]). Little to no attention, however, has been given in this context to boredom. One may justify this state of affairs on various grounds. For instance, one may say that boredom is a normal experience, or perhaps even that it is inherently so. Or one may say that the study of that which is

absent from a field or a discourse entails considerable methodological problems, as such a study demands an account of how it could have been otherwise, making it difficult to distinguish historical contingency from sociological necessity. Nonetheless, in light of the omnipresence of anxiety in psychopathology, the absence of boredom is rendered conspicuous and calls for an investigation.

Against the received view that anxiety and boredom have little in common, this paper puts forth the argument that they are as closely related as anxiety and fear. Just as anxiety has been understood as a generalized form of fear, I suggest that boredom be understood as a generalized form of anxiety. To this end I introduce the notion of graded affective intentionality. While intentionality is usually considered a binary determination—for instance by Franz Brentano, who originally introduced this term into modern philosophical psychology to distinguish mental from physical phenomena, as well as by contemporary scholars (notably Ruth Leys), who have used it to distinguish between cognitivist and anticognitivist approaches to the study of emotions—I draw on Spinoza's philosophy, which incorporates the medieval notion of graded reality (implicit in the ontological proof for God's existence), to suggest that intentionality is in fact a matter of degree. Using this distinction, I further suggest that while the difference between anxiety and boredom is often understood in terms of intensity, it is in fact one of intentionality. Being a generalized form of anxiety, boredom is also a less intentional form of anxiety. On the basis of this theoretical analysis, I argue that the pattern of preoccupation with anxiety and disregard of boredom in psychopathology is a matter of historical contingency rather than sociological necessity: the reason why there are no boredom disorders is not because boredom is inherently normal, but because boredom has not been pathologized as yet—or more specifically, because it had failed to become a "neurosis" by the time the neuroses were reclassified as "disorders."

Edwin Wallace Lecture
Introduction by Jeffrey Bedrick

10.50: **Affect Systems and Psychoanalytic Drive Theory Today – Otto Kernberg**
11.30: **Discussion**

11.50 - 12.00: **Announcement of Jaspers Award Winner**

12.10 - 13.30: **Lunch**

Keynote Lecture
Moderator: Gerrit Glas

13.30: **Dysregulation and its Interpersonal Context – Matthew Ratcliffe**
14.10: **Discussion**

This talk will address the nature of emotion dysregulation in psychiatric illness, focusing on so-called 'borderline personality disorder'. First of all, I will offer an account of what it is that makes 'emotional' intentionality distinctive. Then, I will employ this account to show that (a) unruly emotions are symptomatic of an unstructured experiential world; (b) having a structured experiential world requires being able to relate to

other people in certain ways; and (c) emotion regulation and dysregulation should be conceived of in relational terms.

14.25 – 14.35: Break

Session 3
Moderator: Serife Tekin

14.35: Existential Guilt and Depressive Responsibility – Jake Jackson
14.55: Discussion

The feeling of guilt is often understood as a moral feeling. After all, the feeling of guilt directly implies that one is guilty of some wrongdoing, an ethical burden that must be corrected or atoned for. Guilt plays a major role in moral psychology and our everyday conceptions of how to live with one another. Karl Jaspers (1961) breaks down the concepts of guilt as being either criminal, political, moral, or metaphysical. The latter two concepts directly bear on the question of moral and social responsibility. Moral guilt is the responsibility of being the author of one's actions while metaphysical guilt is the "solidarity among … human beings that makes each co-responsible for every wrong and every injustice in the world" (Jaspers 1961, 32). We often understand guilty feelings as some sort of revelation; we feel guilty, therefore we must act in some responsible way that will relieve that sense of guilt.

Yet feelings of guilt can often exist *without* intentionality towards an action or event, especially within the case of mood disorders. For example, Major Depressive Disorder features the possible symptom of "[f]eelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)" (American Psychiatric Association 2013, 161). Seeing as depression leads to overwhelming or continual feelings of guilt without a direct cause, creating a normative moral psychology out of guilt is a problematic endeavor. Typically, philosophers of emotion exclude mood disorders from their theoretical and ethical commitments: either by explicitly claiming that psychophysical causes disqualify delusional guilt from moral consideration, or implicitly by not even mentioning mood disorder at all. These exclusions may allow for tighter and cleaner theories of emotion, perhaps, but outright fail to understand the deeper nuances of these feelings and leave individuals with mood disorders in the dark. The exclusion of mood disorders in moral psychology often implies that delusional or excessive guilt is somehow morally irrelevant, that this guilt is inherently meaningless. However, the guilt remains despite and those who experience more existential feelings of guilt are left morally and epistemically adrift with conflicting accounts of what to do with overwhelming guilt that is not discernably causal to their actions or being.

The aim of this paper is to discuss what delusional or excessive feelings of guilt within depressive disorders say about moral responsibility. A more comprehensive emotional theory of moral responsibility must engage directly with the experience of mood disorders, otherwise it fails to be a viable account. I particularly will be looking through existentialist phenomenological approaches to guilt, especially aided by Matthew Ratcliffe's (2008, 2015) conception of existential feelings. For Ratcliffe, existential guilt is not necessarily intentional, but is generally feeling guilty, sometimes irrevocably so (2015, 133). My contention is that

depressive guilt, or other forms of uncontrollable and delusional guilt feelings, provide a higher amount of insight into the realm of moral and metaphysical guilt as Jaspers conceives of them above. Guilt feelings are transformative perspectives on the world that look to interconnections, rather than being clear normative claims about the world. Research on 'depressive realism' suggests that the guilt feelings within depressive episodes present a deeper, richer understanding of the connective moral and metaphysical ties between individuals that are often otherwise overlooked by neurotypical individuals; even if detrimental to one's own life, depression appears to provide helpful, deeper moral insight by being confronted with guilty feelings 'without cause'. I will conclude this paper with a sketch for depressive responsibility, a way to respond and make meaning out of 'meaningless' and irrevocable existential guilt feelings.

15.05: Phenomenoloy, Predictive Processing, and Major Depressive Disorder – Zachariah Neemah

15.25: Discussion

"Classical" depression, now called Major Depressive Disorder (MDD), is a disorder of affect, cognition, and the body. Disturbances of affect in MDD include persistent depressed mood and diminished interest in daily activities. Disturbances of cognition include feelings of worthlessness or guilt, an attenuation of concentration, and persistent thoughts of death.

Significant bodily disturbances include weight loss or gain, insomnia or hypersomnia, psychomotor agitation, and fatigue (American Psychiatric Association, 2013, pp. 160-161). From a phenomenological and embodied perspective, these symptoms are expressions of a "complete form of existence" of the affected person (Merleau-Ponty, 1945/2012, p. 110). The bodily, affective, and cognitive changes typical of MDD manifest within broader changes in the being- in-the-world of the depressed person. In this paper, I discuss these psychopathological changes as modifications of nonlinear, polyrhythmic time scales composing the emergent unity of the embodied mind.

Some symptoms have time as their manifest theme, such as feelings of time slowing down, running out, or even feelings of detachment from time (Fuchs, 2013; Ratcliffe, 2012, 2015). As Erwin Straus (1947) notes, however, "there is an intrinsic temporal structure in depressive symptoms which do not have time as their manifest theme" (p. 255). For phenomenology, as for dynamical systems approaches to cognitive science (Van Gelder, 1999), cognition is not merely something that occurs *in* time; it is essentially temporal. The ticks of the clock or the decay of radioactive isotopes occur in regular periods. However, neither the experience of time nor the nonlinear periodicity of neuronal processes occur according to the linear time of clocks. Varela (1999) introduces three nonlinear time scales composing the polyrhythmic *(in music theory, polyrhythms are a simultaneous sequence of discrete rhythms creating an emergent rhythmic pattern (Handel, 1984),* emergent unity of the embodied mind: the elementary scale of neuronal processes, the integrative scale of prereflective consciousness, and the narrative scale. *(I would like to thank Shaun Gallagher for directing me to this paper)*

Each of these time scales are modified in depression. I discuss Husserl's (1991) structure of the passive synthesis (the time of prereflective consciousness) as a mode of the integrative scale. I show how recent developments in predictive processing within cognitive science suggest a rethinking of Husserl's model.

In predictive processing models, regularities in different time scales can influence the predictions of those in different time scales (Hohwy, 2013). Predictions from longer-term time scales can influence predictions from shorter-term time scales, and *vice versa*. I naturalize the Husserlian model to account for the reverse flow from narrative to integrative time scales. This provides a framework for Ratcliffe's (2015, p. 184) analysis of the effects of "teleological" time on the passive synthesis. I then use the naturalized Husserlian model to discuss several of the affective and cognitive changes characteristic of MDD.

I next discuss the role of neural oscillations, the sleep-wake cycle, hormonal cycles, temperature cycles, and other prenoetic processes in depression. Modulations of neural oscillations occur on the elementary time scale, while the others occur on a longer-term scale. The modulations of prenoetic processes do not simply cascade up from one level to the next. They are, instead, nonlinear and dynamic (Varela, 1999). I discuss how these prenoetic desynchronizations interact dynamically with those of integrative and narrative time scales to compose the polyrhythmic, emergent unity of the depressive person's being-in-the-world. Overall, by integrating studies in phenomenology, cognitive science, and cognitive neuroscience, I provide a holistic and humanistic framework for understanding the affective, cognitive, and bodily symptoms of MDD.

15.35 – 15.45: Break

Session 4
Moderator: Phil Sinaikin

15.45: Are All Mental Disorders Affective Disorders? – Michelle Maiese
16.05: Discussion

Kraepelin (1913) famously distinguishes between a) disorders of thought (e.g. schizophrenia), and b) disorders of mood (e.g. bipolar disorder). More generally, there often is a tendency to think that some mental disorders (e.g. ADHD) centrally involve cognitive symptoms while others (e.g. depression) centrally involve affective symptoms. However, I will argue that all mental disorders are, in an important sense, affective. This is because disorders involve some sort of disruption to what enactivist theorists call 'sense-making,' and because all sense-making is thoroughly embodied and affective.

From the standpoint of enactivism as developed by theorists such as Weber and Varela (2002) and Thompson (2007), sense-making involves embodied engagement and is the process whereby living organisms interpret environmental stimuli in terms of their "vital significance." In a basic biological sense, intentional engagement involves openness to the world. Survival and adaptivity require that the living system interact with the environment, regulate its boundary conditions, and seek to actualize future conditions that will contribute to its regeneration. Among humans, the development of a central nervous system has allowed for more sophisticated forms of sensorimotor coordination and problem-solving and more complex ways of adapting to ongoing change in the environment. Increased bodily sensitivity to what is relevant to achieving one's goals contributes to a more developed ability to make sense of one's surroundings and "fare well" in a particular socio-cultural setting. A disruption to sense-making signifies a diminished capacity for adaptive engagement with one's environment, resulting in stress, fatigue, dysfunction, or disorder.

Since subjects respond to worldly items in terms of their apparent significance, there is good reason to think that sense-making ordinarily is thoroughly embodied, deeply affective (Colombetti 2014), and informed by one's needs, interests, and desires. In cases of motor intentionality, one grasps an object and directs oneself toward it. Rather than representing its objective and determinate features, a subject identifies it pragmatically in relation to her interests and goals. Likewise, in perception, she interprets incoming stimuli selectively and in relation to her cares and concerns, so that objects are disclosed as things with potential for future engagement. Such considerations suggest that affective intentionality implicitly underlies all of our worldly encounters (Jacobs et al. 2014). Along these lines, Colombetti has emphasized that "the world takes on significance and value precisely in relation to what the organism is concerned about and striving for" (Colombetti 2014, 19); Ratcliffe (2005; 2008) has highlighted how engagement with the world takes place in and through the feeling body; and Maiese (2011; 2015) describes affective framing as a pre-reflective way of filtering and selecting information that allows us to focus our attention in accordance with desiderative bodily feelings (i.e. feelings of what matters). A disruption to affective framing signifies an inability to attend to what's relevant and ignore what is unimportant.

While it initially might seem as if some disorders more emotional and others more cognitive, enactivism allows us to see that all mental disorders are, simultaneously, affective-and-cognitive. This is because, like 'mood disturbances,' 'thought disturbances' can be understood in terms of a disruption or attenuation in affective framing processes. To illustrate this, I consider language impairments in cases of schizophrenia, executive control deficits found in ADHD, context blindness among subjects with autism, and the ruminative thinking found in cases of obsessive-compulsive disorder. Such examples indicate that a wide range of symptoms impacting thought and language can be understood in terms of a disruption to affective framing. This has important implications for treatment: interventions that target subjects' bodies and emotions have enormous potential to bring about lasting improvement.

16.15: Adaptive and Inadaptive Emotions – Laura Mathews
16.35: Discussion

This paper argues that objective, organismic accounts of emotion and subjective, experiential accounts of emotion can be integrated by appealing to the enactive approach. Enactivism claims that embodied minds, situated in both time and space, necessarily have a perspective on their world that is fundamentally structured by the nature of their embodiment. Embodied minds make sense of their worlds through cognitive-affective engagement with their environments. Through this sense-making they determine the significance of certain features of their environments in relation to their own endogenously created system of values. Cognition then is a dynamic activity that emerges from the relations between the embodied mind and its world.

From an objective standpoint, enactivism understands emotions to be derived from the autonomous bodily organization of organisms, known as their autopoietic structure. The result is the norm of survival instantiated by autopoiesis. Features of the environment become meaningful to an organism through their relation to its autopoietic structure. They either allow for the continuation of the autopoietic process, and hence are good and sought after, or they do not, and hence are bad and avoided. This simple all-or-nothing type norm instantiated by autopoiesis is then elaborated on in the process of adaptivity. Adaptivity refers to

the organism's capacity to alter its behavior in order to *improve* its capacity to maintain itself, thereby moving beyond simple maintenance. Adaptivity consists of the mind's ability to adapt to its changing environment to bring itself closer to stable functioning and away from more dangerous conditions. Autopoiesis alone does not imply the full range of sense-making capacities, since the norm instantiated by autopoiesis cannot distinguish among any conditions that are not life threatening. In other words, adaptivity allows for the proliferation of values beyond the dichotomous survival norm implied by the autopoietic structure.

Enactivism also stresses the importance of explaining subjective experience, instead of explaining it away as a mere epiphenomenon. On the enactive approach, subjective experience is causally efficacious, which can in part explain how emotions serve to motivate behavior. If emotions are not subjectively felt or experienced, they will not function as efficiently as a guide to behavior. Evidence that subjective experience can have real causal impacts on the body come from the success of mindfulness-based treatment approaches to certain types of mental disorders. The success of these programs depends in part on their ability to alter brain circuitry (through mechanisms of neural plasticity) based on the subject's altered experience, through strategies of distancing and decentering, of the very same distressing mental contents.

The enactive approach suggests that a pragmatic understanding of abnormal emotionality. Emotions become pathological when they begin to chronically act against the subject's goals. Emotions, when operating in a healthy way, ought to guide subjects in their behavior and to provide both information about the environment and motivation to act on that information. When they cease to do this, emotions become *inadaptive*, they serve to reduce a subject's capacity to negotiate her environment and improve or maintain her capacity to function or flourish. Emotions can become inadaptive in one of three ways: (1) by effectively limiting the range of activities that an individual can undertake (without any physiological source for the limitation), i.e. a narrowing of one's world, (2) by creating an irreconcilability between the individual's subjective experience and the objective world, which should be more or less accurately tracked by subjective experience, and (3) by creating a gulf between the individual's personal world and the world of interpersonal relations, i.e., by placing a strain on the individual's capacity to develop and maintain healthy and empathic relations with others.

16.45: Adjourn

Sunday, May 6, 2108
Room: Central Park West

Session 5
Moderator: Michael B. First

09.00: Informed Consent, Decision-Making, and Capacity – J.J. Rasimas
09.20: Discussion

Informed consent is a core requirement for proceeding with medical intervention, and for nearly two decades, accepted guidelines for establishing the capacity of an individual to make decisions about treatments have been in place [1]. In the United States, a premium is placed upon cognitive functions that are necessary for understanding information, manipulation thereof, and the use of such faculties to weigh pros and cons in the interest of making a clear choice. However, recent neuropsychological research indicates there are two aspects of human behavior that may not fit well with established models of ethical practice in this area. One, a seemingly practical consideration, is that decisions are profoundly affected by the methods and disposition of the clinician who delivers medical information to be considered [2]. The emotional state of the decision-maker in relation to both his health and that clinician correlate with trends in treatment choice [3-5]. Contextual factors may play a more important role in the actual process of decision-making than rational processes, as well [6]. As a result, it may be misguided to expect untrammeled cognitive reasoning to be the standard by which patients choose.

The other applicable insight from neuroscience is that a-rationality is not just common in human behavior, but essential. Emotional and non-conscious responses to many situations lead people to choose in ways that may be deemed right, wise, and wholly consistent with self-interest. Antonio Damasio has noted that deficits in emotional, "big-picture" processing, such as those that arise from OFC and/or right parietal damage may lead some individuals to make grossly poor choices [7]. While some of these problems may be referable to an inability to "appreciate" in a way that could be divined by neuropsychological examination, other deficits are almost ineffable even though they are scientifically testable and measurable [8]. Acting on "gut-feeling" or "thin-slicing" as highlighted by Malcolm Gladwell is not necessarily inferior to "cognating" about a dilemma [9]. There are strengths and weaknesses to this approach, which has been shown to depend a great deal on patterns of previous relational experience and recent salient events – both infused with emotion. Such behavior does not simply reflect a failure to articulate reasoning to guide choice; decisions of this sort may depend largely on an individual's sense of what is right, and rational analysis can produce less desirable results.

Both of these themes suggest that our standard protocol for assessing decision-making capacity that focuses narrowly upon core cognitive abilities may be providing a sense of procedural comfort that is actually not well-suited to understanding and/or caring for the human animal facing issues of health and mortality. A reasonable degree of understanding is to be demanded of a capacitated individual, but sharing of information occurs within the context of relationships, which themselves have value in the treatment process. Expecting patients to transcend the emotionality of the experience of being sick and/or to abandon their established

emotional selves when critical decisions are to be made may not be human. Taking into account the collection of patients' relationships, current and past, along with the quality of choices—however more challenging to codify as a medical procedure—would fit with a standard of capacity assessment that better incorporates social realities and insights from neuroscience [10]. Perhaps we adopt such a standard already in the majority of situations that proceed smoothly, but then abandon it in favor of Appelbaum's guidelines to sort out cases of conflict by demanding reason under unreasonable conditions.

09.30: Narrative Identity and Psychopathology – Alycia La Guardia-LoBianco
09.50: Discussion

For someone diagnosed with a mental disorder, the decision to take or refrain from taking psychotropic medication as part of a treatment plan can be difficult. Unlike other forms of treatment such as talk therapy, psychotropic medication poses what some take as a threat to one's very self. When effective, this medication alters targeted moods and behaviors, for instance by neutralizing a pervasively depressed affect or easing the onslaught of anxious thoughts. But though these symptoms can be devastating and undesirable, some agents can nonetheless identify with them, taking these symptoms to be an important part of who they are. For these agents, medication that alters or eradicates their symptoms can also alter or eradicate (part of) their self. As the loss of self may be a painful prospect to them, they may resist medication. Yet for others, the very same concern of maintaining one's self can count in favor of pharmaceutical treatment. If one feels a mental disorder has altered who one is, turning one into 'someone else,' psychotropic medication allows a return to normalcy and a reclamation of self. This paper seeks to explain these strikingly divergent attitudes towards taking psychotropic medication by motivating a view of narrative identity and authenticity under conditions of psychopathology.

Central to this view is a resistance to privileging a mentally healthy self as authentic, rather allowing for the possibility that an agent's identity may be consistent with an untreated mental disorder. The challenge is in explaining how the symptoms of a mental disorder, including characteristic affect, behavior, and thoughts, can be fundamental to some agents' identities such that losing these traits *would* be a loss of self for them. I argue for this possibility within a framework of narrative identity, which posits personal identity in terms of a meaningful narrative created by the agent. Who one is and the events of one's life are understood in terms of one's narrative, which, though influenced by outside forces, is ultimately determined by the agent his or herself. Understanding identity as narrative leaves opens the possibility that some narratives can meaningfully include the symptoms of mental disorders. For instance, one might view the affective component of depression as fundamental to one's orientation to the world, indicative of and crucially wrapped up with a set of values and beliefs that define them. I draw on personal accounts from Lauren Slater and others to motivate the notion that some agents can meaningfully identify with symptoms of mental disorders such that these are part of their narrative identity.

If the symptoms of a mental disorder can constitute a narrative identity for some agents, it seems that pharmaceutical treatment can pose a genuine threat to authenticity for them. Yet, these agents may also have a strong desire to seek relief from their painful symptoms as well as a responsibility to promote her own well-being by taking medication. How can an agent negotiate these complications? I explore these questions using

a Sartrean perspective of freedom and choice. Key to this perspective is the notion that there is no prescribed answer to any of these questions. Rather, agents must authentically choose for themselves in order to realize their values, and I argue that this approach is in keeping with the creation of their narrative identity. The choice of taking medication can be riddled with existential questions of authenticity, but this can also point to a resource for agents concerned with staying true to themselves.

10.00: Integrating Narrative and Clinical Contexts: The Role of Emotion in the Experience of Psychotic Disorders – Kathleen Lowenstein

10.20: Discussion

Current clinical research on schizophrenia spectrum and other psychotic disorders understands schizophrenia as a brain-based illness over which individuals have little control. Within this framing, the role of emotion in psychosis is generally afforded little to no attention. In standard clinical frameworks, if emotion in psychosis is considered at all it is framed in terms of expressed emotion within family systems, which understands emotion as something that happens outside of the individual, rather than as a personal negotiation with both symptoms of illness and the disease category itself.

However, this framing of psychosis as a brain-based illness separate from the lived emotional world of the individual experiencing psychosis exacts a fundamental disconnect between current clinical understanding and the emotional experience of those diagnosed with schizophrenia spectrum or other psychotic disorders. This disconnect has served as a tension point between the standard clinical reading of affect in psychotic states as something which can be observed and classified namely in terms of its pathology, manifest in symptoms such as flat affect, and individuals' phenomenological experience of psychotic states, which remains a largely unexplored avenue in clinical research.

One of the vanguards of current schizophrenia research is the point at which individuals experiencing first episode psychosis initially come into contact with psychiatric services. Individuals who engage with effective mental health services earlier in the course of their illness, or prior to their illness meeting full criteria for an official diagnosis of psychosis, have better long-term outcomes, evidencing both greatly reduced morbidity overall and (frequently) decreased duration of illness. Accordingly, the importance of the first clinical encounter cannot be emphasized enough. However, the role that emotion plays in individual experience of first episode psychosis has, until recently, been the subject of scant attention in the research literature.

This paper will argue that integrating clinical understanding of psychosis with service user narratives of distress and illness highlights the importance of considering the role of emotion in psychotic states. In particular, it will interrogate the way in which individual report of fear and shame in experience of first episode psychosis has a marked impact on subsequent clinical trajectory. Using cross-cultural examinations of experience of first episode psychosis, it will argue that emotional response to psychotic states plays a significant role in long-term morbidity. As such, understanding individual response to initial experience of psychotic states is integral to understanding cultural factors that impact long-term morbidity. In particular, it will highlight the role of fear and shame in the framing of first episode psychosis, arguing that this frequently overlooked connection between individual emotional response to illness and illness course itself is integral to understanding differences in long-term morbidity in schizophrenia spectrum and other psychotic disorders. As

such, research on individual experience of first episode psychosis points to the fundamental need to consider emotional response to and experience of psychotic states as not just indicative of pathology. Rather, these responses serve as a point at which individual experience of prevailing clinical frameworks can be both negotiated and ameliorated.

10.30 – 10.45: Break

Session 6
Moderator: Don Mender

10.45: Culture and Interpersonal Emotions in Depression: an Iranian Case study – Moujan Mirdamadi

11.05: Discussion

Even though moods and emotions have a defining role in the experiences of depression, there have been few studies examining the way in which these experiences and their articulations are shaped by culture. The aim of this paper, looking at emotional experiences in depression among Iranian patients, is to show how cultural values and frames of thought influence these experiences. I will draw on empirical data obtained through a questionnaire distributed among patients diagnosed with depression in Iran, while adopting a phenomenological perspective to account for what seems to be culturally specific ways of articulating and experiencing certain emotions involved in depression.

Emotional experiences play a central role is in relationships with others. Iranians often complain about having negative emotions towards others when depressed. Such emotions are accompanied by feelings of being a victim, not being empathised with, and ultimately a desire to isolate oneself from others. More importantly, the feeling of guilt, one of the central feelings in depression in many cultures, seems to be absent in Iranians' experience of depression, and is instead replaced by anger and aggressiveness towards others. This latter point can in part be accounted for through the sociological differences between Iran as a collectivist society, and a country such as the UK with an individualistic society. Psychological research suggests that feelings of guilt are seen more frequently in individualistic societies compared to collectivist ones, since given the strong emphasis in collectivist societies on personal relationships, individuals see their success or failure intimately linked with the way others conduct themselves. In such a society, it is more common to see others as responsible for a certain event, meriting an aggressive behaviour, than it is to see oneself as the sole cause, and therefore having a self-directed feeling such as guilt.

In addition to these psychological accounts, however, I argue that the relative absence of guilt can in part be accounted for in the wider context of emotional experiences in interpersonal domains. Using Sartre's phenomenological theory of emotions, in which these are construed as active responses to changes in one's space of possibilities in the world, I argue for a progression of experiences, viewing different emotional experiences as connected with one another and with the sociocultural setting in which they occur. The existing literature accounts for the negative attitudes towards others brought about by the existential change one goes through in depression. However, in the context of Iran, as a collectivist society where the cause of one's

suffering is attributed to an outside source, and where depression is stigmatised in the society, the negative attitude towards others is seen more strongly. This is since, in this setting, the Others' lack of understanding and empathy is seen as one of the sources of one's suffering. In a culture and society in which there is a strong expectation for people to be helpful to an individual in need, the lack of empathy leads to one seeing herself as a victim and seeing those around her in a hostile light, manifested in negative emotions directed towards others. Seeing others as at least in part responsible for one's suffering, and the negative emotions arising from this viewing, in turn merits outward-directed anger and aggressiveness, rather than inward-directed feeling of guilt. And it is against such a background that in Iran, rather than feeling alone, individuals with depression feel the urge to isolate themselves and escape from social situations.

I argue that such an understanding of emotional experiences in depression, which considers the sociocultural factors as well as the phenomenological ones, is necessary for a holistic account of emotions in depression.

11.15: Cultural Affordance and Experience Framing: Making Sense of Emotions and "Mental Health Culture" – Ana Gomez and Samuel Veissière

11.35: Discussion

Can the objective, organismic, way of conceptualizing emotion and the personal, narrative, sense of emotion be integrated?

In this paper, we inverse one of the central premises of this call for papers to ask if the objective, organismic ways of conceptualizing emotion can be separated from the narrative, and cultural mediation of affective experience. We focus on the current epidemic of depression as a case in point to propose a novel way of theorizing the connections between culture, affect, wellness, and distress.

Drawing on the philosophy of enactivism, predictive processing models in cognitive neuroscience, and the recently formulated cultural affordances framework, we begin by questioning the existence of a purely objective state of emotional experience.

We argue that the idea of having to re-integrate these concepts stems from a dichotomous western philosophical tradition that erroneously distinguishes cognition from affect, and continues to shape the field of psychiatry.

Properly speaking, emotions are displayed compositions of short-lasting inner states triggered by environmental cues. These neurobiological responses we commonly term 'emotions' are patterned through selective allocations of extero- and interoceptive attention mediated by shared cultural practice and a dynamic contextual interaction. As such the artificial delineation between the objective, organismic and the personal, narrative, dissolves. As decades of research in cognitive science have shown, the process through which these inner states become 'meaningful' (that is, the process of sense- making through which inner states are monitored, appraised, named, and framed) typically occurs post- hoc. 'Emotions', on this view, are simply cognitive interpretations of sense data. While these Spinozan views are no longer controversial, the extent to which cognitive-affective processes are embodied, embedded, extended, and enacted within broader cultural affordances has yet to be fully appreciated by cognitive and clinical scientists alike. Predictive-processing paradigms in cognitive neuroscience also have much to

add to this conundrum. In these models, perception (we include emotions here) in the present is understood as mediated by expectations of the future based on prior learning. Bodily states, as such, are not simply interpreted within what cultural narratives afford, but are rather *predicted,* framed, and enacted within a course of possible future states.

This novel understanding of the cultural objectification and framing of experience carries important implications for rethinking simplistic dichotomies between 'function' and 'dysfunction', and for making sense of current epidemics of mental illness.

After briefly delineating theoretical underpinnings of the cultural affordances model, we focus on current questions in the etiology and nosology of depression to illustrate our framework. We argue that recent ideological shifts toward what we term "mental health culture" have led to widely spread noxious effects on two counts. First, they exacerbate the Cartesian fallacy of privileging a dissociated real of "mental" experience as separate from the body. Second, they provide an overwhelmingly negative interpretive framework that allocates shared attention toward 'depressive' symptoms, and thereby predicts and directs experience in powerfully negative terms, producing 'depressogenic looping effects'. As an example, recent work by Drysdale et al (2017) on biotypes of depression has identified anhedonia as a central characterizing symptom but has failed to factor in the influence of the research context, one where the preoccupation with the care of the self and the hedonic dimensions of experience are reaching unprecedented levels.

11.45 – 13.15: Lunch

Keynote Lecture
Moderator: Peter Zachar

13.15: Culture, Psychiatry, and Ontology – Jesse Prinz

There is an enormous body of evidence that culture can influence psychiatric kinds. At one extreme, there are culturally-bound syndromes, but even those diagnostic categories that have some cross-cultural robustness can vary along many dimensions including symptoms, behavior, time course, effective remedies, biological correlates, clinical thresholds, prevalence, and distribution. Here, these variations are explored, with a focus on affective disorders. Against this background, two questions are raised: what is the best account of cultural influence and what implications does it have for ontology? Explanations for variation range from modest modulation theories (e.g., work on display rules and RDoC approaches that seek a biological core) to strongly constructivist accounts (e.g., dramaturgical and script theories). There are also accounts that try to divide and conquer, including psychiatric dualisms that distinguish culturally malleable conditions from genuine disorders. Correspondingly, there is also a wide range perspectives on the ontological status of psychiatric kinds. These include anti-realism, promiscuous realism, essentialism, causal cluster theories, network theories, and theories that relocate psychiatric reality at the level of symptoms. It is argued that cultural

variation is deep, rather than superficial, favoring a position on the constructivist end of the spectrum. This puts considerable pressure on the strong forms of realism that have attracted philosophers in the literature on natural kinds, but other forms of realism are preserved, acknowledging social realities, structural disability, as well as lived experiences that profoundly impact individual.

14.10 – 14.20: Break

Session 7
Moderator: Kathryn Tab

14.20: Managing One's Cognitive-Emotional Life to Achieve Good Ends: Is Empathy Helpful? - Christopher Caulfield

14.40: Discussion

There is intuitive appeal to the view that empathy is helpful and desirable for moral development, motivation, and judgment. Prinz (2011a, 2011b) and Bloom (2016) have challenged that view; they make distinct arguments for the conclusion that empathy presents serious risks of error which make it, all things considered, so risky that one ought to avoid practicing affective empathy while forming moral judgments. Risks include biased judgement and vicarious distress leading to unhelpful avoidance responses. This paper contributes to the literature by comparing Prinz's sentimentalist account with that of Slote, and by conversing with a highly developed and underappreciated body of research in developmental psychology on stress reactivity and self-regulation. Research by Narvaez supports a view that moral experience involves a network of interconnected psychological, social, and neurobiological processes which underpin human morality, including capacities for self-regulation. I argue the following: (1) empathy is not ruled out as being necessary for moral development, for moral motivation, and for moral judgment (necessary in some situations, but not all), contra Prinz and Bloom. (2) For purposes of motivating prosocial behavior, research supports potential synergy between capacities for affective empathy, moral outrage, and guilt. (3) Recent research indicates that interventions to build capacities for self-regulation and related interventions such as meditation practice can mitigate risks associated with empathy, such as vicarious distress. (4) Embodied cognition, involving both affective and cognitive processes, is an epistemic resource for interpreting and communicating with others in ways which are impossible in the absence of embodied cognition. (5) Normative theories of moral judgment which advocate minimization or subordination of affective empathy fail to account for the potentially constructive role of affective empathy as an epistemic resource, and as a modulator of emotion regulation, moral development, moral motivation.

References can be obtained from the author: lvchris@gmail.com

14.50: From Affective Science to Psychiatric Disorder: Ontology as a Semantic Bridge – Rasmus Larsen and Janna Hastings

15.10: Discussion

Emotion, affect, and mood are a central aspect of diagnosis, treatment, and research into psychiatric disorders. Yet, there have been relatively few attempts to formalise the many different entities within the affective domain and their interconnections to the psychiatric disorders within the mental health domain. Studies detailing the relationships between sadness and depression, for example, or fear and anxiety disorder, or anger and intermittent explosive disorder, are significantly outnumbered by studies dealing with individual categories in isolation. This is unfortunate, since progress in mental health research and treatment depends on our ability to harness and integrate advances in basic biology, such as in genomics and neuroscience, and psychology and the cognitive sciences, but this integration is difficult to achieve without a shared, rigorous semantic framework encompassing both affect and psychiatric disorder.

The incentives to structure mental health research in accordance with rigorous semantic frameworks are becoming more and more manifest. This reflects a growing community-wide perspective that the standard practices of research in isolated diagnostic categories have not led to sufficient progress in relieving the burden of psychiatric disorder, and thus that a holistic semantic framework is both urgent and necessary, perhaps to a degree where research progress in mental health depends on its application and integration. One of the more ambitious efforts within this broader development is the *National Institute of Mental Health*'s *Research Domain Criteria* (RDoC) project. The RDoC project was initiated as an attempt to re-organize research efforts into studying upper-level traits (e.g. negative valence), instead of the traditional (heterogeneous) diagnostic categories. The motivation for this is partly that studying upper-level traits more genuinely reflects the dimensional nature of mental health diagnoses, but more crucially, that re-directing research efforts into a shared framework of upper-level traits is expected to facilitate a more efficient integration and sharing of knowledge across the relevant sciences.

However, although valence and arousal are central constructs in the RDoC, emotion, affect and mood are not explicitly defined therein, and the overall organisation of the RDoC matrix does not contribute to the conceptual clarity needed to integrate across emotion and psychiatric disorder. Indeed, the challenges researchers are facing in attempting such integrative work appear to be manyfold, of which a few are obvious. First, any concerted effort of studying emotion traits in mental health seems to presuppose fundamental agreements, such as, what *is* emotion, what *is* affect, and what *is* mood. Second, by relating emotion traits to psychiatric disorders we convey a message about emotional dysfunction in the patient, implying agreement on what exactly emotional *abnormality* or *dysfunction* is. Researchers (and practitioners) evidently disagree on such fundamental questions, but this should not necessarily be ground for pessimism about research progress. Importantly, as we shall suggest, such disagreements can be bypassed by embracing a shared *operational* set of semantics.

In this contribution, we propose such a semantic framework, more specifically, an ontological framework for explicitly capturing the complex interrelations between affective entities and psychiatric disorders. We build on and enhance the categorisation of emotion, affect and mood within the previously developed Emotion Ontology, and that of psychiatric disorders in the Mental Disease Ontology. This effort further draws on developments in formal clinical ontology regarding the distinction between *normal* and *abnormal* in order to formalise the interconnections. And as we shall demonstrate, this operational semantic

framework has significant relevance in many distinct applications including: *clarifying psychiatric diagnostic categories*, *clinical information systems*, *integration* and *translation* of research results across disciplines. Embracing this form of applied ontology has the potential to substantially attenuate the interdisciplinary efforts toward improving psychiatric treatment strategies.

15.20 – 15.30: Break

Session 8
Moderator: Robyn Bluhm

15.30: Affection for Thinness: Conceiving Anorexia and Bulimia using Spinoza's Affect Theory – Nathalie Zidanic

15.50: Discussion

The affect theory à la Spinoza was compatible with conceptions of mental illness emerging throughout the late 18th century. The non-causal and directly correspondent relationship between the movement of mind and body closely mirrors the current understanding we have of illnesses of the mind. I would like to put forth an understanding of anorexia and bulimia nervosa using Spinoza's take on passions and affects. I will speak to how the same affects can be brought about by different passions and how this fits into the recovery process.

17th century philosopher Benedict de Spinoza provided an account of affect within his *Ethics.* He established what is arguably one of the most extensive directories of passions of the human condition. For the most part, Spinoza categorized the passions as one of three primary affects: joy, sadness or desire. Each affect correlated with a different external influence; as such, Spinoza maintained that the variety of passions and emotions was undeterminable. The passions were conjunctive mind-body reactions that occurred as a result of external influences. The account of mind-body interaction Spinoza put forth separated the two conceptually yet saw them the same in essence. The mirror-like correlation he attributed to mind and body implied that external physical factors and subsequent passions affected both components of our being.

Anorexia and bulimia nervosa are currently the most fatal psychiatric disorders. Left untreated, approximately 20% of individuals die as a result of the harsh effects of anorexia and bulimia on the body. Eating disorders are complex and involve a series of emotions or passions; it can be argued that all three of the primary affects identified by Spinoza - desire, joy and sadness - are experienced by the anorexic and bulimic. Looking at the affects experienced by anorexic and bulimic patients, the same affects can be brought on by different passions and external stimuli depending on the patient's stage in their recovery. Typically, those in the throes of an eating disorder experience a cycle of desire for thinness, distress or sadness surrounding food and joyous satisfaction upon achieving weight loss. However, at a later stage in the patient's quest towards health the tables often turn: desire for recovery and the return to normalcy can be seen in lieu of a desire to attain thinness; joy is experienced as a result of entering remission rather than as a celebration of weight loss; sadness is felt as a reaction to the effects that the eating disorder has had on the individual and not as a reaction to food. Much like many other mental disorders, recovery from anorexia and bulimia is a long and winding road. It is interesting to note that there is often a point during recovery

where the same three affects can simultaneously be experienced as a reaction to both positively- and negatively- internalized influences; this is reflective of the turmoil that accompanies recovery.

The proposed presentation will aim to conceive of eating disorders in light of Spinoza's affect theory. I will categorize some common sentiments of anorexics and bulimics in the way that Spinoza categorized the passions through affects. Using Spinoza's conception of affects, passions and the relationship between the mind and body, I will strive to make sense of how those affected by eating disorders can experience both negative and positive variants of the affects through different passions brought on by a number of external factors. Ultimately, I will shed light on the complex experience of anorexics and bulimics, from the early stages of illness and through the process of recovery using Spinoza's framework.

16.00: The Emotional Life of the Schizophrenic – Abel Franco
16.20: Discussion

This paper is about the emotional life of the schizophrenic, in particular, (1) about the "negative symptom" of schizophrenia referred to in DSM-5 as "diminished emotional expression"; and (2) about what in her emotional life can be considered distinctive of the schizophrenic experience. For the psychiatrist, this may help determine whether there is anything *to be treated* regarding that emotional life (and what, and at which cost). For the philosopher, this may have important implications to test and revise philosophical theories of emotions as well as theories of the subject.

Numerous studies have shown that whereas schizophrenics seem to experience emotions in a way similar to non-schizophrenics, they also seem to show a lack or deficiency regarding the *expression* of their emotions (see. e.g. Kring's work). I will discuss first whether this could be understood as a *loss of reality,* understanding by such a sort of loss with respect to what we might consider within the range of *appropriateness* in our emotional *responses*. Then I will pay attention, in particular, to some of the explanations that have questioned the idea of the *loss* to understand similar symptoms in the schizophrenic. Among these explanations, particularly significant is Louis A. Sass's view in his *Paradoxes of Delusion* (1994) that the problem might not be so much a *deficiency* but rather as a "detachment from normal forms of emotion and desire" (p.12) or "a cerebralization of instinct and the body" (p.117)--or as others have interpreted the idea, as a sort of "hyperreflexivity" (ver Ecke and Grady, 2003), that is, an excess of *rationality* so to speak. Finally, I will open the question about whether, if the differences with respect to the non-schizophrenic do not fall—as it could be argued based on different studies—outside what might be proper of a self-controlled and (maybe) somehow pessimistic personality, we should say this represents a *disorder* that must be treated.

The second part of the paper will consist of an attempt to extract the *emotional world* that seems distinctive of the schizophrenic, especially what the lived experienced and its intentionality might reveal. In order to maintain the conversation with Sass, I will use mainly his own primary source: Daniel Paul Schreber's *Memoirs of My Nervous System*, and I will complement with the more recent self-account of her schizophrenic experiences by Elyn R. Saks, *The Center Cannot Hold* (2008). Is there something distinctive, in its etiology, intentionality or function, in the emotions the schizophrenic seems to experience--especially while undergoing different delusions or hallucinations? Which impact do these episodes have on the overall emotional life of the

schizophrenic and how does this resulting *schizophrenic emotional life* affect the life of the subject as a whole? (I will address at this point the suggestion that the emotional *episodes* the schizophrenic might go through while experiencing delusions or hallucinations might be comparable in some sense to the short *emotional lives* we might go through as we watch a movie or read a book—although with relevant differences as well, one being that in the latter case we seem to be able to have more control over our immersion in that emotional episode).

Within a broader point of view, Sass's view could be seen as a modern version of a long philosophical tradition regarding views of the subject—and, in particular, of the emotion-reason relation--that joins Plato and the Stoics to contemporary representatives of the so-called "judgment theories" of emotions (among whom R. Solomon and M. Nussbaum are significant representatives). On the other, the experience of the schizophrenic subject—both the lack of expressivity of lived emotions and the place of emotions within, as Sass views it, a "solipsistic lifeworld"—present challenges to theories of emotion (a key component of its constitution—the expression--and a key component of its function—sociability—seem to be questioned). It seems, though, that the so-called "feeling theories" (represented, among others, by J. Prinz and J. Robinson), given their emphasis on the body, would have more to explain if, in fact, the emotional experiences of the schizophrenic are not fundamentally different from those of the non-schizophrenic (recall W. James' "we do not cry because we are sad, we are sad because we cry").

16.30 Closing Remarks - Gerrit Glas and Jeff Bedrick