EPISTEMIC AND PSYCHOLOGICAL BENEFITS OF DEPRESSION

by

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ABSTRACT

In this thesis I propose a new way of understanding depressive illness as not exclusively harmful, but as related to particular, empirically evidenced, epistemic and pragmatic benefits for the subject, alongside the associated costs.

For each of the benefits considered, I provide and concisely analyse the empirical evidence both in its favour and against it, suggest ways in which these benefits could apply in the circumstances presented, discuss some outstanding problems for that application as stated, and describe potential implications. The issues discussed involve topics in cognitive psychology as well as in ethics, which I regard as complementary to the debate.

I take the view that depression related phenomena such as low mood, low self-esteem, and mood-congruent delusions offer potential benefits to a subject under certain circumstances, but not under others. In discussing the hypotheses presented, I argue for a more complex view of depression, which includes its potential epistemic and pragmatic benefits as well as its costs and I propose possible directions for future research.

For Graham, Helen, and Julian

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"You say you're 'depressed'-all I see is resilience. You are allowed to feel messed up and inside out. It doesn't mean you're defective-it just means you're human."

***David Mitchell**, Cloud Atlas*

INTRODUCTION

Depression begins when everything else slows down and when an infinite diversity of colours bizarrely fade to monochrome; where all that you have known so well become dead, cold and indifferent; where the only progression you make is to slip further downwards, further into the dark space of loneliness. The time ahead of you feels infinite: it has no shape and no limits; neither has it any handles to grab nor signposts to offer you a clue of where you are going. Ironically, your past has become your present, blindly galloping forward, still in a hurry, reminding you of all the chances you ever wasted, all the people you ever hurt, all the hopes you ever failed. Depression has the body of an old, bitter individual, full of self-pity, needle-sharp guilt, and bad intentions. She spits in your face, she calls you names, she says you are too old and too worthless to live; she takes away your heart, your will, and your senses. Slowly, with no warning signs or even a sound, with a magic wand of self-doubt, she turns you into a lifeless piece of rock. Without awareness, you suddenly enter the realm where life and death no longer matter, where love or hatred no longer exist and where anything you do no longer makes a difference. Depression is a detachment from life; it detaches you from yourself.

But depression is not at all poetic. Ironically, it can be almost banal: feeling too tired to get dressed in the morning or to wash the dishes up after last night, being too anxious to answer the phone or too afraid to open the letter. Depression can be quiet, cold and deserted, but it can also be busy and noisy, surrounding itself with drama, involving others in a reckless game of guilt and punishment. It may come as a long-repressed anger, as a postponed disintegration, as a rejected pain, an unwanted choice, or as a defence against joy. It may come invited or completely unwanted; it may come as a reaction to loss, as a no longer bearable memory of a childhood trauma, or it may slip into your life for no legitimate reason. Depression has touched the lives of all of us, one way or another, directly or through the eyes of the loved ones, and yet it remains the most poorly understood of all the forms of psychopathology (Seligman, 1975, p. 76). Many people mistake depression for sadness. We commonly use the expression 'being depressed' to describe feeling sad after something has gone wrong or when we grieve. Kay Jamison reflects on this common and unfortunate misunderstanding:

> Others imply that they know what it is like to be depressed because they have gone through a divorce, lost a job, or broken up with someone. But these experiences carry with them feelings. Depression, instead, is flat, hollow, and unendurable. It is also tiresome. People cannot abide being around you when you are depressed. They might think that they ought to, and they might even try, but you know and they know that you are tedious beyond belief: you are irritable and paranoid and humorless and lifeless and critical and demanding and no reassurance is ever enough. You're frightened, and you're frightening, and you're "not at all like yourself but will be soon," but you know you won't. (Jamison, 1996, Epilogue)

For those who suffer from severe depression, life becomes relentlessly bleak and meaningless. The lack of motivation makes sleep the only worthwhile activity if you only were able to fall asleep. The overwhelming and disproportionate guilt is the poison in a body and mind,

keeping you awake at night and casting a shadow on every minute of your day. Depression is living in hell.

On such a picture of despair, to ask whether there might be anything at all positive related to depression sounds ridiculous at first. It might be regarded as pathetic and naïve. The intensity of suffering and the number of lives that have been taken away by depression usually removes the question of possible benefits out of the picture.

Being aware of the above risks, I take up the challenge and ask: is there anything at all positive about depression? It is not my intention in this thesis to cast a doubt on the established facts related to the enormous harm and suffering caused by depression, neither do I want to deny that it is an illness that can be treated by pharmacological, behavioural or cognitive means. My intention here is to propose a new, more complex way to think about depression, as a source of unique experiences associated not just with mental and physical harm, but also with certain short- or long-term benefits of cognitive, emotional, pragmatic and epistemic character. Here I use the word 'benefit' to indicate a local and context-dependent advantage which does not necessarily translate into a source of *value*. For example, when children play on the edge of the river bank it might be beneficial for them to be warned by a loud shout in order to stop them falling into the river. However, in other circumstances (for example, when reading a book at home), being unexpectedly shouted at might not be perceived as beneficial and may not contribute to their wellbeing.

I want to show that depression is an experience which can sometimes constitute a creative force; an experience which has the potential to teach us more about ourselves, if we only want

to listen; an experience which might support us in noticing the truth, when others choose to put on rose-tinted glasses; an experience which equips us with greater empathy and urges us to search for a deeper meaning. My hope for this thesis is that once we see the wider picture of this undoubtedly harmful and difficult illness, we shall be able to help those who suffer make more sense of their puzzling and unwanted experience.

The impetus for this work is a direct but complex result of my repeated reflections and insights, made upon the number of consultations and therapy sessions I had over seven years with people who suffered from depression. These encounters were as beautiful as they were difficult; they were full of hope and they were full of exhaustion; they were filled with emotional drama and they were filled with sixty minutes of blunt silence. The story of every person was different and-at the same time-all the stories were somehow similar. After having heard many of them throughout the years of my psychological practice I came to conclusion that the common link for all the stories about depression is one's feeling of resignation: resignation from attachment, resignation from involvement, resignation from giving attention, resignation from getting up, resignation from showing up, resignation from saying 'yes' and resignation from saying 'no'; resignation from living here and now, resignation from having hopes and dreams, resignation from trying and from fighting. Depression felt like a crush of the mental immune system. It felt like there was nothing left for people to hold on to, nothing to get happy about-or at least they were somehow unable to see it.

However, as their stories unfolded, they started taking new, unexpected, interesting turns, often revealing that there was more to the experience than the excruciating pain of surrender. Whilst my role, as a cognitively-oriented therapist, was to re-focus clients' attention away

from depression towards more positive aspects of their lives, it frequently occurred, much to our mutual surprise, that some of the 'good' things came into clients' experience together *with* depression, rather than *despite* it. In other words, people frequently made a discovery, that some of the positive aspects of their lives had not been available to them before their depression started. For example, one of my clients who had been suffering from depression for many years discovered that the illness made her more open to the suffering of other people. This openness gradually led her to take up a volunteering job in a charity helping young people fighting addictions. Despite battling her own illness, this woman was able to see the potential in her own enhanced emotionality and, with therapeutic support, consequently act upon it in order to make sense of her depressive experience. A number of recent empirical studies, both in social psychology and neuroscience, provides evidence that depression is highly correlated with empathy, a claim which I further investigate in Chapter 5 of this thesis. In the case of my client, such a connection has not only been discovered but also, by having been acted upon, turned into an altruistic achievement, a therapeutic tool in its own rights.

Another example comes from the memory of a man whose long-term depression prevented him from working. Working previously as a manager of a busy public relations agency, he used to be responsible for organising large music events, liaising with a variety of people, working under time pressure, carrying a heavy responsibility for famous people's time and money. After he fell ill, this man felt he could no longer fulfil his job's demands and took an extended time off needed for recovery. Encouraged to record his days and express his moods and feelings with pen and paper, this man discovered his love for writing. With his consent, one of his artist friends turned his writings into song lyrics and went on to perform them at

public events. This client of mine found a new passion for writing and never looked back on his old job. The suggestion that suffering from depression enhances our creative potential is perhaps the most widely researched claim out of all the claims regarding beneficial aspects of depression. Chapter 6 explores this in more depth and addresses the key questions related to creativity and depression.

It may be argued that the above examples are rare; that the majority of those who experience depression will have no chance to discover new talents or to change their careers as the result of their experience. Some of the people affected by the illness may not even have the opportunity to receive psychological support and, therefore, their chances of finding similar encouragement will be limited. Whilst it is true that depression does not reveal its beneficial sides and that in order to find them much time and effort is needed, the possibility of depression–related benefits is a huge and important discovery both for the psychological treatment of people affected by the illness and for philosophy.

The time for pursuing this issue could not be more appropriate, as the exploration into the practical use of possible benefits of human cognitive and emotional imperfections has recently started. The idea that people may epistemically or psychologically benefit from otherwise harmful experiences may sound familiar to psychoanalytically oriented psychologists but is still relatively new to philosophers-with some exceptions. It has been my privilege and pleasure to be a part of the team which pioneered such research in the United Kingdom. Based at the University of Birmingham, Lisa Bortolotti and the project PERFECT team (which I joined from October 2014 to September 2017) made a series of philosophical inquiries into the complex nature of mental imperfections, providing arguments for their

epistemic and psychological benefits (see for example Bortolotti and Antrobus, 2015; Antrobus and Bortolotti, 2016; Bortolotti and Miyazono, 2016; Sullivan-Bissett et al., 2016;). The notion of epistemic innocence, developed by Bortolotti (2015b), has been primarily applied to beliefs and suggests that some beliefs that are epistemically costly, because they are inaccurate or weakly supported by the evidence, can nonetheless play an important epistemic role, for instance by allowing the person to remain connected with her environment or react to the often paralyzing effects of anxiety on learning.

Another example of related philosophical inquiries is the model of value-based medicine (VBM) (e.g. Jackson and Fulford, 2002; Fulford, 2004; Fulford, 2011). The proposition here is that the values underlying mental illness are legitimately diverse: depression can be evaluated as either a positive or a negative experience, depending on the person making the evaluation. The proposed value-based practice that follows from that approach relies on a number of factors and in particular, specific *clinical skills* that can be learned to support balanced decision-making where values conflict. The values in question apply predominantly to ethics, but also encompass values of many other kinds-preferences, needs, hopes, expectations, and so forth-and all these are important areas of values in medicine (Fulford, 2008). According to Fulford, the most important reason for the inclusion of values in medicine has to do with the emergence of a model of patient-centred practice in which the values of individual patients are principal to evidence-based clinical decision-making. Fulford's proposition is close to the approach presented in this thesis in such respect that a particular depression-related experience might be regarded as either costly or beneficial for the subject depending on one's subjective evaluation and their personal circumstances. In

some cases, the same experience turns out to be both costly and beneficial, contradicting the stereotypical clinical view of depression as an exclusively harmful phenomenon.

Researchers rarely speak directly of the possible beneficial aspects of mental illness; those who do, focus predominantly on bipolar disorder: illness-related characteristics such as elevated mood or quicker mental associations seem to offer more immediate and measurable benefits. For example Galvez and colleagues (Galvez et al., 2011) provide a short review of empirical evidence pointing at correlations between bipolar disorder and various personality traits such as spirituality, empathy or creativity. Kay Jamison (Jamison, 1993; Jamison, 1995) in turn offers extensive research exposing links between creativity and bipolar disorder, predominantly in famous artists. Finally, Nassir Ghaemi (Ghaemi, 2010; Ghaemi, 2011) shows that affective disorders might sometimes have a beneficial impact on personality; the author argues that many famous people such as Winston Churchill or Abraham Lincoln were able to achieve extraordinary things in life not *in spite*, but *because of* the illnesses they were battling.

However, the very argument which I develop in this work, that – in certain circumstances – symptoms of depression can deliver epistemic and psychological benefits to the subject alongside the associated costs, has not yet been made. One explanation for this gap in the literature is that the psychological and epistemic costs of depression are so obvious that the very possibility of them being somehow good for us is dismissed before being carefully examined. The existing psychological, philosophical and psychiatric literature tends to focus exclusively on the harmful effects of depression and to identify strategies to ‘treat' them or to correct them. Very rarely are intellectual or clinical resources dedicated to the detection of

beneficial aspects of depressive symptoms, and when some benefits are identified, they are approached as interesting but practically unhelpful marvels. This is also due to our current Western frameworks of mental wellbeing, which promote continuous 'optimism' attitude in life and prioritise it over other virtues such as strong character, knowledge or altruism. Meanwhile, as the mounting empirical evidence shows, optimism can sometimes be associated with serious psychological and epistemic costs to the subject (e.g. Baumeister et al., 1996; Robins and Beer, 2001). For example, overly optimistic people frequently fail to make rational and unbiased decisions, often with catastrophic consequences; they are also prone to positive illusions about reality, preventing them from making accurate judgements about themselves and self-related circumstances. It is by no means my intention to discourage anyone from having a positive attitude in life; this has been repeatedly linked to good health and better achievements. My intention is rather to show that the links between low mood, pessimism and their costs and benefits are more complex than it is sometimes presented both in clinical literature and in popular science. Too often we are told that being optimistic is undoubtedly 'good' for us, whilst feeling sad or having low self-esteem is 'wrong' and ought to be treated. The story behind depression is more complicated and deserves thorough multi-disciplinary research in order to determine what exact function various symptoms have to play in one's life. This is both a difficult and a long-term task. The ambition of the thesis is therefore twofold: in the first place, based on empirical evidence, I will argue that depression is not an exclusively harmful phenomenon, but is related to particular epistemic and pragmatic benefits for the subject, alongside associated costs. Secondly, I will conclude that certain depression-related phenomena are beneficial to the subject under certain conditions, but not under others.

My methodology is to critically analyse and to evaluate empirical literature and make my own arguments based on the conclusions. My investigation into the question of whether depression might be linked to any benefits has brought in some interesting and unexpected results. The claim that depression can be somehow 'good' for us, received a considerable amount of attention in empirical science. Out of a large amount of research I selected seven returning themes, indicating *realism*, *defensive pessimism*, *self-handicapping*, *mood-congruent delusions*, *empathy*, *creativity* and *spirituality* as alleged beneficial traits associated with depression.

Throughout the thesis, I present and analyse selected empirical literature exploring links between depression (or certain clinical symptoms related to depression) and the seven benefits of psychological, epistemic or/and pragmatic character. For each of the benefits considered, I provide and concisely analyse the empirical evidence both in its favour and against it, suggest ways in which these benefits could apply to the circumstances presented, discuss some outstanding problems for that application as stated, and describe potential implications.

I begin in chapter 1 by providing an overview of the phenomenon known as *depressive realism*, the claim that people who suffer from depression make more accurate inferences about reality than 'healthy' individuals. I carefully examine the empirical evidence for and against such a claim and outline the applications and constraints. I show that the phenomenon of depressive realism is real for people who suffer from mild or moderate symptoms of depression, but not for individuals suffering from severe, clinical forms of the illness. Moreover, I show that the circumstances in which depressive realism is observed, relate to the self and self-associated circumstances, but not to other situations.

Can symptoms of depression enhance wellbeing? In chapter 2 I present examples of practical applications of *low mood, low self-esteem*, and *anxiety*. Based upon the investigation into the empirical literature I show that these depression-related symptoms may play the key role in successful implementation of *defensive pessimism* and *self-handicapping;* these are psychological strategies, the role of which is to protect the subject from greater psychological harm.

In chapter 3, building on the conclusions coming from the previous chapter, I take a closer look at the phenomenon of *positive illusions* in order to address the question whether holding unrealistically optimistic beliefs with regards to oneself is a hallmark of mental health, as suggested by some authors (for instance Taylor and Brown, 1988; Taylor, 1989). Based on the review of psychological literature I argue that unrealistically positive self-related beliefs come at a serious psychological costs, and that therefore, they cannot be considered as psychologically beneficial. Instead, I argue that optimistic self-related beliefs grounded in realistic evaluations are more desirable than illusions and linked to psychological benefits.

In chapters 4, 5, 6 and 7 I provide a detailed analysis of the empirical literature investigating alleged beneficial aspects of depression. In chapter 4, based on psychological cognitive theories, I develop my own analysis of what is involved in the process of forming depressive delusions. I propose that depressive delusions constitute acknowledgements of self-related beliefs acquired as a result of a negatively biased learning process. Furthermore, I show that the key role of mood-congruent delusions in depression is to preserve a person's overall coherence and narrative identity at a critical time. Therefore, I argue that depressive delusions have the potential for psychological and epistemic benefits despite their obvious epistemic

and psychological costs. From this point of view it is possible to view mood-congruent delusions in depression as *epistemically innocent* (Antrobus and Bortolotti, 2016).

In chapter 5 I expand my search for beneficial aspects of depression by looking into associations between depression and empathy. Based on the data coming from psychology and neuroscience I argue that people who suffer from depression show elevated levels of empathetic response to the suffering of others. Next, I ask whether enhanced empathy in depression can be seen as beneficial. Upon further analysis of the empirical literature, I show that the answer is a complex one. Deeper empathy in depression is evidenced to be linked to increased personal distress and, in a majority of cases, does not constitute a basis for charitable action. From this viewpoint, increased empathy cannot be seen as a beneficial trait. However, in many cases, it has also been linked to temporary relief from loneliness and strengthening the feeling of social belonging. On this basis, it is possible to see enhanced empathy in depression as a source of a particular psychological benefit, in spite of associated costs.

Chapter 6 is occupied with an investigation into the links between depression and creativity. I provide the detailed overview of the empirical literature dealing with the question of whether people who suffer from depression are more creative. Based upon the available evidence I argue that depressive symptoms are evident among famous artists (especially poets), but not in the general population. Based on a further investigation into psychology and neuroscience I offer a possible hypothesis to explain this phenomenon. I argue that famous artists are more likely (than people in the general population) to exhibit a specific, spontaneous and automated mode of creation, which has been empirically linked to certain depressive symptoms.

Finally, in Chapter 7, I assess the empirical evidence examining the claim that depression is associated with enhanced spirituality and religiosity. I propose that the concepts of religiosity and spirituality should be understood as distinct, on the basis that they involve different types of experience and associated behaviour. Drawing on the empirical data I show that by offering one's life a meaning, spirituality has been linked to better mental health. However, routinely following religious practices with no sense of deeper connection has been repeatedly associated with low mood and other symptoms of depression. Interestingly, on the other hand, attending religious orders and ceremonies frequently offers a sense of belonging to the wider community and prevents loneliness. This leads to the conclusion that although spirituality and/or religiosity cannot be seen as direct benefits of depression, they can – under certain circumstances – support psychological wellbeing and mental health, and therefore, they may be actively used in depression prevention strategies.

The last part of this work contains my final conclusions, together with some suggestions for future research.

CHAPTER 1: REALISM

This chapter presents a critical analysis of a certain conception of the relationship between mood spectrum in depression and the accuracy of one's judgements. More specifically, I want to take a closer look at the phenomenon known in cognitive psychology as a 'sadder but wiser' and ask whether it is true that people who suffer from depression are in any way 'wiser' than those who have not been affected by depressive symptoms.

As depression is commonly perceived as a mental illness that compromises wellbeing, the analysis offered in this chapter puts special emphasis on the rather overlooked question of whether the symptoms of depression may deliver any benefits despite the harm they cause. Specifically, I will investigate the impact of depressive mood on the accuracy of one's beliefs.

For a very long time I have been intrigued by the popular idea that pessimists seem to be 'wiser' than optimists, where 'wiser' is understood (in the folk view) as 'more realistic' or 'more detailed' in their beliefs about the world. The traditional clinical definition of depression as an exclusively deteriorating mental illness seemed to me merely evasive, and the philosophical question of possible links to 'wiser' cognition, neglected. I have written this chapter with a desire to investigate this possibility in more detail.

The analysis presented here is largely based on a thorough inspection of the available empirical studies. Historically, there have been a number of either enthusiastic advocates or sceptical opponents of the idea that 'feeling low' may somehow enhance the accuracy of human thinking. Both enthusiasts for and opponents of the phenomenon (nicknamed as

‘depressive realism’) still wave the files of data in support of their view-and their evidence, surprisingly, seems equally reliable.

During my work as a clinical psychologist and psychotherapist I met many wonderful people, whose lives have been greatly affected by depression. Their ability to see the world as a friendly place and to greet every new day with hopeful excitement (abilities, which many of us take for granted) was long gone and with no prospect of a quick return. At the same time, despite their generalised pessimism and overwhelming sadness, many of them could offer a detailed and accurate analysis of their own circumstances during therapeutic encounters. Whilst talking to a person diagnosed on the depressive spectrum of conditions, I often felt amazed by the amount of detail they provided when describing recent events or recalling particular memories. I did not feel satisfied with the functioning definition of depression as a ‘debilitating mental illness’ and believed, rather intuitively, that the clinical description of cognitive and emotional deficits related to depression was only one side of the more complex story. I saw many people who despite being categorised as ‘depressed’ coped well with reality thanks to their unique insight into the limitation of their own mental resources. I also saw many ‘depressed’ people who-in the final analysis-put much more conscious reflection and incomparably more detailed attention into some aspects of reality than most ‘healthy’ individuals I knew.

These encounters led me to believe that there might yet be some, unexplained factor (or factors) in depression, which enhances the accuracy of one’s beliefs. I decided to make an attempt to investigate whether-and under which conditions-such a hypothesis was true. This chapter presents the results of my investigation.

In section 1.1 I review and assess the relation between depression and the thinking presented in philosophy and fiction. In section 1.2 I turn to the notion of depressive realism itself and describe its epistemic features that can be constructed as the acquisition of more accurate beliefs with regards to certain aspects of self and reality. In section 1.3 I consider empirical evidence supporting the claim that certain factors in depression carry epistemic benefits to the subject. Subsequently, in section 1.4, I review and analyse empirical studies providing evidence against such a claim. Finally, in section 1.5, I argue that certain depressive symptoms (namely, depressive mood) may lead the subject to the acquisition of more accurate beliefs related to self, and therefore might be seen as epistemically beneficial.

1.1 DEPRESSION AND THINKING

What is the relationship between depression and thinking? Or to put the question in a different way does one's thinking change together with the experience of depression? Aristotle, who famously claimed that the insight coming from melancholy is of great value for self-knowledge (*Problemata* XXX.1 953a10-14) made an important discovery, the significance of which has not yet been fully recognised until now. Following the development of the clinical view of depression as a mental illness which leads to the deterioration of one's cognitive and emotional processes, philosophers have mainly been focusing on illness-bounded human suffering and distempered mood. Whilst psychiatric investigations were focusing on 'clinical symptoms' and argued about 'diagnostics', countless phenomenological works offered a unique insight into personal narratives and subjective experiences of depression-an insight impossible to overestimate (Ratcliffe, 2014) Similarly, striking examples of depressive

narration come from the literature and other works of art, depicting intensity of human emotions woven with pain, sadness, regret and guilt, to name only a few. It seems apparent that the cognitive side of such dramatically portrayed emotional states will be implicated as similarly impaired belief states: I am worthless, incompetent, sinful, nothing good will happen to me, and so on (Radden and Varga, 2013). Thinking about oneself and about the world in depression will have to be dominated by generalised negativity, judgements of one's own failure, expectations of things going wrong, ruminating on past mistakes and in the most severe forms of the illness by delusions. Indeed, one of the most popular psychological accounts of depression (so-called cognitive model) provides strong empirical evidence in support of the view that depressive thinking is dominated by negative bias and other cognitive errors, such as 'learned hopelessness' described by Martin Seligman (1972) as a phenomenon of not attempting an effort after previously having failed in a particular task.

What kind of insight then did Aristotle have in mind when he suggested that melancholy (as chronic sadness was called those days) helps one acquire self-knowledge? Is not such a claim counter-intuitive given what we now know about depression, and what has been measured and evidenced in countless experimental settings? Are there any forms, or elements, of depressive thinking, which might be related to more accurate or more realistic beliefs, as opposed to what is assumed by clinical theories of depressive thought disorders and irrationality?

There has been a surprisingly long gap in time between Aristotle's claim and empirical findings which shed some light on the evidential implications of his words. Only in 1979 two experimenters, Alloy and Abramson (students of the renowned cognitivist Seligman),

accidentally discover an intriguing relation: people who experienced symptoms of depression were more realistic than healthy participants, when assessing their own control over uncontrollable (random) events. The results of this study were repeated in subsequent trials. The suggestion, that people with depression may think in any way more realistically, more accurately, or, colloquially saying, be wiser with regards to reality than healthy ones was simply counter-intuitive and contradicted all the earlier presumptions.

The phenomenon of depressive realism, as the discovery has been named, became an attractive subject of on-going debates in scientific and literary circles; the related question ‘are sadder people also wiser?’ became a central point of philosophical speculations. Quite rightfully, the wisdom-loving discipline had more interest than others in discovering the truth about depressive thinking. Perhaps Aristotle was right, after all? An idea that one’s beliefs may be closer to truth when one experiences sadness sounds like an interesting one. Some argue that the best philosophers are melancholics, therefore, there must be a strong link between these two (see for instance Schwitzgebel, 2015). Depressive realism has become an inspiration for novelists, who, drawing on the discovery, spoke about the ‘sad nature of life’ through the mouth of their fictional characters (e.g. see. Houellebecq, 2006) kept passing on the message that life is in its nature bleak and unkind (Jeffery, 2011).

In sum, the idea that sad people know better or know more became an inspiration for many interpreters, artists and free thinkers and gave rise to countless works of art and intellectual debates. However, do the ‘sadder but wiser’ experiments support the idea that it is better to be realist? Is the hypothesis that people with depression are wiser than others true or is it merely wishful thinking?

This is the basis for my investigation into the nature of depressive realism. In the next section, I will examine the available empirical data starting from the original experiment by Alloy and Abramson, followed by subsequent variations of this famous study in order to determine whether particular symptoms of depression might indeed be related to more realistic insight. Such a hypothesis, if confirmed, would mean that having a mental illness (which has been commonly associated with a mark of irrationality and thought disorder) might be actually linked to certain epistemic benefits.

1.2 DEPRESSIVE REALISM

Depressive realism is the thesis that people with depression make more realistic inferences than 'healthy' individuals (Alloy and Abramson, 1988). The term refers to the phenomenon discovered in 1979 in a series of experiments designed around assessing the judgment of contingency tasks (Alloy and Abramson, 1979). Participants are asked to press a button and observe whether or not pressing the button results in a light switching on. In reality, the experimenters have predetermined the frequency of illumination and participants have no control over its occurrence. The *dependent variable* (that is, the factor which is a subject of measure) is the participants' judgment of causal dependence between switching on the button and the light switching on. In other words, the participants are asked to estimate how much control they think they had over illumination (that is, to assess whether the light came on as a result of them pressing the button). In reality, the illumination was pre-determined by experimenters and independent of the participants' actions.

The results of this estimation were very surprising for the experimenters. The assessments made by participants with depressive symptoms turned out to be more accurate than those made by 'healthy' individuals. The difference between the two groups was statistically significant and repeatedly confirmed. People with depressive symptoms judged their control over the illumination correctly: their judgment of contingency was convergent with reality. At the same time, judgments made by individuals without depressive symptoms have been shown to exhibit a positive cognitive bias. Healthy participants significantly overestimated the degree of control they had in the contingency task.

The two phenomena-the accurate inferences made by people with depressive symptoms and the positively biased judgments made by healthy individuals have been since referred to, respectively, as depressive realism and the illusion of control.

1.3 SADDER AND WISER?

The outcome of Alloy and Abramson's experiment surprised the scientific world. If the authors' conclusion was true, the view of depression as the condition associated with negatively biased cognition was wrong. According to at least two significant and well-established theories of depression, i.e. Beck's cognitive theory (Beck, 1967, Beck et al., 1979; Beck 1987) and Seligman's 'learned helplessness' model (Seligman, 1972), this clinical condition was associated with an overall negative bias, consisting of deeply held dysfunctional beliefs about the self, the world and the future. The implication was that in

people with depression cognitions were systematically less informed by reality, and therefore more irrational than in people without depression (Beck, 1987). The new 'depressive realism' hypothesis (hereafter, DR) presented an alternative view to what had been believed so far: individuals who experience symptoms of depression are capable of making realistic inferences about certain aspects of reality. What is more, they do so to a greater extent than 'healthy' individuals, at least in some specific circumstances.

The results obtained by Alloy and Abramson shed a new light on the phenomenon of depression. Could people who experience depressive symptoms really be closer to the truth in any domain than 'healthy' individuals? This question seems to be of vital importance for clinical research. Indeed, to find the right answer could mean a better understanding of the nature of depression-associated cognitive processes and of elements of depressive aetiology, and, most importantly, could lead to new, more effective therapies.

But to understand the phenomenon of DR is also a critical challenge for epistemologists. DR can shed light on (1) how people acquire knowledge about reality and about themselves, (2) whether they process information about themselves differently from information about others, and (3) what makes their representations more accurate in some circumstances. A reflection on the epistemic aspects of the DR hypothesis could help us understand our cognitive capacities and limitations. So far, it has not been clear to what extent people with depression are capable of holding more realistic beliefs. The set of psychological studies examining DR is broad and immensely diverse in terms of design and measured variables, including experiments' settings, types of participants, variety of empirical tasks and methods. Whilst

making the reader aware of all those differences, which might affect the way the experimental results are interpreted, I want to pay special attention to two factors.

The first one is the way in which the authors define depression itself. This aspect is especially important because the nature of the depressive spectrum is distinct and complex; in order to meaningfully claim that depression is linked to the acquisition of more realistic beliefs, we ought to reach at least minimal agreement on what we take depression to be.

The second factor I want to focus on is the content of participants' judgments, more specifically, what exactly was measured in subsequent studies. Similarly to depression, the notion of 'accurate judgments' has been deployed imprecisely in a range of different contexts. As we saw, the original assessment of accuracy referred to the estimation of agents' control over externally determined events (Alloy and Abramson, 1979). Since the Alloy and Abramson study, the notion of accurate judgement has been stretched and applied to a variety of cognitive tasks, including accuracy in making financial decisions for other people, accuracy in recalling events from the past, or even accuracy in predicting future events, such as the results of sport games.

Alloy and Abramson used a slogan to talk about their discovery of the DR effect, 'sadder, but wiser'. The label is catchy and seems to convey the main message that the authors hoped to spread into the scientific world: people affected by depression feel less happy than controls but their beliefs seem to be more realistic. Unfortunately, in hindsight, this slogan has not contributed to meticulous research. Colloquial meanings of both adjectives ('sadder' and 'wiser') have been used in subsequent research to either support or deny the Alloy and

Abramson's conclusion even when they used the terms 'sad' and 'wise' with different connotations from the original ones, and applied them to an excessively broad range of contexts.

In the next section I will examine and analyse the empirical evidence supporting the claim that DR is a real phenomenon-people with depressive symptoms are capable of making more accurate judgments about certain aspects of reality than 'healthy' individuals.

1.3.1 Empirical findings in favour of DR

Here I examine a selection of empirical studies which support this hypothesis. To present the evidence in the clearest possible way, I adopt a *paradigm-centred* approach. I split the reports into five categories, based on the type of variable measured (that is, the topic of the participants' judgments), with the studies of the closest similarity to the original study by Alloy and Abramson at the beginning. Reviewing the evidence this way highlights the evolution of DR in the empirical literature.

First I shall present the studies whose focus resembles most closely that of the original Alloy and Abramson study. The objective of these studies is to either replicate the results of the experiment by Alloy and Abramson (1979) in similar circumstances, or to examine comparable data in a variety of differing predetermined contingency conditions (Abramson et al., 1981; Alloy et al., 1981; Martin et al., 1984; Ford and Neale, 1985; Vazquez, 1987; Dobson and Pusch, 1995; Presson and Benassi, 2003).

Second, I shall review studies utilizing a slightly different methodological paradigm. Here, the participants get involved in various tasks; next they are asked to rate their performance in

either the presence or absence of external feedback. Their self-appraisal is then compared to their actual performance in order to check its accuracy (DeMonbreun and Craighead, 1977; Nelson and Craighead, 1977; Rozensky et al., 1977; Lobitz and Post, 1979; Gotlib, 1983; Dennard and Hokanson, 1986).

Third, I shall consider studies investigating *self-related expectancies* (predictions related to one's own future). The novelty here is the reference to future events, rather than the judgments about past performance that were examined in the previous two clusters of studies. Both groups of participants are asked to predict their success or failure in a variety of tasks, or, alternatively, to forecast the probability of the future events of either positive or negative character-e.g. getting married or becoming terminally ill (Golin et al., 1977; Alloy and Seligman, 1979; Alloy and Abramson, 1980; Kapci and Cramer, 1998; Keller et al., 2002; Hoerger et al., 2012; Thimm et al., 2013; Garrett et al., 2014; Korn et al., 2014).

Fourth, I shall consider the results of the studies investigating judgments related to people's real-life experiences. Unlike previous reports, which followed the laboratory based response-outcome procedure, studies in this category are largely focused on a person's actual life events. Here I shall examine differences in judgments of personal relationships, state of health and other life circumstances between participants with-and without symptoms of depression (Clare et al., 2011; Gordon et al., 2013; Mograbi and Morris, 2014).

1.3.1.1 DR in self-judgments of control

What does it take to be 'depressively realistic'? Consistent with the original Alloy and Abramson's findings, a number of subsequent studies provide evidence for the DR hypothesis in tasks of estimating one's own control over pre-determined conditions.

Intrigued by the initial discovery that people with depressive symptoms accurately judged their control over random events, whilst 'healthy' individuals were prone to illusions and biases (Alloy and Abramson, 1979; Alloy and Seligman, 1979; Abramson and Alloy, 1981) the researchers aimed to test whether this effect can be obtained, when moods are induced experimentally (Alloy, Abramson and Viscusi, 1981). In this interesting study, depressive and elated moods were induced transiently in naturally (where the word 'naturally' refers to the participants' mood *prior to* the experiment) non-depressed and depressed students, respectively. Next, the participants' judgment of contingency was assessed. It turned out, that healthy participants who then were made temporarily sad went on to give accurate judgments of contingency, while naturally sad students who were induced with an elated mood showed an illusion of control and overestimated their impact on an objectively uncontrollable outcome.

The results of the above study deserve special attention: the conclusions that can be drawn from Alloy, Abramson and Viscusi's experiment not only offer support for DR, but also indicate that low mood, more than any other symptoms of depression, might be linked to realistic judgments. When induced in experimental settings, the mood shifted participants' beliefs to the opposite (as to 'natural' state) effect.

The other conclusion from Alloy, Abramson and Viscusi's experiment is even more intriguing. If elevating sad moods results in the illusory self-related beliefs, how does it affect the aims of cognitive therapy for depression? It has been believed that people with depressive symptoms show a negativity bias which leads them to believe that they have little or no control over own lives. Cognitive therapy has been perceived as a way to help people learn to see themselves as having more control. Meanwhile, the presented study suggests that cognitive therapy might instead be 'tricking' people into positive illusions, that is, positively biased self-related judgments.

Do people get happier at the expense of their accuracy and objectivity? The case of DR and cognitive therapy for depression illustrate, to some extent, such a possibility. It may seem that wellbeing is safeguarded at the expense of truth when the positive illusion is successfully adopted. What is more, one could argue that the techniques, which enable us to perceive our impact on reality in a positively biased way, can be learnt and manipulated in real life, similarly to what happens in the experimental settings. Such a view has been supported by more recent studies (e.g. Wegner et al., 1987; Kunda, 1990; Baumeister and Newman, 1994; De Bono and Muraven, 2013), which show that in order to live successful lives and achieve their goals, people use a variety of cognitive enhancement techniques, related mainly to self-control and will power.

1.3.1.2 DR and the recall of self-performance

In the studies investigating the self-assessment of a task performance, participants get involved in a task, and then rate their own performance with-or without the benefit of the feedback. Next, their evaluation is compared to their actual performance in order to check its

accuracy. Out of all the recall studies analysed, a vast majority confirm the theory that people suffering from depression exhibit more realistic assessments. Interestingly, some of the presented studies had been conducted even before Alloy and Abramson articulated their 'sadder but wiser' idea. Although, for some reason, the earlier research did not attract closer attention from the scientific community, the results obtained are just as intriguing as later, better known examples.

In the study conducted in 1977 by Nelson and Craighead, the participants are asked to engage in a task, after which they are given feedback. The feedback consists of either positive reinforcement or punishment. After having completed the task, participants are asked to recall what amount and what type of feedback they received. It turns out that participants with depression recall their feedback correctly, whilst non-depressed subjects underestimate the frequency of negative feedback. Whilst analysing the results, at least two limitations are in order: firstly-the participants exhibit low mood rather than suffering from severe forms of depression (similarly to the study by Alloy, Abramson and Viscusi, 1981). Secondly, the results were obtained only in the circumstances of low frequency of negative feedback. In the presence of a high amount of negative comments, the difference in accuracy between 'low mood' group and controls was no longer significant.

The results obtained by Nelson and Craighead were replicated in other studies (e.g. DeMonbreun and Craighead, 1977; Rozensky et al., 1977; Lobitz and Post, 1979; Gotlib, 1983; Dennard and Hokanson, 1986). These findings suggest that while 'healthy' people may filter out a certain amount of low frequency negative feedback in order to maintain a positive self-image, people with depressive symptoms remain particularly sensitive to the instances of

punishment. Also, because the results are no longer significant at a high level of negative feedback (people with low mood *overestimate* the amount of punishment they receive), it might be hypothesised that low mood supports accurate judgments only in a situation of limited negative experiences. In other words, if we attempted to interpret the above results in a real-world situation, it could be claimed that low mood is related to more realistic beliefs (thus, bringing epistemic benefits) only under the condition that the subject is not exposed to an excessive amount of negative experiences (punishment). In the circumstances of a large number of adverse experiences, realism might be replaced by an overall negative bias.

1.3.1.3 DR and self-related predictions about the future

This group of studies aim to test whether people with depression-related experiences exhibit a negative cognitive bias in their expectations and updating beliefs about future events related to themselves (e.g. Golin et al., 1977; Alloy and Seligman, 1979; Alloy and Abramson, 1980; Kapci and Cramer, 1998; Keller et al., 2002; Hoerger et al., 2012; Thimm et al., 2013; Garrett et al., 2014; Korn et al., 2014). According to cognitive theories, depression is linked to an overall pessimism about one's personal future (Sharot, 2011). For example, when evaluating the likelihood of encountering positive and negative everyday life events (e.g. being invited to a party or getting a parking ticket) within the next few weeks, people with symptoms of depression would expect more negative and less positive events than they eventually experienced, whereas 'healthy' subjects show the opposite pattern (Cropley and MacLeod, 2003; Strunk et al., 2006; Strunk and Adler, 2009).

The aim of a study by Korn and colleagues (2014) is to check whether people with and without symptoms of depression would update their predictions as a result of being informed

by reality. First, the participants are asked to estimate the likelihood of experiencing desirable and non-desirable events in the future. Next, they are confronted with the comparable statistical data (consisting of the overall statistical probability of such events), their ability to update their beliefs is assessed. The results of this experiment show that when updating their beliefs, 'healthy' people exhibit positive bias: they overestimate the likelihood of positive events and underestimate the likelihood of negative ones. The updates made by people with symptoms of depression are more accurate.

The results of this experiment seem to support the hypothesis of DR, but – again - a couple of considerations ought to be taken into account. Firstly, although the updates made by people with depression-related symptoms seem accurate, the effect seems to apply only to the circumstances of negative life events, but not to the desirable ones: in the latter situation people's updates exhibit a negative bias. Secondly, the results are conclusive only in the subjects with light or moderate depression; people suffering from Major Depressive Disorder (MDD) present a negative bias in all experimental circumstances (Korn et al., 2014). Not surprisingly, in accord with the cognitive theories (e.g. Beck et al., 1979), people with severe depression present a pessimistic view of the future and overestimate the likelihood of adverse events happening to them.

The latter conclusion is also supported by the studies testing the DR hypothesis in contingency tasks, which were discussed in the previous section. Here, similarly, DR comes into effect in very particular circumstances. More specifically, participants with low mood make correct judgements in situations when they do not possess any actual control over the events (or possess very little control). When the outcome indeed depends on their actions,

those participants significantly underestimate the relation, judging the results as random (Alloy and Abramson, 1979; Alloy and Seligman, 1979; Abramson and Alloy, 1981).

1.3.1.4 DR and personal circumstances

A number of studies investigate links between DR and the judgments related to personal life circumstances, such as relationships or wellbeing (Cramer and Jowett, 2010; Clare et al., 2011; Gordon et al., 2013; Mograbi and Morris, 2014). The majority of results confirm that people with depression–related symptoms perceive various aspects of their lives more realistically than 'healthy' subjects. These assessments include-for example-the quality of their relationships, work commitments or symptoms of their own illness. For example, people with depression often report feeling misunderstood by the closest members of their families. Such feelings of misunderstanding may, in turn, escalate their perceived loneliness and increase the severity of depressive symptoms. Whilst many cognitivists (e.g. Beck 1963) frequently ascribe such complaints made by people with depression to a general negative cognitive bias, some more recent authors argue that such negative self-reports are actually very accurate. Gordon and colleagues (2013) conducted a series of studies investigating whether the evidence could support such reports. The participants who score high on depressive scales were involved in conflict conversations (verbal arguments over certain subject) with their spouses. It turns out that partners of the participants who felt misunderstood, indeed did not understand their feelings correctly, although they were not aware of it.

Two qualifications are in order. First, the participants in the above study have been recruited out of the 'healthy' population, having obtained high scores on depressive mood scales (they do not suffer from severe depression). Secondly, the results supporting the DR hypothesis are obtained in specific circumstances (that is conflict conversation), rather than generally. If we consider a conflict conversation as an adverse event, this finding does not sound surprising: the previously analysed data showed a similar effect: people with depression seem to be more accurate when the circumstances of their assessment have adverse character.

The study analysed above is of a special importance. Firstly, the methodological paradigm here aims directly to the practical issues of life, whilst the vast majority of other studies discussed explore the phenomenon in laboratory settings, followed, only later, by some hypotheses about how the results impact on real-life situations. Secondly, a discovery that people with depression or related symptoms report being misunderstood accurately, carries significant consequences for the quality of life in affected people and their families. According to many studies, people who feel understood in their relationships live longer and have better functioning marriages (e.g. Long and Andrews, 1990; Long, 1993; Swann et al., 1994; De La Ronde and Swann, 1998; Meeks et al., 1998; Swann and Pelham, 2002; Pollmann and Finkenauer, 2009). Further research into the links between depression and personal relationships could shed some light on the type and nature of everyday challenges faced by affected people. This, in turn, could potentially lead to better targeted psychological interventions for depression, including relationship and/or family therapy.

1.3.2 Empirical evidence against the DR hypothesis

In the previous section, I have reviewed some of the literature suggesting that certain aspects of depression might be associated with more accurate judgments regarding specific aspects of reality. In this section, I present and analyse the findings which question the plausibility of this claim.

To start with, I shall review some of the research focusing on participants' judgment of other people and neutral circumstances. The aim of these studies is to investigate whether people with depressive symptoms perceive other people and/or the neutral circumstances related to others in a more accurate way than 'healthy' individuals do (e.g. Martin et al., 1984; Gotlib and Meltzer, 1987; Pyszczynski et al., 1987; Vazquez, 1987; Ahrens et al., 1988; Alloy and Abramson, 1988; Siegel and Alloy, 1990; Ahrens, 1991; Jain et al., 2013; Garcia-Retamero et al., 2015).

A second group of studies explore whether the judgments made by people with depressive symptoms immediately after stimulus are more accurate than the judgments made after a time delay. Participants get involved in certain activities, after which they are asked to present a judgment with regards to that situation-either immediately or after certain length of time (e.g. DeMonbreun and Craighead, 1977; Nelson and Craighead, 1977).

In a third group, I shall examine the studies investigating whether there might be any other, as yet unidentified factor mediating accurate judgments in depression. Studies from this group test the hypotheses that factors other than depressive mood (albeit indirectly related to

depression) might be responsible for more realistic judgments (e.g. Tennen and Herzberger, 1987; Bynum and Scogin, 1996; Moore and Fresco, 2007; Blanco et al., 2012).

Finally, in a fourth group, I shall look at the research involving participants with clinical forms of depression. A number of studies investigate the question of whether there might be any circumstances which would enhance realistic judgements in people suffering from severe depression (e.g. Ackerman and DeRubeis, 1991; Dobson and Pusch, 1995; McKendree-Smith and Scogin, 2000; Carson et al., 2010; Moore and Fresco, 2012).

1.3.2.1 DR and non-self related judgements

The vast majority of empirical studies on DR aim to investigate whether people affected by depression make more accurate judgments with relation to themselves (this was analysed in more detail in section 1.3.1). The enhanced accuracy of judgments is proven to be true especially in cases, where people estimate such things as their control over pre-defined conditions, the likelihood of upcoming adverse life events, the severity of symptoms of their own illness, and so on.

Interestingly, when asked to present estimations related to strangers or to emotionally neutral circumstances, people with depression-related symptoms do not seem to be more accurate than controls. In one study participants were asked to make financial decisions for other people, after having read a variety of scenarios (Garcia-Retamero et al., 2015). The predictions made by people affected by depression appear to be no more accurate than those made by ‘healthy’ participants and exhibit cognitive bias. In another study, participants were

asked to predict the results of football games (Jain et al., 2013). It turns out, that people with depressive symptoms are less accurate than controls in their predictions.

The above findings are compatible with the evidence presented in the previous section, according to which people with depression exhibit enhanced accuracy when making judgments related to themselves, but not in other circumstances (DeMonbreun and Craighead, 1977; Nelson and Craighead, 1977; Rozensky et al., 1977; Lobitz and Post, 1979; Gotlib, 1983; Dennard and Hokanson, 1986). Pyszczynski et al. (1987), who investigated cognitive processes in depression, offer one possible explanation for this phenomenon. The authors present the data in support of the claim that people who suffer from depression exhibit relatively high levels of self-focused thinking and self-awareness. We can further hypothesise that this self-absorbance gives participants with depression extensive self-related knowledge, which may lead to more accurate judgments with relation to self, but not to others. However, although plausible, this alleged relation ought not to be simplified. Empirical research shows that when people suffer from more severe forms of depression, their self-related judgements are no longer accurate. This conclusion is convergent with the clinical and cognitive views of depressive illness. But what could be the explanation for this phenomenon? One way to address this question would be to conduct an experiment exploring whether people who are highly self-focused, but with no symptoms of depression, exhibit enhanced accuracy of self-related judgments. If this hypothesis turned out to be true, one might argue that it is the self-absorbance and self-awareness that contribute to the DR phenomenon, rather than depression itself. Increased self-focused thinking might be associated with depression, but can also be a trait of a narcissistic personality or simply a result of temporary life events affecting one's life.

1.3.2.2 DR in immediate and delayed judgments

A limited number of studies investigating realistic judgments in depression show that the DR phenomenon is not significant when the judgment is produced after a certain time interval, although it seems to be quite evident immediately after the stimulation. In two subsequent studies the researchers discovered that, when people with depression are asked to recall their memories after a certain time delay, their judgments are less accurate and are more negatively biased than when they produce a memory immediately after the event (DeMonbreun and Craighead, 1977; Nelson and Craighead, 1977).

Interestingly, participants without depression demonstrate the opposite, positive bias in both immediate and delayed judgments. In other words, ‘healthy’ participants recall the events from their past as more positive than they were, both immediately after the events took place and after certain time delay. It is not clear what mechanisms could be responsible for this phenomenon. From a theoretical standpoint, these findings are most consistent with Beck's cognitive formulation of depression and offer empirical support for his assertion that the depressed person is "…hypersensitive to stimuli suggestive of loss and blind to stimuli representing gain" (1976, p.119). In other words, due to the selective thinking process, a person with depression is likely to remember negative events from the past well and ignore or underestimate the positive ones. ‘Healthy’ individuals, on the contrary, are prone to the optimism bias, meaning that they are likely to remember past events through rose-tinted glasses (Garrett et al., 2014). This hypothesis explains the negative bias effect in participants with depression as opposed to controls, however it remains unclear why the memories produced after a certain time were affected more intensively than the immediate recall.

1.3.2.3 DR and mediating variables

According to some authors (Tennen and Herzberger, 1987; Bynum and Scogin, 1996; Moore and Fresco, 2007; Blanco et al., 2012) enhanced accuracy of certain judgments might be directly related to independent factors. Such variables could be potentially associated with depression, but they might also occur independently in other circumstances. For example, Blanco and colleagues (2012) conducted a series of experiments which resembled the original Alloy and Abramson's study from 1979 but additionally measured the time of participants' responses. The overall results were similar to the original one: people with depression were more accurate. However, unlike Alloy and Abramson, Blanco and colleagues do not explain the results as affected by depression but rather by longer time of responses: participants who take their time offering their response, appear more accurate than those who rush with the answers. As affected people press the light switch button less often and with greater hesitation, they improve their chance of greater accuracy. This effect could be caused by the fact that the participants realise that the lights turn on without their previous action, therefore they get a better grasp of the actual contingency. When the frequency of responding is empirically controlled, the DR phenomenon is no longer present in this group. In conclusion, the authors hypothesize that enhanced accuracy is not so much related to low mood, as it is to the overall passivity that leads to fewer responses. This, in turn, might constitute a result of independent circumstances (such as, for example, severe tiredness) or related to depression. Further investigation is required to explore this possibility in greater detail.

1.3.2.4 DR and severe forms of depression

The most frequent counter argument against DR is such that there is not much sense in describing the supposed realism as 'depressive', since it does not occur in people affected by clinical forms of depression.

Indeed, the vast majority of empirical studies that involve participants with severe forms of depression speak in favour of traditional cognitive theories (which suggests that people with depression exhibit negativity bias) rather than the DR phenomenon. Clinical depression does not seem to be linked with more accurate judgments but rather with multiple cognitive difficulties, including lack of concentration, decreased accuracy of judgments and significant negative bias (e.g. Ackerman and DeRubeis, 1991; Dobson and Pusch, 1995; McKendree-Smith and Scogin, 2000; Carson et al., 2010; Moore and Fresco, 2012). Carson and colleagues (2010) designed a study to investigate the phenomenon of depressive realism in a *bona fide* clinical sample, using a task that provides an objective standard of accuracy. Participants with and without depression are exposed to a variety of situations reinforced for either an active response or a passive nonresponse and then asked to generate judgments of control. People with depression appear consistently more negative than their healthy counterparts and - when they turn out to be more accurate in their judgments of control - it is mainly because they apply the wrong heuristic to less accurate information. Carson's findings do not support the notion of depressive realism and suggest that depressed patients distort their judgments in a characteristically negative fashion.

Several other studies fail to find links between severe depression and more realistic judgements; the phenomenon seems to be true mostly for the people with mild/moderate

forms of the illness, especially with low mood. Depression, when conceptualized as clinical form of sadness, does not offer much realistic insight.

1.4. SUMMARY

The results obtained by researchers exploring the relation between depression and cognitive accuracy lead us to the conclusion that there might be a limited number of circumstances in which depression constitutes a source of epistemic benefits for the subject.

Firstly, most of the evidence presents DR as a real phenomenon in relation to low mood, but not to severe/clinical cases of the illness. This poses the question of whether there might be a certain level of low mood, beneficial for the subject who aspires to acquire accurate beliefs. If that hypothetical level is exceeded, an individual exhibits a negative bias, leading to distorted cognition. Such a possibility would have great significance for our understanding of depressive illness, especially in the diagnostic context. Situating depression-related symptoms on the continuum of their intensity helps not only offer better-personalised treatment to those who suffer; it makes it possible to intervene early on those who might not express clinical symptoms just yet, but-due to an increased number of negative self-related beliefs-are in a high risk group for developing the illness. This takes us to the second conclusion: the evidence of depressive realistic judgments is strongest in estimations related to the self rather than judgments about other people or about situations with no emotional links to the subject. People with low mood are more accurate than controls when estimating their own control over certain outcomes, when recalling their own performance in a variety of tasks, when

estimating the probability of events, which might happen in their personal life or-when expressing feelings of being misunderstood by their family members. A further analysis of empirical data brings us to the conclusion that the phenomenon of DR seems to be less significant or completely absent in the situations of estimating neutral, non self-related circumstances, predicting future random events or producing a judgment after time delay. People also do not produce accurate judgments when suffering from severe forms of depression; instead they are prone to negative cognitive bias.

A number of studies suggest that factors other than depressive symptoms (which however are also associated with depression) are responsible for better accuracy of self-related judgments. A lower level of cognitive activity (slower reactions) and a self-focused thinking style are suggested as possible links.

CHAPTER 2: DEFENSIVE PESSIMISM AND SELF-HANDICAPPING

In chapter 1 I examined the evidence for the phenomenon of depressive realism and its possible underlying mechanisms. In this chapter I ask whether being pessimistic might have any beneficial effects for the subject.

The idea that people may epistemically or psychologically benefit from otherwise harmful experiences sounds familiar to psychoanalytically oriented psychologists, but is still relatively new to philosophers-with some exceptions. For example, the advocates of value-based medicine mentioned earlier in this thesis (VBM) (e.g. Jackson and Fulford, 2002; Fulford, 2004; Fulford, 2008; Fulford, 2011) propose to view mental illness as a phenomenon which relies on diverse values and which can be seen as either positive or negative experience, depending on the subject making the assessment. Based on Fulford's suggestion, in some cases depression may turn out to be both costly and beneficial, depending on the distinct values of the subject, her immediate surroundings, medical staff and personal circumstances.

Another notion that can potentially inform clinical practice is that of epistemic innocence (e.g., Bortolotti 2015a, 2015b; Antrobus and Bortolotti 2016). The notion has been primarily applied to beliefs and suggests that some beliefs that are epistemically costly, because they are inaccurate or weakly supported by the evidence, can nonetheless play an important epistemic role, for instance by allowing the person to remain connected with her environment or react to the often paralyzing effects of anxiety on learning.

Here is the plan for this chapter: in Section 2.1 I challenge *the trade-off view* exemplified by the work by Taylor and Brown (1988), according to which depressive realism (a phenomenon I examined in some detail in chapter 1) and psychological wellbeing are mutually exclusive. Based on empirical evidence I show that the relation between realism and psychological well-being is more complex than presented by the trade-off view. In order to provide arguments for my claim, in Section 2.2 I analyse the phenomenon known in psychology as *defensive pessimism* - a strategy of taking cognitive control over one's feelings of *anxiety* (understood as overwhelming generalised fear related to anticipated danger) in order to cope with situations that are risky or pose potential threats to self-esteem (Norem and Cantor, 1986a). I ask whether low mood can be seen as an enhancing factor in the success of such a strategy and argue that people affected by low mood are more likely than optimists to apply the defensive pessimism strategy with success.

In Section 2.3 I present a further psychological phenomenon of *self-handicapping* (the strategy aimed to help people avoid an effort in order to keep potential failure from hurting self-esteem (Berglas and Jones, 1978). I conclude that self-handicapping strategy illustrates in either a direct or an indirect way how certain psychological benefits might be obtained on the basis of realistic self-evaluation or as a direct consequence of the *pessimism bias* (a cognitive tendency to focus on negative aspects of oneself and the world).

Finally, I conclude that the links between self-related realism and psychological well-being are more complex than could be accounted for by the trade-off account and that both low mood and low self-esteem carry the potential for psychological and epistemic benefits.

2.1 THE TRADE-OFF MODEL

In Chapter 1, I reviewed the studies suggesting that low mood has a positive effect on the accuracy of certain beliefs. People affected by low mood hold more accurate judgements with regard to themselves and self-related circumstances. The assessments made by participants with symptoms of depression are accurate, whilst the judgments made by healthy controls exhibit a positive cognitive bias. The two phenomena-the accurate inferences made by people with depressive symptoms and the positively biased judgments made by healthy individuals-have been since referred to, respectively, as ‘depressive realism' and ‘illusion of control'.

On the basis of these studies, Shelley Taylor (1989) claims that, in order to maintain a healthy mind, one ought to cordon off negative information. Taylor presents empirical evidence for the view that certain belief patterns, which she calls ‘positive illusions’, although epistemically unjustified, enhance mental and physical wellbeing. Believing that one is healthier, smarter or more attractive than warranted by the evidence contributes to a more effective functioning and this-according to Taylor-benefits one's health. Positive illusions bring pragmatic and psychological advantages and are particularly adaptive when one is threatened by adversity. “Effective functioning in everyday life appears to depend upon interrelated positive illusions, systematic small distortions of reality that make things appear better than they are.” (Taylor, 1989, p. 228) Accordingly, holding accurate beliefs about the self does not contribute-according to Taylor-to psychological wellbeing. Taylor and Brown (1988) challenge the pre-existing traditional view in psychology that good mental health requires accuracy of cognition, that is, an ability to see things the way they ‘really’ are (e.g.

Maslow, 1950; Jahoda, 1953). The view about the costs and benefits of low mood emerging from the depressive realism effect and the positive illusions literature seems to be based on the idea of a trade-off: for a person to hold more realistic beliefs about herself, she needs to forego her well-being. Therefore, one of the implications of the trade-off model would be that one cannot hold realistic beliefs about oneself and feel psychologically well at the same time. Something has got to give. Such a claim highlights the trade-off character of the relation between epistemic and psychological benefits of low mood and is commonly stated in the empirical literature. One of the early examples of this view can be found in Sigmund Freud's essay 'Mourning and Melancholia':

> It would be equally fruitless from a scientific and a therapeutic point of view to contradict a patient who brings these accusations against his ego. He must surely be right in some way and be describing something that is as it seems to him to be. Indeed, we must at once confirm some of his statements without reservation. He really is as lacking in interest and as incapable of love and achievement as he says. But that, as we know, is secondary; it is the effect of the internal work which is consuming his ego-work which is unknown to us but which is comparable to the work of mourning. He also seems to us justified in certain other self-accusations; *it is merely that he has a keener eye for the truth than other people who are not melancholic*. When in his heightened self-criticism he describes himself as petty, egoistic, dishonest, lacking in independence, one whose sole aim has been to hide the weaknesses of his own nature, it may be, so far as we know, that *he has come pretty near to understanding himself*; we only wonder why a man has to be ill before he can be accessible to a truth of this kind." (Freud, 1917, p. 245, my emphasis)

Freud notices that, in order to achieve access to a certain self-related truth (that is to have epistemically correct beliefs about oneself) a person pays the significant price of her own wellbeing. But is the trade off assumed in the quote and in much of the literature really so straightforward? Based on the empirical research, here I present some challenges to the trade-off model. I argue that certain phenomena related to depression, such as low mood and low self-esteem, carry the potential for psychological (as well as epistemic) benefits to the subject, despite the associated costs.

2.2 DEFENSIVE PESSIMISM

Defensive pessimism (DP) is a psychological strategy that was first observed and described by Julie Norem and Nancy Cantor (Norem and Cantor, 1986a; Norem and Cantor, 1986b). It is explicated as the action of taking cognitive control over one's feelings of *anxiety* (an overwhelming generalized fear related to anticipated danger) to cope with situations that are risky or pose potential threats to self-esteem. The notion of *defense* applies when the cognitive act of pessimism takes place in order to prevent a greater harm from occurring (e.g. when the level of anxiety becomes debilitating). The notion of *pessimism* applies to the cognitive strategy of noticing and acknowledging negative aspects of one's own current situation (for example with regards to one's own capabilities) and setting realistically low expectations for the success of one's own performance (a situation that is a source of anxiety). 'Realistically low' expectations apply to the judgment of one's abilities-the judgment that is free from positive illusions (which are, in turn, common for 'healthy' individuals (Taylor, 1989)). For example, someone who is about to present her first public lecture but who requires a certain amount of work in order to make the task successful reacts with high levels of anxiety and feels insufficiently prepared for the challenge. Instead of focusing on her questionable strengths and assuming that 'everything will go fine', this person realizes that she is not sufficiently prepared for the task and acknowledges gaps in her knowledge. Drawing on that focus, she may imagine herself failing in the task, not being able to deliver the lecture and becoming embarrassed in public. This seemingly catastrophic scenario is actually a part of a wider psychological strategy. By mentally preparing herself for a potential

disaster, the person copes better with her own anxiety and – in this sense – experiences a psychological advantage.

Here is an example:

For the last three years Julie has been suffering from low mood and has been diagnosed with mild depression. She works as an academic and is about to present a public lecture to a wide, unfamiliar audience. She considers the lecture to be a psychologically challenging situation. She reacts to the challenge with increased levels of anxiety. She perceives herself as not well enough prepared to deliver the lecture. The task which lies ahead is a potentially rewarding one, but at the moment of her judgment generates more negative than positive feelings. Julie thinks about the upcoming talk with anxiety: she imagines herself standing in front of the public and forgetting what she is supposed to say; she visualises herself speaking with a shaking voice and not being able to answer a single question from the audience. She mentally prepares herself for a fiasco. Julie starts realising that in order to avoid psychological breakdown and save her professional career she has to put in extra work by thorough preparation. She spends a night before the lecture reading her presentation several times in order to ground the content in her memory. She comes up with possible questions and criticism that might come from the audience and searches for the answers. As a result, Julie manages to deliver a decent, well-researched lecture. The audience is interested in her studies and several people ask for more information on her research. One of the professors attending the talk asks Julie to join the team of researchers working on a related project. Julie promises to consider the offer and comes back home satisfied after a socially stimulating event.

In the case above Julie exits a stressful situation feeling better off than she felt before she had entered it. That which she initially feared and felt anxious about turned out to be a rewarding experience. Julie benefits from the situation on a pragmatic level, as she manages to complete the task and expands her professional network; this, in turn, enhances her academic career and offers further work opportunities. This pragmatic success enhances Julie's self-esteem and makes her feel better about herself in a psychological sense; she realises she is capable of preparing and delivering an interesting talk, despite feeling anxious. Moreover, Julie recognises that her research is important and interesting; this makes her feel happier and motivates her to study her topic in even more detail. She returns psychologically better off than she was before taking on the task. This was achieved due to the DP strategy which she adopted in order to cope with the situation that was causing her anxiety.

Here I suggest that people who experience low mood (a symptom of mild/moderate depression) are more likely than people with higher mood to apply the DP strategy with success and-as a result-come to be better off psychologically. This controversial claim has some empirical justification. In their original article, Norem and Cantor primarily explain DP as a method of controlling one's own anxiety ahead of a performance. Situations such as passing an exam, giving a speech or putting on a show undoubtedly constitute a source of anxiety for everyone, regardless of other psychological problems that people may experience. A person may attempt to perform the DP strategy in order to take control over the anxiety experienced and to succeed in a task. It is plausible to think that the process of forming pessimistic expectations with regards to oneself will come easier to someone who already experiences depression-related low mood than to a 'healthy' subject. The latter one will be-most likely-prone to positive illusions, which may be reflected in an overly optimistic view of

herself and her future performance-something that would not be particularly desirable in order to make DP work. Moreover and most importantly, as mild depressive symptoms are linked to more accurate self-related judgments (Alloy and Abramson, 1979), we have reason to believe that people with low mood will base their DP strategy on more realistic grounds and, therefore, will be more likely to succeed.

Whilst moderately low mood seems to be advantageous, the same claim cannot be made about more severe symptoms of depression. The evidence coming from empirical studies indicates that in the face of anxiety people with Major Depressive Disorder (MDD) avoid taking risks and participating in challenging tasks (e.g. Trew, 2011). They prefer to withdraw from stressful situations even if participating would substantially benefit them in the long-term. One of the possible explanations for risk avoidance in depression comes from *learned helplessness* theory (Seligman, 1972) which argues that frequent exposure to harm that could not be avoided causes people to give up their efforts to cope with the situation, even if they have control over it. Other empirical studies (for instance Kuiper, 1978) exploring defensive strategies in subjects with clinical depression back up this hypothesis. Similarly, empirical evidence coming from the studies exploring depressive realism shows that those who suffer from severe depression maintain an overly negative view of themselves (e.g. Moore and Fresco, 2012) and, even if they are successful, they attribute the cause of success to external circumstances.

Although most people will agree that severe depression does not help a person succeed in a challenge, the claim that having low mood would be more beneficial than having a ‘healthy’ one sounds counterintuitive. Nevertheless, in the face of the anxiety caused by an upcoming

task, it seems better for the person to have a moderately low mood rather than remain an optimist. This is because the person ought to have the emotional capacity to set up 'low expectations' with regards to herself. This strategy, in turn, will be easier to perform for someone who already finds herself in a low mood (and perceives herself in a more accurate manner) than for somebody who has an optimistic state of mind. The research on the phenomenon of positive illusions shows that people who do not suffer from depressive symptoms are often prone to having an overly optimistic view of themselves, maintaining false, but psychologically useful beliefs with regards to their own capacities (Taylor, 1989). Although these beliefs allow people to feel better about themselves, they may also be psychologically and pragmatically disadvantageous. People who are overly optimistic often do not work as hard as pessimists do, due to the belief in their own talent or 'luck' (e.g. Lench and Bench, 2012). As a result, optimists may not achieve the success they hoped for. The literature regarding the phenomenon of positive illusions also indicates that the bigger the disparity between a person's self-related optimistic beliefs and her actual capacities, the less likely it is that she will benefit from her optimism. For example, Seligman (2006) argues that positive self-regard is beneficial as long as it is based upon a realistic evaluation.

Norem and Cantor emphasize that DP is a strategy exclusively related to overcoming anxiety. In those cases when people do not feel anxious ahead of the task, there is no need for them to build defenses. However, if one feels anxious, the low mood might play an important role in constructing an effective defense against potential failure and in accomplishing the task successfully. As Norem and Cantor put it "…this strategy may be thought of as a method by which individuals are able to cope with their anxiety, in effect, change it from a debilitating to a *motivating* force." (1986b, p. 1209, my emphasis). For that reason, I argue that depression-

related low mood may offer a contextual benefit (advantage) to the person who experiences anxiety ahead of the upcoming task: it helps her to set up very low expectations with regards to herself and-eventually-succeed in the task.

In sum, low mood and related realism might constitute an advantage in a situation when one attempts to adopt a successful DP strategy in the face of anxiety. Being 'healthy' (having no mood-related problems) might-in turn-be beneficial in situations when people do not feel anxious ahead of the task; empirical evidence shows that being optimistic usually positively correlates with academic and non-academic achievements (e.g. Yates, 2002). However, in order to successfully cope with task-related anxiety, when a person attempts to set up low expectations in order to protect her own self-esteem from harm, having a realistic rather than optimistic view of herself is more desirable. This conclusion is compatible with the study conducted by Isaacowitz and Seligman (2001) which shows that pessimists are less prone to depression than optimists after experiencing negative life events, such as the death of a friend. The pessimists have likely spent more time bracing themselves mentally for unpleasant events, and have become more resilient. Acknowledging the role played by low mood in the successful implementation of the DP strategy by people who are anxious about an upcoming task helps better understand how-in certain circumstances-low mood may deliver psychological benefits, despite its other costs.

2.3 SELF-HANDICAPPING

Self-handicapping (SH) is a psychological strategy first introduced by Steven Berglas and Edward E. Jones (1978) and defined as the way in which people avoid effort in order to keep

potential failure from hurting self-esteem. Self-handicaps are understood as obstacles either created or claimed by the individuals who anticipate failing a performance. Norem and Cantor describe self-handicapping this way:

> Anticipating a threat to self-esteem, they [self-handicapping people] restructure the attributional situation so as to minimize that threat. By withdrawing effort (or "sabotaging" themselves), self-handicapping persons avoid negative ability attributions. Failure is simply attributed to lack of effort, which is presumably less "incriminating" than lack of ability because it is an unstable cause that is potentially under the control of the individual. In the unlikely event of success, where the self-handicapper has succeeded despite a lack of effort, the implication is that he is exceptionally able. (Norem and Cantor, 1986a, p. 349)

Self-handicapping is a strategy used by people in order to justify their failure. Examples of self-handicapping may include drug use, excessive procrastination, fatigue, and overwhelming anxiety, all of which shift direct responsibility for failure from the individual to less incriminating handicaps. The no-lose character of the situation becomes obvious as one realizes that, in the event of success, the individual must be considered exceptionally able, considering the obstacles that were overcome (Berglas and Jones, 1978; Norem and Cantor, 1986b). The process of self-handicapping can be performed in two different ways. The first method relies on people making a task harder for themselves (or not successfully completing the task) in order to be able to blame the difficulty of the task, rather than themselves, in case they fail. For instance, one may ask for a more difficult set of questions in the situation of an exam, so that if she fails she can put the blame on the questions rather than on her lack of skills, or other self-related factors. This technique is known as *behavioural handicapping*, as the individual actually creates real obstacles to her own performance. Other examples of this kind may include alcohol consumption prior to a performance (Bordini et al., 1986), the selection of unattainable goals (Greenberg, 1985), and the refusal to practice or to rehearse before the actual performance (Harris and Snyder, 1986).

The second way in which people self-handicap is by expressing verbal excuses for their potential failure so that if they do not succeed, they can blame the circumstances as the reasons for their failures. Researchers call this technique *claimed self-handicapping* as a person merely verbally states that the obstacle exists. For example, one may claim to be highly anxious before an interview, so that she may point at her anxiety as the reason why she has not landed a job. Other physical and psychological symptoms might be used as excuses in claimed self-handicapping techniques.

What role does depression-related symptomatology play in SH? A clue can be found in the empirical research on low self-esteem, a phenomenon proved to be strongly correlated with an onset of depression (see for example Sowislo and Orth, 2013). The empirical data allow us to view low self-esteem as an enhancing factor for the strategy in many ways. For example, the research by Baumgardner (1991) and Higgins and colleagues (2013) suggests that people who suffer from low self-esteem, and therefore are more sensitive to the way others perceive them, are more likely to use SH than those with high self-esteem. Furthermore, as self-handicapping allows people to avoid responsibility and guilt, those suffering from depressive symptoms might benefit from the strategy to the greatest extent. According to the cognitive account of depression (e.g. Beck, 1967), self-blaming and related guilt are the main features of the depressive illness. Successfully performed SH benefits people with depression in the sense that they do not feel bad in the situation of failure because the reasons for not succeeding lie beyond their personal capacities. Finally, as people with mild to moderate depression are capable of more accurate judgments with regards to themselves (depressive realism), their SH

tactics are likely to be more realistically founded, and therefore, turn out to be more successful.

Not every person suffering from low self-esteem will have depression. Similarly, not every individual with depression will handicap. However, based on the existing psychological data, it is plausible to think that in order to protect their self-image particularly prior to the performance or other forms of self-presentation, people with low self-esteem are more likely than others to use handicapping with success.

In the light of the above, it is important to emphasize that the alleged benefits of SH come as an implicit and temporary relief to the person, rather than a long-term, permanent psychological improvement. The aim of SH strategy is to release a temporary tension such as the guilt-or other unpleasant feelings-related to a particular event, rather than to contribute to a long-term pragmatic benefit, as it was the case in DP. Having asserted that, SH still is a useful self-therapeutic tool in situations of intermittent stress, when a person might have no other way to achieve psychological relief. For example, if a person had acknowledged that her failure in the exam was due to her lack of relevant knowledge, she might have felt worthless and decided not to attempt the exam again, or even not to put herself through something similar ever again. In this case, blaming external circumstances rather than the self offers the person a temporary relief from worse psychological harm and constitutes a psychological advantage. It is important to note that the strategy described here relates to a common and implicit psychological mechanism that people use on an everyday basis, rather than to a deliberate and tailored therapeutic intervention. In other words, placing the burden of guilt

outside oneself is likely to offer a temporary relief, however, it should not be promoted as a way of solving one's underlying psychological problems.

There is another interesting link between depression-related symptoms and self-handicapping. As Berglas and Jones note

> …therapists have long been aware of the appeal of the "sick" role to those who wish temporarily to drop out of life's competition. This is a form of self-handicapping where the body is seen as outside the system of personal responsibility. Many clinicians have noted that even the roles of "neurotic" or "mental" patients may be partly strategic in nature. (1978, p. 201)

In a study conducted by Baumgardner (1991), people used their negative mood as a handicap in the situations of public performance only when they had been previously informed that their mood may indeed negatively affect the task. In a study by Weary and Williams (1990), frequent self-handicapping strategies were related to lower self-esteem and high levels of depression. Carson (1969) points out that the acquisition of the label 'mentally ill' is not invariably treated as a major disaster by a person with such a diagnosis. Instead, it becomes a cover story for various types of rule breaking ('it's not me who is doing this, it's my illness'). In these instances, having depression is used as an excuse for wrong-doing, regardless of whether the illness actually affects the person's actions. Exaggerating existing symptoms is one of the most frequent handicapping strategies. As Alfred Adler explains

> …the patient selects certain symptoms and develops them until they impress him as real obstacles. Behind his barricade of symptoms, the patient feels hidden and secure. To the question 'What use are you making of your talents?' he answers, 'This thing stops me; I cannot go ahead', and points to his self-erected barricade. (Adler, 1929, p. 13; quoted also in Higgins et al., 2013, p. 1).

It is critical to notice at this point that the existence of depression-related self-handicapping suggests neither that people lie about their symptoms in order to gain some benefits, nor that they fake their illness. Those who do not comprehend the complexity and authenticity of mental health issues sometimes make such wrong presumptions; this way they inadvertently contribute to the social stigma surrounding depression. Whilst it is true to some extent that a certain number of people might attempt such ill-health performances, these manoeuvres do not constitute the point of interest in the debate presented here. Instead we are interested in addressing the questions of whether one may use *actual* and *existing* depressive symptoms in the strategy of self-protection.

To sum up what I have said so far, the two strategies described above are means of self-protection and are especially useful prior to a challenging performance. By setting critically low expectations or by claiming (or exhibiting) her own handicaps, the person protects her own self-esteem and/or self-worth from the psychological harms of failure. Both strategies work well for people affected by moderate symptoms of depression but are not effective in the case of MDD. Whilst SH seems to be a short-term solution applicable to specific tasks, DP is a disposition potentially contributing to long-term benefits such as self-realization or success. This can be further explained by the motivational character of the strategy: in a situation that triggers anxiety, setting low self-related expectations works as a motivational force. Some researchers have proposed psychological techniques of a similar character: the technique of the worst-case-scenario (WCS) used in some schools of the cognitive-behavioral school of therapy (CBT) might serve as a good example. A client is asked to imagine the worst possible scenario for her problem: this allows her to face her own anxiety and take a cognitive control over it. As a result, the client becomes able to approach the problem in a

more constructive way (see for instance Meichenbaum, 1977). The analysis of empirical studies on these two strategies suggests that behaviours associated with depression, low mood and low self-esteem can bring psychological benefits, despite being otherwise harmful. Some of the benefits can also be regarded as epistemically significant. The relation between depressive symptomatology and epistemic and psychological benefits in the two strategies is two-fold. First, by enhancing accurate self-related judgments, low mood delivers pragmatic and psychological benefits as mediated by the epistemic ones (DP). Second, by playing the role of preserving positive self-esteem (SH), the low mood has the potential to psychologically benefit the person in a direct, non-mediated way. However, psychological benefits, in this case, may be acquired at the expense of epistemic ones. For instance, a person's handicapping strategy allows her to protect her self-esteem by attributing the reasons for her failure to external circumstances, but at the same time, she might acquire false beliefs as a result ('I did not pass the exam because I got the wrong set of questions').

2.4 SUMMARY

In this chapter I asked whether being a pessimist might be linked to any psychological or epistemic advantage. It is important to consider the possibility that low mood and low self-esteem can enhance realistic thinking and protect one's self-image when challenges emerge. To acknowledge the positive as well as the negative aspects of phenomena such as low mood and low self-esteem that have been described in the diagnostic criteria as 'symptoms' might provide us with new, important tools for effective treatment.

One of the implications of the trade-off view is that one cannot experience low mood (and have realistic beliefs about the self) and enjoy psychological wellbeing at the same time. The cases discussed here present a practical challenge to such a claim. Depression-related phenomena such as low mood and low self-esteem can enhance psychological wellbeing either long-term (as in DP) or short term (as in SH). In this chapter I argued that low mood and low self-esteem do not necessarily compromise psychological wellbeing and, due to the complexity of the relationship among them, the issue of the contribution of low mood and low self-esteem to wellbeing deserves a more detailed investigation. Similarly, the epistemic consequences of the strategies I presented, DP and SH, need a more thorough examination. The person who adopts DP may acquire false beliefs with regards to herself (e.g. 'I am not good enough to perform this task') in order to gain motivation for further work. This may lead to the quick conclusion that DP is epistemically costly. However, the strategy enables the person to deliver a successful performance, thanks to supporting the person's effort to improve her knowledge or skills. This translates into an epistemic advantage (and plays the role of mediating psychological benefits, as was explained earlier in this section). Moreover, given that the person benefits from increased self-esteem and trust in her own skills, she is likely to gain a further epistemic advantages by investing her own resources into the subsequent acquisition of skills and knowledge. In the case of SH, the person's psychological gains (in terms of preventing greater psychological harms) have epistemic costs. In order to protect self-worth and self-esteem, the person may acquire false beliefs (e.g. 'I did not pass this exam as I felt poorly on that day').

Viewing certain depressive symptoms as pathological reflects only a part of a complex story. Without denying that experiences such as low mood and low self-esteem come with epistemic

and psychological costs, it becomes critical to recognize that frequently these phenomena also play a subtler positive role. Whether they help to enhance motivation to pursue personal goals or they offer a temporary relief from the burden of guilt, they become a part of a rational psychological strategy. Further research is needed to extend our knowledge about the positive role of low mood and low self-esteem as well as to turn such knowledge into adequate therapeutic tools for clinicians.

CHAPTER 3: POSITIVE ILLUSIONS AND WELLBEING

According to the trade-off view, realistic cognitions are unavoidably associated with psychological costs. More specifically, authors like Taylor (Taylor, 1989) suggest that although a realist sees things 'as they really are', she pays the price explicated in psychological costs, such as low mood.

In the previous chapter, I argued that the view of realism as psychologically unfavourable has some serious limitations and that the relation between realistic cognitions and their costs and benefits is more complex than believed and needs re-visiting. I described the phenomena of defensive pessimism and self-handicapping as psychological techniques offering the potential of enhancing one's wellbeing. The analysis of these techniques shows that low mood-although contributing to psychological problems-might also carry the potential for mental health as well as lead to more accurate self-related judgements.

In this chapter, I want to further develop my view of realistic cognitions as epistemically and psychologically beneficial. In order to do this, I question the claim made by Taylor and Brown that an 'illusory' (that is, unrealistic) factor of optimistic beliefs contributes to one's wellbeing.

Here is a plan of this chapter: in section 3.1 I describe the phenomenon of positive illusions (hereafter: PIs) in the wider context of empirical research on optimism. In section 3.2 I argue that-contrary to the claims made by Taylor and Brown (Taylor and Brown, 1988; Taylor, 1989)-unrealistically optimistic beliefs with regards to oneself may carry significant

psychological costs to the subject and-as a consequence-negatively affect her wellbeing. In section 3.3, based on the psychological literature, I show that realistic self-evaluation is an enhancing factor for optimistic beliefs to turn beneficial. I conclude that from the wellbeing point of view (similarly to the DP and SH strategies analysed in the previous chapter) it may be more beneficial for the person to hold realistic self-related beliefs than to be subjected to illusory beliefs about one's own capabilities. I further conclude that the relation between self-related positive illusions and mental health are more complex than proposed by Taylor and Brown: when departing from the reality they lead to negative psychological consequences.

3.1 POSITIVE ILLUSIONS AS INSTANCES OF OPTIMISM

What are positive illusions? The term originates in a 1988 paper by Taylor and Brown (1988) and is defined as unrealistically favourable attitudes that people have towards themselves or people that are close to them. The authors maintain that certain PIs are highly prevalent in psychologically healthy people and predictive of criteria traditionally associated with mental health. According to Taylor and Brown (1994), there are three general kinds of PIs: (1) an inflated assessment of one's own abilities, (2) unrealistic optimism about the future, and (3) an illusion of control.

> Contrary to much traditional, psychological wisdom … the mentally healthy person appears to have the enviable capacity to distort reality in a direction that enhances self-esteem, maintains beliefs in personal efficacy, and promotes an optimistic view of the future" (Taylor and Brown, 1988, p. 204).

A classic example of inflation is the *better-than-most effect*. People tend to find themselves warmer, kinder, more sincere, etc., than the average person and these self-appreciating views are correlated with higher achievements. Similarly, children who overestimate their capacities develop better language, problem-solving, or motor skills (Taylor and Brown, 1988; Taylor, 1989; Taylor and Brown, 1994). People affected by serious illness who believe that they are coping better than other patients are found to experience reduced stress (Brown, 1993; Taylor and Armor, 1996; Folkman, 1997).

Unrealistic optimism about the future is the phenomenon by which "people anticipate that their future will be brighter than can reasonably be justified on statistical grounds" (Taylor and Brown 1994). People who are optimistic in this way are more creative, and cope better with stressful situations. Taylor and colleagues (1992) studied men who had tested seropositive for HIV and found that they were more optimistic about not acquiring AIDS than men who knew they were seronegative. This unrealistic optimism has been correlated with health-promoting behaviour and use of positive coping techniques. Taylor and Brown have shown not only that PIs are widespread in non-clinical populations, but that there are strong links between certain forms of positive illusions and mental health (in terms of creativity and productivity), and physical health (in terms of prolonged longevity).

Another type of positive illusion is the *illusion of control.* In a lottery situation, people who have been assigned random tickets prefer to swap their tickets for tickets they choose themselves, even if this does not impact on their chances to win (Langer 1975). According to Taylor and Brown people believe that they have control over random events and circumstances. The illusion of control effect was discussed in more detail in chapter 1 of this thesis, in the context of depressive realism. People's belief that they can change external

circumstances for the better contributes to better adjustment in the context of trauma or chronic illness.

Taylor and Brown not only propose that PIs are psychologically beneficial; they further argue-rather boldly-that those who do not hold the PIs are psychologically worse-off:

> …individuals who are moderately depressed or low in self-esteem consistently display an absence of such enhancing illusions. Together, *these findings appear inconsistent with the notion that accurate self - knowledge is the hallmark of mental health*." (Taylor and Brown, 1988, p. 197, my emphasis)

The idea that mentally healthy people maintain beliefs which depart from the truth, and that the lack of such illusions is linked to psychological costs, turned the existing model of mental health upside down and ignited much philosophical interest. Up to that moment, it was believed that mentally healthy people have accurate cognitions and that their beliefs reflect reality. Taylor and Brown's proposition not only questioned the importance of realism as a warrant of mental health but-most importantly-implied that people may be healthy *thanks to* their illusory beliefs. Such a claim is intriguing and controversial. In order to verify its plausibility, I shall examine the circumstances in which the concept of PIs itself arose. Situating Taylor and Brown's theory into this context will shed light on the cause of its popularity at the time of its birth as well as enhancing our understanding of the contribution that research on PIs have made to positive psychology.

3.2 POSITIVE ILLUSIONS IN CONTEXT

Early approaches to optimism do not present it as a desirable aspect of human nature. Carr points out that, up until the late 1970's, optimism was generally considered "a psychological deficit, a sign of immaturity or weakness of character" (Carr, 2004, p. 76). Peterson (2000) argues that this deficit-based view of optimism has been reflected in writings of such diverse authors as Sophocles, Nietzsche, and Freud. Indeed Sigmund Freud (2012/1928) in his work entitled "The Future of an Illusion" argues that optimism is part of human nature but only as a by-product of the conflict between instincts and socialisation. Optimism enhances civilisation, especially when institutionalised in the form of religious beliefs. However, religious optimism comes with its costs: the denial of our biological, instinctual nature and, therefore, the denial of reality. Religious optimism is at the core of what Freud called the universal obsessional neurosis of humanity and is necessary for the masses to thrive; educated individuals-argues Freud-do not need the illusion of optimism, as they rely on the laws of rationality. As Freud's psychoanalytically inspired ideas became highly influential in psychology, his view of optimism as illusory and related to religious beliefs has affected many other theorists, who indicate that the *accurate* perception of reality should be the benchmark of good psychological functioning (Snyder, 1988; Taylor, 1989). According to Jahoda, for example, "the perception of reality is called mentally healthy when what the individual sees corresponds to what is actually there" (Jahoda, 1958, p. 6).

In order to remain in a good mental state, the individual is required to exercise 'reality testing'; only fairly modest expectations about the future could pass the test and anything

beyond is regarded as denial or illusion (Akhtar, 1996) and indicates deviation from the standards.

However, this psychodynamically influenced view of accurate reality testing as a warrant of mental health was soon subjected to the challenge coming from an unexpected direction. Cognitive psychologists present an array of research documenting that most people are not accurate in how they think. For example, Matlin and Stang (1978) precipitate a paradigm shift when they (in the so-called "The Pollyanna Principle") provided evidence that thought, language, and memory are selectively positive: people tend to use more positive than negative words whilst speaking or writing; they also judge themselves more positively than they judge others; in free recall, people produce positive memories before they produce negative ones, and so on. These findings demonstrate not only how widespread PI's really are, but-most importantly-they proved that it is particularly typical for psychologically *healthy* individuals (Peterson, 2000). Tiger (1979) took this understanding forward by arguing that being able to think optimistically was, in fact, adaptive from an evolutionary viewpoint: it motivates people to continue to struggle to survive, even given the inevitability of our eventual death. Because optimism involves thinking about the future, Tiger argued, it first appeared when people began to think ahead and developed fears related to their own mortality. Optimism developed to counteract their fear and despair and to offer some hope. On Tiger's account, optimism is inherent in human nature, not a mere by-product of some other psychological traits. Similarly, McKay and Dennett (2009) suggest that positivity biases can be biologically adaptive for mental and physical health as well as for economic success. The Error Management account of unrealistic optimism, in turn, explains the evolutionary benefits of unrealistic optimism by saying that unrealistically optimistic predictions are beneficial because they allow us to make the least costly error. Error management theory holds that when making decisions under

ambiguous circumstances, it is best to form beliefs where the cost of acting on erroneous beliefs is low and the potential gain resulting from a correct belief is relatively high. (Haselton and Nettle, 2006; Jefferson, 2017).

An even more original and influential account of optimism has been proposed by Anthony Greenwald (1980), who compares human nature to a totalitarian regime, where the self can be seen as an organisation of knowledge about one's history and identity. This organisation, argues Greenwald, is biased by information-control strategies: everyone engages in a continuous process of fabricating and revising their personal history (Peterson, 2000). Every person is the central figure in his or her own narrative, takes credit for good outcomes and dismisses responsibility for bad events. Furthermore, people resist changes in how they think. To sum up, the ego maintains itself in the most self-appreciating way possible, similarly to a totalitarian political regime.

Meanwhile, Taylor and Brown (1988) review a great number of studies on social cognition. The authors argue that people are generally biased toward the positive and that the lack of such bias might be related to anxiety or depression related problems. The authors ultimately conclude that

> contrary to much traditional, psychological wisdom... the mentally healthy person appears to have the enviable capacity to *distort reality* in a direction that enhances self-esteem, maintains beliefs in personal efficacy, and promotes an optimistic view of the future (Taylor and Brown, 1988, p. 204, my emphasis).

Indeed, it is Taylor and Brown who first proposed the term "positive illusions", which they defined as pervasive tendency to see oneself in the best possible light (1988). The authors believe that these illusions are beliefs maintained through biases in encoding, interpretation,

and retrieval of information. The examples include selective attention and benign forgetting, cognitive drift (explained as a temporary change in one's beliefs), acknowledging pockets of incompetence (e.g. accepting a lack of talent in one area of life whilst maintaining belief in a general competence). The alleged biases enable people to avoid situations exposing their lack of skills-instead, they encourage people to construct a self-enhancing world in which to live (Taylor and Brown, 1988). Taylor (1989) argues that PIs are related to a range of benefits such as happiness, the ability to care for others, creativity and productivity (through enhanced motivation and the ability to develop relevant skills), the ability to function under stress, physical health and the ability to cope with trauma. Building on this, many of the `more recent studies have emphasised the benefits of PIs in relationships. For example, Murray and Holmes (1997) found that positive relationship illusions predict greater satisfaction, love, and trust (as well as less conflict and ambivalence) in both dating and marital relationships.

By developing the concept of PIs, Taylor and Brown contributed to a new understanding of the role of optimistic beliefs in people's lives. How is the construct of PIs different from other instances of optimism? Taylor and Brown's novel approach to the psychological benefits of optimism seems to be such that-according to the authors-it is the 'distortion' aspect of certain beliefs that makes them psychologically beneficial. They put their emphasis on *the illusion,* that is the inaccuracy of cognition through unrealistically positive views, which contributes to better mental health. "Evidence indicates that self-enhancement, *exaggerated beliefs* in control and *unrealistic optimism* can be associated with higher motivation, greater persistence, more effective performance and ultimately, greater success" (Taylor and Brown, 1988, p. 199, my emphasis). But is it true? I argue that the role of reality distortion in the case of optimistic beliefs is much more complex than the authors present. The empirical evidence shows that optimistic self-beliefs indeed carry psychological benefits, however, their alleged

departure from reality seems to bring more harm than good. Let us have a look at some examples.

3.3 THE PSYCHOLOGICAL COSTS OF ILLUSORY BELIEFS

Under the weight of critical responses to the claim of the beneficial role of illusory beliefs (e.g. Colvin and Block, 1994), Taylor has become more cautious over the years and in a later article (Taylor et al., 2000) she notes that in order to provide a benefit, the illusion should be "mild" (e.g. p. 100). In their response to the criticism the authors attempt to clarify their position by warning that "at extreme levels… illusion may well be maladaptive" (Taylor and Brown, 1994, p. 24) and that "it is absolutely clear that certain illusions or distortions (e.g. delusions of grandeur) are associated with mental illness" (p. 25). Taking into account Taylor's further claims that psychological mechanisms such as repression and denial distort reality and (therefore) are maladaptive, whilst positive illusions, although they also distort reality, are adaptive (Carr, 2004) it becomes unclear how much distance from reality do the authors consider as 'mild' (and, therefore, beneficial). Unfortunately, Taylor and Brown do not provide any empirical nor conceptual definition of alleged 'mildness', making the issue of whether reality distortion is beneficial very difficult to address.

Below I want to defend the claim that in the case of beliefs called 'positive illusions', it is *not* the 'illusory' (reality-departing) factor that makes the beliefs in question beneficial for mental health. Quite opposite: the empirical evidence shows that optimistic beliefs with regards to self are psychologically beneficial for the subject when they are based on realistic (rather than illusory) self-evaluation. However, if such psychologically beneficial beliefs appeared to

contain a certain degree of reality distortion, such a distortion is ‘mild’ and limited; otherwise, such beliefs, when founded on considerably unrealistic self-assessment, are evidenced to carry significant psychological costs: too much of an illusion is bad for us psychologically. For these reasons, it is not plausible to claim that it is ‘distortion from reality’ which contributes to mental health; the story appears to be much more complex.

3.3.1 The psychological cost of self-enhancing illusions

Robins and Beer (2001) analyse illusory self-related beliefs and argue that only those that contain a relatively mild departure from reality can be considered as beneficial. The authors also point out that the same or similar belief might be considered either less or more ‘illusory', depending on a person making the judgement; the added factor of individual differences makes our assessment of the beneficial role of those beliefs more complex. However, as the authors argue, we do not need to look at extremely distorted beliefs to be able to see that illusions are not good for us and linked to fundamentally unfavourable outcomes. For example, let’s take a look at moderately self-enhancing beliefs: the empirical research indicates that they might be linked to narcissistic personality disorder (Robins and Beer, 2001). Similarly, Baumeister and colleagues (1996) present evidence that frequently people’s self-enhancing beliefs result in them having high but unstable self-esteem; this, in turn, leads to psychologically negative consequences, such as undertaking violent behaviour in situations when they feel threatened. Yet another study (Baumeister et al., 2005) shows that children whose self-enhancing beliefs result in overly high self-esteem do not turn out to do better academically or socially; instead, they tend to get involved in more risky behaviours than their less confident peers.

Another set of empirical evidence shows that although certain self-enhancing illusions have a capacity to temporarily improve people's mood, they have a negative impact on people's health in the long run. Robins and Beer (2001) found, through the combination of laboratory and longitudinal methodologies, that PIs may have both positive and maladaptive consequences. For example, participants who think they did better at a task than they actually did, feel happier after the task than usual; however, this advantage decreases over time: self-enhancers' ratings of their well-being and self-esteem are lower when compared to the individuals with realistic self-perceptions. Furthermore, the authors discovered that self-enhancers tend to withdraw their interest from the areas where they are not meeting their goals. They also show no correlation with long-term successful performance – on the contrary, they are slightly less likely to graduate from college than those with realistic appraisals of their abilities. The study by Robins and Beer is uniquely important because of its longitudinal character (which means that the outcomes of particular stimuli were measured and assessed over a long period of time) and provides one piece of evidence for a long-term negative impact of PIs on one’s well-being.

People who hold illusory optimistic beliefs about their own health prospects can receive immediate psychological benefits, because they become less worried about their future if they think that they are unlikely to develop a certain disease (e.g. Lench and Bench, 2012). But underestimating the risk of suffering from a certain condition leads to negative consequences, as people fail to adopt preventive measures that would improve their health prospects (Shepperd et al., 2013). For instance, the belief that one is at low risk of developing lung cancer might lead them to the decision to continue smoking; similarly, believing that we are unlikely to contract sexually transmitted diseases impacts our decision not to use

contraception (Lench and Bench, 2012), and so on. In sum, the evidence coming from psychological research indicates that although a positive outlook generally supports the wellbeing of people affected by serious conditions and predicts more successful therapeutic interventions, realistic attitudes to chronic degenerative conditions seem to be more beneficial than optimistic ones (Hurt et al., 2014; Bortolotti and Antrobus, 2015). People who hold illusory beliefs with regard to their own capabilities risk experiencing a catastrophic failure because the reality will not fulfill their expectations:

> Constant striving for control over events without the resources to achieve it can take a toll on the individual who faces an objective limit to what can be attained regardless of how hard he or she works. If optimism is to survive as a social virtue than the world must have a causal texture that allows this stance to produce rewards. If not, people will channel their efforts into unattainable goals and become exhausted, ill and demoralised. Alternatively, people may rechannel their inherent optimism into other goals. (Peterson, 2000, p. 51)

This conclusion is further strengthened by psychological research over the benefits of realistic optimism. Below I present some relevant examples.

3.3.2 The benefits of optimism based on realistic self-evaluation

The studies investigating the beneficial impact of optimistic beliefs on our psychological health largely confirm the claim that ‘believing in yourself' and feeling confident is associated with greater resilience and better mental health. However, it is not ‘cheating yourself’ that does the trick, but-quite the opposite-an honest and realistic evaluation of one’s own resources and possibilities. Let us take a look at the following example: Ann wants to apply for a job as a translator. She is aware that she does not have sufficient work experience; this may put her behind some other, more experienced, candidates. However, Ann reckons that her first-hand excellent knowledge of the language (her mother was a native speaker) may perhaps place her ahead of the competition; this positive expectation offers Ann confidence and motivation to

send her resume to her prospective employer. Ann does not hold a positive illusion with regards to her skills by believing-or example-that she suits the job description better than anyone else who might apply (the phenomenon known as the 'better than average' effect, Alicke and Govorun, 2005) or that she will be chosen regardless of her limited experience. She acknowledges her limits and realises that other candidates might have a longer-or stronger-work history. In that understanding, Ann is mentally well prepared for the fiasco. However, this realisation does not discourage her from trying her chances, based on her belief in one of her strengths. This is where she focuses her attention and decides to apply for a job. This decision turns out to be beneficial for Ann-she has been selected for an interview.

Ann's honest evaluation of her capabilities has been a basis for her decision of focusing her attention on her strong points. This strategy is known in psychology as *positive denial* and has been described by Lazarus (1983) as a cognitive strategy of deliberately focusing attention on opportunities and potential positive outcomes *without denying the reality of the situation* (my emphasis). To put it in another way-positive denial occurs when one gives herself permission to temporarily disregard situation which needs not be addressed at the moment. For instance, people diagnosed with cancer may use positive denial to focus more on the possibilities for healing than on the life-threatening and negative aspects of their condition (Lazarus, 1998; Barnett 2006). They do not deny being ill: quite opposite, they are well aware of the gravity of the situation. They do not ignore their doctors' recommendations and maintain the treatment. However, they deliberately choose to focus their attention and their effort on their chances of recovery and on a positive prognosis. A number of researchers showed that positive denial can keep morale up, reduce anxiety, and prevent individuals or groups from becoming preoccupied with minor problems at the expense of long-term essential goals

(Lazarus, 1998; Barnett 2006; Friedel et al., 2007; Kaplan and Midgley, 1999). Empirical evidence coming from the research comparing the outcomes of illusory and realistically grounded optimism indicates that overly positive and ungrounded self-enhancement frequently leads to a fiasco in a given task. For example, based on their empirical research, Tero and Connell (1984) distinguish between adaptive and maladaptive coping strategies depending on the outcome of a given task. In adaptive/positive coping, the participants appear to take a realistic approach to the task prior to planning a solution: they seek their mistakes, analyse their faults, and plans their time accordingly. In maladaptive coping, on the other hand, the participants ignore the failures or do not consider them as their own errors, but-instead-they tend to blame their teacher, their parents, and people around them for their own mistakes (see also Friedel et al., 2007 for more examples). Generally, adaptive coping strategies have been based on a realistic assessment and act as a buffer between a stressful environment and psychological wellbeing of the person (Subasi and Tas, 2016). The strategy of positive denial allows people to focus their effort on the positive side of their situation, without cheating themselves by illusory and unsupported beliefs.

In his renowned research on optimism and its benefits, Martin Seligman shares a similar view on realistic bases of ‘good' optimism (Seligman, 2006). The author argues that the tendency to focus attention on the positive sides without denying the negatives of the ambiguous and complex situation is a *cognitive ability* rather than an implicit bias. Seligman calls such an ability a *positive explanatory style* and provides evidence for its countless psychological benefits. According to the author, this cognitive strategy, although it requires a certain cognitive effort, is potentially available to everyone and may constitute a subject of learning. Seligman contradicts it with *depressive explanatory style*, which he explicates as the cognitive

tendency to focus on the *negative* sides of ambiguous events. Such reaction, argues Seligman, is a default one in people who suffer from depression. People who exhibit this style tend to explain (interpret) ambiguous events as negative, hostile, catastrophic and unfavourable, before making a rational evaluation. In some more severe cases, they may refuse to make such evaluations or reject the evidence if it is not convergent with their beliefs. According to Seligman (2006), depressive explanatory style is related to substantial psychological costs for the subject, including-in the long run-severe depression and delusions (I further explore depressive delusions in chapter 4).

Some more arguments for the claim which I want to endorse, that the realistic foundation of optimism offers more benefits than the illusory one, comes from theoretical work in theology. Paul Tillich (1965) considers optimism as a form of hope, explicated as an expectation that something positive will happen. Before we get into the details of Tillich's idea it is important to note that his account of hope is distinct to theories presented in philosophy and ought not to be regarded as philosophical but as an empirical account. It is not the purpose of this chapter to examine a variety of approaches to the complex concept of hope in philosophy. Rather, I want to show-using Tillich's account as a useful example-how very distinct authors across domains express their similar views on the role of realism in future-oriented beliefs. Tillich argues, for example, for the beneficial role of realistically grounded expectations and makes a distinction between a *genuine* and *foolish* hope. A genuine hope occurs when the resources (even if only in a 'seed form') of that which is expected are already present. As the author explains:

> Where there is genuine hope, there that for which we hope has already some presence. In some way, the hoped for is at the same time here and not here. It is not yet fulfilled and it may

> remain unfulfilled. But it is here, in the situation and in ourselves as a power which drives those who hope into the future. There is a beginning here and now. And this beginning drives towards an end. The hope itself, if it is rooted in the reality of something already given, becomes a driving power and makes fulfilment, not certain, but possible. Where such a beginning of what is hoped for is lacking, hope is foolishness. (Tillich, 1965, p. 373)

and

> In the seed of a tree, stem and leaves are already present, and this gives us the right to sow the seed in hope for the fruit. We have *no* assurance that it will develop. But our hope is genuine. There is a presence, a beginning of what is hoped for. And so it is with the child and our hope for his maturing; we hope because maturing has already begun; we don't know how far it will go. We hope for the fulfilment of our work, often against hope, because it is already in us as vision and driving force. We hope for a lasting love because we feel the power of this love present. But it is hope, not certainty." (Tillich, 1965, p. 373)

Tillich contradicts genuine hope against the foolish one; the main difference between the two seems to be that the latter one has no realistic grounding. A person who holds hope (that is, positive expectation) against all available evidence is a fool, according to the author and will receive unpleasant repercussions. Tillich's account of two 'hopes' supports the argument of a beneficial role of realism in optimistic beliefs: although in this case, we speak about the general expectations rather than strictly self-related beliefs, the pattern seems to be very similar. Those expectations which depart from reality are undesirable and makes a man 'foolish'. These which take into account the reality, on the other hand, lead to positive outcomes for the one who 'hopes'. Simon Critchley (2014) offers a similar idea when he draws the dividing line between *realistic* and *blind* hopes, pointing at the latter one as a source of disadvantage:

> You can have all kinds of reasonable hopes… But *unless those hopes are realistic* we will end up in a blindly hopeful (and, therefore, hopeless) idealism… Often, by clinging to hope, we make the suffering worse (Critchley, 2014, my emphasis)

Critchley and Tillich make a similar point: the destructiveness of ‘blind’ (or ‘foolish’) hope seems to be firmly related to its lack of *justification* (grounding in existing, even if minimal, realistic resources). This type of hope is likely to lead to increased frustration and despair, as hope is not fulfilled, although the subject can derive short-term pleasure from daydreaming. Critchley’s ‘hopeless idealism', as a product of foolish hopes, may sometimes become a dangerous social or political doctrine when certain expectations are imposed on people who lack realistic resources to fulfil them (Critchley, 2014). In such cases, foolish hope becomes harmful not just on a personal, but also on a social and political level.

Furthermore, Miriam McCormick in her recent paper entitled “Rational Hope” (2017) helpfully distinguishes between rational, or justified hope and irrational, or unjustified hope. According to the author, both theoretical and practical norms are significant when assessing hope’s rationality. McCormick argues that a hope is rational when it contributes to agential success, even if there is little evidence for the object of such hope. This is because “as the practical importance of hope increases, the demand for the level of evidential support lessens and as the stakes get lower, the evidence for the likeliness of the hoped-for outcome coming to be must go up for the hope to be rational” (McCormick, 2017).

3.4 SUMMARY

In this chapter I addressed the question of whether PIs are linked to better mental health. The general conclusion coming from the literature on PIs is such that positive self-regard seems to be beneficial as long as it is based upon realistic evaluation; the lesson we learned from Taylor and Brown is that in some cases illusory beliefs might still be adaptive, but only if they contain a very mild (minimal) level of reality distortion. The so-called trade-off view, according to which, in order to be psychologically healthy, one ought to cordon-off realistic information, does not sound plausible in the light of the evidence presented in this chapter: people are psychologically better-off when they consider the reality prior to pursuing their goals. Conclusions coming from this debate point to the necessity of re-visiting the claims that realism and wellbeing are mutually exclusive. The wide array of existing and oncoming empirical research shows that optimistic beliefs, which are linked to an increase in psychological and physical well-being, are most frequently based upon prior realistic evaluations. Although minor deviations from realism do not seem to be problematic, more significant instances of reality distortion in optimistic beliefs are evidenced to be detrimental. More meticulous research is needed in order to fully comprehend the complex relationship between realism, optimistic beliefs, and wellbeing.

CHAPTER 4: DEPRESSIVE DELUSIONS[1]

What are delusions? It is common to define delusions as implausible beliefs that are held with conviction but for which there is little empirical support.

> Delusion. A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility (APA, 2013, p. 819).

For instance, Leslie who has delusions of persecution may come to believe that other people intend to cause her harm. Such a delusion has epistemic and psychological costs for Leslie. By interpreting many of her experiences in the light of her delusions, Leslie misrepresents the intentions of her family members and colleagues, and comes to regard their behaviour towards her as more hostile than it really is. Persecutory delusions also have a negative effect on Leslie's wellbeing by contributing to her increasing distress and anxiety. Apart from persecution, common delusional content found in depression involves guilt, illness, and loss of one's financial integrity.

Delusions of guilt articulate the concern to have lost one's moral integrity, that is, one's commitment to be there for the others. Delusions of illness express the concern to have lost one's physical integrity, the worry not to be autonomous and to be a burden for the others. Finally, delusions of ruin are about the concern to have lost one's financial integrity, thus, the worry to get the others involved in one's bankruptcy (Stanghellini and Raballo, 2015, p. 174).

[1] The content of this chapter has previously been published (Antrobus, M. and Bortolotti, L. (2016) *Depressive Delusions*, Filosofia Unisinos 17:2, pp. 192-201)

Delusions in general, and delusions of persecution in particular, have been the object of extensive psychological and phenomenological research (Freeman et al., 2001; Boyd and Gumley, 2007; Campbell and Morrison, 2007; Freeman, 2007; Freeman et al., 2008), and they have recently become a subject of philosophical investigation as well (Bortolotti, 2010; Radden, 2010; Gerrans, 2014). Most of the literature concentrates on delusional experience as part of schizophrenia or of the wider category of psychosis. But some of the recent research on depression (e.g., by Stanghellini and Raballo, 2015) suggests that delusions also emerge in the context of major depressive disorders and present different characteristics from those found in psychosis.

In this chapter I am interested in the nature of depressive delusions and ask whether they have some benefits despite their obvious epistemic and psychological costs. Here is the plan. In section 4.1 I describe what the existing literature identifies as different features in schizophrenic and depressive delusions. In section 4.2 I consider cognitive distortions in the learning processes that may contribute to severe depression. In section 4.3 I argue that the content of depressive delusions is related to the content of those beliefs that people acquire about themselves due to negatively biased learning. In section 4.4 I suggest that depressive delusions are acknowledgments of previously acquired self-related beliefs and I maintain that, despite its costs, the adoption of depressive delusions also has some psychological and epistemic benefits. Depressive delusions can reduce anxiety caused by inconsistent cognitions, and can also be viewed as epistemically innocent, where epistemic innocence is a property of epistemically costly cognitions that have significant epistemic benefits and whose benefits cannot be easily attained via less costly cognitions.

4.1 SCHIZOPHRENIC DELUSIONS VERSUS DEPRESSIVE DELUSIONS

A severe form of depression, sometimes called psychotic depression or depressive psychosis, is a major depressive episode that is accompanied by psychotic symptoms such as delusions and hallucinations (Hales and Yudofsky, 2003; Gerretsen et al., 2015) as well as by intense depressive symptoms, including very low mood, lack of interest in everyday matters, problems with sleeping, feelings of guilt, and obsessive self-accusations. The vast majority of delusions appearing in severe depression are mood-congruent, which means that their content matches the mood experienced by the person (Hales and Yudofsky, 2003). According to the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013), common themes of depressive delusions are persecution, guilt, punishment, personal inadequacy, or disease, with half of the affected people experiencing delusions with more than one theme. It has been estimated that depression involving delusions occurs in 16% to 54% of people suffering from depression (Rothschild et al., 1999).

It is a matter of dispute whether depression involving delusions is a severe form of unipolar depression (sometimes also referred to as melancholia) or a condition that falls into the broader category of psychosis (see for instance: Frances et al., 1981; Parker et al., 1992). One argument for the latter hypothesis comes from empirical research showing that people suffering from these severe forms of depression do not get better with antidepressant medication alone (e.g. Brown et al., 1982; Gaudiano et al., 2008). Other researchers (e.g., Nelson and Bowers, 1978), however, argue on the basis of clinical studies that depression involving delusions should be understood as a sub-type of major depressive disorder and that it is continuous with, and not detached from, other forms of depressive illness. Stanghellini

and Raballo (2015) provide further support for this claim and point to several differences between schizophrenic and depressive delusions. According to them, delusions that emerge in schizophrenia take the form of a revelation by uncovering some new content, unfamiliar to the person, whereas delusions that emerge in depression confirm self-related information that is already known and familiar. This seems to be an important point. According to Stanghellini and Raballo (2015), the experience of schizophrenic delusions amounts to being struck with a 'something' that opens up a new meaning, a new identity, or a new understanding of the world that is deeper and more personal. This new awareness manifests as a sudden disclosure (Stanghellini and Ballerini, 1992), or as a kind of aesthetic experience (Parnas, 2013). The revelation follows a phase of uncertainty and tension and signals a radical change. The revelation is the 'dawn of a new reality' (Stanghellini and Rosfort, 2013). This feature of schizophrenic delusions has been captured by several other authors in the classic literature on schizophrenia. Karl Jaspers (1963) speaks of how endorsing the delusional content puts an end to a long period of uncertainty.

> This general delusional atmosphere with all its vagueness of content must be unbearable. Patients obviously suffer terribly under it and to reach some definite idea at last is like being relieved from some enormous burden …The achievement brings strength and comfort …No dread is worse than that of danger unknown (Jaspers, 1963, p. 98).

And Klaus Conrad introduces the concept of 'apophany', the manifestation of a meaningfulness that was previously hidden. Here is a case study on which Conrad relies for his analysis of delusions as a revelation:

> Due to possible psychosis, a 32-year-old first-class private, Karl B., was brought to Dr Conrad's hospital. In his interview with Conrad, the patient reports that "everything begins" one morning as his unit breaks to leave camp. When the sergeant asks him for the key to his quarters, it is suddenly clear to him that it is a ploy to "test" him. While departing in the bus, he notices that his comrades are behaving strangely: They know something that he is not

> supposed to know. One of his comrades asks "conspicuously" if he has any bread. At midday, they arrive in a town to relieve units positioned there. A few in his company are charged with finding quarters for the rest of them. This is only a ruse for the few to receive instructions in how to deal with him while he waits with the others in the motor coach. One after another, groups of men leave the coach only for the others to return. "It is clear that they are all receiving their instructions" about him. The patient is unable to explain how he sees this. He simply "sees it" (Mishara, 2009, p. 9).

In schizophrenic delusions new content is revealed. People affected by schizophrenia often describe the adoption of the delusion as a discovery, such as the discovery of the true meaning of life, or of a new purpose for humanity (Stanghellini and Raballo, 2015, p. 173), although delusions can and often do incorporate aspects of the person's everyday reality and past experience (see for instance Parnas and Sass, 2001; Freeman et al., 2008).

Do depressive delusions share the same features as schizophrenic delusions? Not quite. There is wide agreement that depressive delusions confirm the person's previously acquired self-related beliefs and her feelings (see Kraus, 1983), instead of manifesting as a revelation or as the discovery of something new. Delusions of guilt in severe depression may validate a feeling of guilt and confirm the person's conviction that she has done something wrong. The idea that depressive delusions are preceded by moods and beliefs that are congruent with their content has been put forward in several contexts. For instance, Matthew Ratcliffe (2008), who adopts the Heidegger-inspired term 'existential feelings' to describe what the clinical literature refers to as 'moods', maintains that existential feelings provide the basis for further experience and thought, including delusional thoughts. Josef Parnas (2013) suggests that depressive delusions deal with the worldly affairs in which patients are engaged and for which they seek evidence. As depressive delusions have a direct link to previous experience and are about everyday feelings, Parnas calls them 'empirical', to distinguish them from the more

‘metaphysical’ delusions that give an insight into the nature of reality and are typical of schizophrenia.

4.2 LEARNING ABOUT THE SELF IN DEPRESSION

According to Swiss developmental psychologist Jean Piaget (1977), there are different stages of cognitive development explaining how children acquire and process knowledge. Some of Piaget’s findings have been used to explain cognitive abnormalities in mental disorders such as schizophrenia and depression (e.g., Beck et al., 1979). Here I am going to refer to one of Piaget’s concepts, the equilibration of cognitive structures model (hereafter, ECS) in order to shed light on the mechanisms involved in the acquisition of self-related beliefs in depression.

The central concept in the ECS model is that of a schema. A schema can be defined as a set of linked mental representations of the world, which people use both to understand new situations and to respond to them. A schema can be exemplified as a stored representation of a pattern of behaviour. A person might have a schema about buying a meal in a restaurant, which includes looking at a menu, ordering food, eating, and paying the bill. Whenever a person with this schema finds herself in a restaurant, she retrieves the schema from memory, and applies it to her situation. Piaget described how schemata were acquired and modified.

According to the ECS model, when the person’s existing schemata can explain what she experiences, then we have a state of equilibrium, or cognitive balance. Two key processes are required for maintaining cognitive balance: assimilation, which is using an existing schema to

deal with a new object or situation; and accommodation, which happens when the existing schema does not correctly apply to a new situation and needs to be modified as a result. A correct development of cognitive structures (also called ‘adaptation’) requires effective implementation of both processes, assimilation and accommodation. If one of the two processes does not perform its function, the other one attempts to compensate to ensure adaptation. The main aim is to avoid conflicting cognitions and maintain coherence. Processes such as assimilation and accommodation serve this purpose. When equilibrium cannot be achieved, increased levels of stress and anxiety are experienced. Consider the following example:

> Raymond, seeing a panther for the first time, says, ‘look, there is a black leopard.’ He has fit the new animal into an existing mental structure because he is already familiar with leopards and just assumes that the panther is a leopard of a different colour. He is using assimilation, making the new information fit into what he already knows. Monique, however, has never visited a zoo and has seen some wild animals only on television or in books. Seeing unfamiliar llamas she considers what these might be. They resemble horses, but Monique immediately dismisses this category because she knows that horses have smooth hair and shorter necks. She also dismisses camels because she knows they have humps on their backs. She decides finally that this must be an animal she does not know and asks the teacher what it is. Monique is using accommodation, creating a new concept into which this new information can be fitted (Essa, 2012, p. 117).

Seeing llamas for the first time and not being able to categorise them causes a state of cognitive dissonance. This state resembles Piaget’s lack of equilibrium and is defined as the mental stress or discomfort experienced by an individual who holds two or more contradictory beliefs, ideas, or values at the same time; performs an action that is contradictory to one or more beliefs, ideas, or values; or is confronted by new information that conflicts with existing beliefs, ideas, or values (Festinger, 1957; Festinger, 1962).

The theory of cognitive dissonance helps us understand the extent to which people strive for coherence. When people experience inconsistent cognitions, they become psychologically

uncomfortable and are motivated to reduce the inconsistency-as well as actively avoid situations and information likely to increase it (Festinger, 1957). When people are confronted with information that conflicts with their previous beliefs and cannot change such beliefs, they attempt to restore consistency in other ways, for instance by reinterpreting their experience, rejecting the new information, or seeking additional support for the previous beliefs from other people who share such beliefs (Harmon-Jones, 2002). There is evidence suggesting that people who remain in a state of cognitive dissonance for a prolonged period of time experience increased levels of anxiety and symptoms resembling those of post-traumatic stress disorder (Eysenck, 2013).

The hypothesis I wish to explore and ultimately defend is that people with severe depression acquire increasingly negative beliefs about themselves because the process by which they acquire self-related information is disrupted. The balance between assimilation and accommodation is compromised in that people with depression become increasingly less able to use accommodation as a way of processing new self-related information. Instead, they distort the content of newly acquired information in order to assimilate it successfully and make it consistent with their previous beliefs.

As we saw, people use schemata to understand the world, including themselves, and to learn from their experiences. Schemata have been shaped by past experiences, memories, social interactions, and conscious reflection, as well as by a number of other factors. Human experiences vary, and people who experience more harmful events throughout their lives may come to store self-related representations that are more negative. Schemata can be modified and when this happens, learning occurs. When people are not able to assimilate new

information because it does not match their schemata, they modify their schemata in order to accommodate the new information.

As we remember from the previous chapters of this thesis, people who experience symptoms of mild depression, specifically low mood, tend to adopt more accurate beliefs about themselves. These judgements may include judgements about their own performance, estimation of future self-related events, or memories of the type of feedback they received. Whilst at least in some circumstances people with low mood perceive and assess themselves more accurately than people with no depressive symptoms, people affected by severe forms of depression form negatively biased beliefs about themselves and their circumstances. The more severe depressive symptoms they have, the more negative self-related beliefs they adopt. Indeed, people who experience major depressive disorder often have critically low self-esteem, perceive themselves as incapable and helpless, are filled with guilt and regrets, and believe that they deserve punishment (Goodwin and Jamison, 1990). They become their most severe critics and their harshest enemies; their thoughts become ruminative and centre on self-condemnation.

4.3 A HYPOTHESIS ABOUT THE DEVELOPMENT OF DEPRESSIVE DELUSIONS

Cognitive models share the premise that maladaptive thinking and negative assessments of the self contribute to the development of depression. Aaron Beck's original theory (Beck, 1967; Beck et al., 1979) served as the catalyst for an explosion of research on the so-called 'cognitive vulnerability to depression' (Ingram, 1984; Teasdale and Barnard, 1993; Teasdale,

1997; Ingram et al., 1998; Hankin and Abramson, 2001; Abramson et al., 2002; Beevers, 2005). Some of the most recent cognitive models of depression have involved a refinement and further articulation of the basic model, which has it that maladaptive cognition contributes to the onset of depression in the context of stressful life circumstances (Dozois and Beck, 2008). For my purpose, which is to understand the nature of depressive delusions, it is useful to briefly revisit this model.

Beck (1967) argues that there are three main levels of thinking involved in the onset, maintenance, and aggravation of depression: depressive self-schemata, maladaptive beliefs, and negative automatic thoughts. Schemata are central to Beck's cognitive model. Although they have been defined in a variety of ways, most definitions incorporate the idea that they consist of both structural properties and propositional elements (Ingram et al., 1998; Dozois and Beck, 2008). As an organized structure, a schema is often adaptive insofar as it facilitates the speed with which people process information. However, well-organized internal representations are sometimes associated with a cost: the information may be selectively attended to, encoded, and retrieved in a manner that is coloured by one's internal representation. For instance, a schema of the typical Italian person (emotional, pasta-eating, coffee-drinking, etc.) may give rise to stereotypical, and ultimately incorrect, beliefs about how a group of persons is likely to behave (Linville, 1982).

In the case of depression, the efficiency associated with the use of a schema involves a bias toward attending to, encoding, and retrieving schema-consistent (that is, negative) information about the self, at the expense of positive or neutral information. Previous experience and knowledge structures influence the processing of new information, and self-

schemata “are considered dysfunctional in that they embody a constellation of dysfunctional attitudes that lead to negative perspectives about oneself, the world, and the future” (Scher et al., 2005: 489). According to Beck, depressive self-schemata develop during early childhood but remain hidden until activated later in life by adverse circumstances (see Beck et al., 1979; Young et al., 2003; James et al., 2007). Leslie who is vulnerable to depression has core beliefs about being fundamentally inept and unlovable. She does not succumb to depression, however, as long as her core beliefs are not activated. Once her negative self-schema is triggered by an experience of rejection, Leslie becomes vulnerable to information processing biases (see Scher et al., 2005) and experiences negative thoughts that focus on themes of loss, failure, worthlessness, defectiveness, incompetence, and inadequacy (Beck et al., 1979; Beck et al., 1985). When depressive self-schemata are activated by negative life experiences, cognitive errors, and negative automatic thoughts follow (Dozois and Beck, 2008). Automatic thoughts refer to the stream of cognitions that arise by association in people’s day-to-day lives and are not accompanied by any direct consideration or volition. Automatic thoughts are more superficial and proximal to the given stimulus than are thoughts at higher levels of cognition, and are functionally related to people’s deeper beliefs. They are the cognitive by-products of activated schemata. Different aspects of people’s core belief system are activated by external environmental cues, or as reactions to internal states and emotions (Dozois and Beck, 2008). These thoughts usually take the form of a negative view of the self, the world, or the future, what Beck et al. (1979) called the cognitive triad.

To sum up, cognitive models of depression rely on the activation of negative self–schemata triggered by adverse life circumstances. In our example, Leslie adopts increasingly negative beliefs about herself that contribute to her experiencing depressive symptoms. Compatibly

with Beck's cognitive model of depression, one can argue that in depressive illness the process of accommodating new information about oneself in one's self-schemata is disrupted, and works selectively. People suffering from depression are not capable of successful accommodation, that is, they cannot modify their negative representations of themselves to match new, contradicting information. Because the new information cannot be assimilated in its original form, people distort its content in order to match their self-schemata, and then they assimilate the distorted content. In this way, they compensate for the missing part of the adaptation process, and avoid dissonance. The empirical literature provides strong evidence in support of this hypothesis. For example, it has been shown that people with depression verify their self-representations by seeking negative-rather than positive-appraisals (Swann et al., 1992a). Similarly, people suffering from dysphoria or depression prefer unfavourable evaluations and relationship partners who offer such evaluations (Swann et al., 1992b). Although people with depression desire praise, they also seek confirmation for their own negative self-related judgments. Their desire to obtain confirmation for their own negative self-related judgements overrides the desire for praise (Swann, 1990), and their efforts to obtain confirmation intensify when others' positive appraisals present a challenge to their self-views (Ingram, 2009). Using Festinger's cognitive dissonance framework, we can say that, as positive appraisals contradict the person's negative self-schema, they become a source of cognitive dissonance and anxiety. Because of that, they are rejected. The process goes as follows:

(i) New information becomes available that does not match the existing self-schema.

(ii) The accommodation process is disrupted. Therefore, the modification of the schema in order to match the new information is not possible.

(iii) The new information gets distorted in order to be assimilated in the existing negative schema.

(iv) Extremely negative self-related beliefs are adopted.

Here is an example. John sees himself as a bad father. He works long hours and travels on business most weekends. He feels permanently guilty for not giving his children the time they deserve. He brings his children little souvenirs from his trips. The children are always excitedly waiting for his return home and seem to be very grateful for the gifts. However, seeing their joy and love does not change John's view of himself as a bad father. He believes that the children smile because they were told by their mother to show gratitude. 'They hate me and one day they will be tired of pretending'-he thinks.

In the example, John has a negative schema of himself-let us call this 'a bad father' self-representation. There is nothing peculiar about it-people have negative representations of themselves that apply to various aspects of their lives. When confronted with contradicting evidence, i.e. the joy and gratitude of his children, John is unable to assimilate the fact that he makes his children happy, as it does not match his 'bad father' schema. Unlike many other people, he is also unable to accommodate this new information by modifying his representation of himself. In order to successfully complete the process of adaptation and to maintain coherence, John distorts the new information in order to preserve his negative self-schema and he interprets his children's joy as an act of pretence. The process of what we may call selective or distorted assimilation is repeated every time contradicting data become available. The self-schema expands, enriched with new matching content. The more of the self-related negative content is assimilated into a schema, the more difficult it becomes to

modify the schema. The so-called ‘depressive vulnerability’ described by Beck can be seen as a large number of related negative self-schemata. Some people hold negative self-representations that apply to many areas of their lives but do not develop clinical symptoms: this is due to their ability to modify self-representations in order to assimilate new, positive information about themselves. They gradually come to perceive themselves in a better light.

However, accommodation does not work for everybody, and depression emerges as a consequence. Positive information becomes distorted in order to be assimilated in negative self-representations, and thus existing self-schemata expand, enriched with apparently matching content. Negative self-related information is quickly assimilated, because it matches the existing schemata that become more and more articulated. The expansion of negative self-schemata is reflected in the judgments that people with depression express about themselves: ‘I am worthless’, ‘I have done nothing good in my life’, ‘I deserve to be punished’, etc.

Why do people with depression distort new positive information to match their negative self-representations? Living in an almost perpetual mental state of cognitive dissonance resulting from the inability to carry out a successful adaptation would cause overwhelming stress and anxiety. Judgements such as ‘I am worthless’ keep the anxiety caused by cognitive dissonance at bay, but may be another source of anxiety due to their content which emphasises loss, deprivation, self-deprecation, and hopelessness (Beck, 1967; Beck et al., 1979; Dozois and Beck, 2008). A person who experiences severe depression resolves cognitive dissonance but only temporarily: John’s negative self-appraisal of himself as a bad father, and his sense of guilt, lead him to expect lack of affection and detachment from his children, which he believes he deserves. However, as his ‘bad father’ beliefs do not necessarily represent reality

accurately, the reaction he expects is not observed, and the coherence of his self-representation is under threat again.

4.4 PSYCHOLOGICAL AND EPISTEMIC BENEFITS OF DEPRESSIVE DELUSIONS

According to the ECS model, preserving consistency is a priority for human cognition (Festinger, 1957; Brehm and Cohen, 1962; Festinger, 1962; Abelson, 1968; Elliot and Devine, 1994; Goetzmann and Peles, 1997). People have a general tendency to restore coherence between their views, and between their views and the views of others, when this is compromised (Heider, 1946). If a person finds herself in a state of extreme cognitive dissonance, she needs to validate her prior beliefs and offset the cognitive dissonance emerging from those beliefs and newly acquired information. Mood-congruent delusions in depression play this key role. In particular, they may offer validation for one's own intensively experienced guilt, shame, hopelessness, and dismay. The claim that one is being spied upon in one's own home-for example-matches the belief that one is not trustworthy and should be monitored at all times. Undoubtedly, such delusions come with psychological costs. The delusional content is woven with unpleasant, sometimes terrifying events, such as being watched, followed, or threatened. But, by reducing dissonance, delusions also offer psychological relief from dissonance-related anxiety. The delusion-induced anxiety that replaces the dissonance-related anxiety has the advantage of reinstating consistency: the negative beliefs about the self are confirmed.

Is the hypothesis that depressive delusions validate and confirm prior beliefs about the self compatible with the prediction-error theory of delusion formation (Corlett et al., 2007; Fletcher and Frith, 2009; Griffiths et al., 2014) which has already been applied to delusions in schizophrenia? According to the model proposed by Philip Corlett and colleagues for schizophrenic delusions, delusions are formed in response to aberrant prediction-error signals, those signals that indicate a mismatch between expectation and actual experience (Miyazono et al., 2014). A prediction error happens when new incoming information does not match the person's existing representations (schemata) and, therefore, cannot be successfully integrated in the person's model of the world (assimilated). It indicates that the internal model of the world from which the prediction is derived is incorrect and needs to be updated. By updating the model in such a way as to minimise prediction errors, the person gains a better understanding of the world. In this framework, prediction-error signals play a fundamental role in learning. In a recent reconstruction of the stages of delusion formation in schizophrenia (Mishara and Corlett, 2009), three stages are identified:

(i) Anxious expectation, when the agent bombarded with prediction-error signals is constantly expecting something important to happen and the processes underlying automated and habitual learning are disrupted.

(ii) Revelation, when the delusion is formed putting an end to overwhelming anxiety and to the sense of unpredictability. The events previously experienced as inexplicable and distressing no longer require attention and the processes underlying automated and habitual learning resume their normal function. The person's model of the world has been updated to include the delusion.

(iii) Reinforcement, when the delusion is stamped into the agent's memory and reinforced every time the previously inexplicable events are experienced.

Prediction-error theorists argue that abnormal prediction-error signaling contributes to the formation of delusions (Miyazono et al., 2014). In particular, they hypothesize that in people with delusions prediction-error signals are excessive and they are produced when there is no real mismatch between expectation and experience. The excessive prediction-error signals falsely indicate that the person's internal model of the world needs to be updated even though, as a matter of fact, it does not have to be.

In the case of depressive delusions, the process differs as people err on the side of conservatism as opposed to revisionism. Instead of changing their representation of the world to match the unusual experience, validating new experience at the expense of previously acquired beliefs, people with depressive delusions preserve their representation of themselves despite the new information that conflicts with it, validating the existing self-schemata at the expense of the new information that is reinterpreted and distorted to fit the schema. When this happens, in the language of the ECS model, an adaptation process has to occur for the system to regain cognitive balance. If the person is unable to update her internal model on the basis of the incoming data, she will reinterpret and distort the content of the data in order to match the schema. The delusions that emerge are mood-congruent and bring validation to the original, negatively biased, self-representation.

In the prediction-error model described by Corlett and colleagues, the adoption of delusions in schizophrenia has some positive contribution to make and delusions should not be seen exclusively as a deficit. In particular, the claim is that, in the context of the disruption of the learning process caused by excessive prediction-error signals, delusions "permit continued engagement with an overwhelming world, and ongoing function in the face of paralyzing difficulty" (Fineberg and Corlett, 2016, p. 73). The claim makes reference to the notion of epistemic innocence that has been applied to motivated delusions and elaborate and systematised delusions in schizophrenia (Bortolotti, 2015a; Bortolotti, 2015b). Can this notion also be applied to depressive delusions?

Epistemically innocent cognitions are not necessarily free from epistemic faults, but they do have significant epistemic benefits that would be unattainable otherwise (Bortolotti, 2015a). My suggestion is that, if the adoption of a delusional hypothesis helps avoid bad epistemic consequences and adopting another (non-delusional) hypothesis would not have the same benefit, then the adoption of the delusional hypothesis is an acceptable response to what we can view as an emergency situation. Here are the two conditions for the epistemic innocence of delusions:

1. Epistemic benefit: The adoption of the delusional hypothesis confers a significant epistemic benefit to a given agent at a given time.

2. No alternatives: Alternative hypotheses that would confer the same benefit are not available to that agent at that time.

Some qualifications are in order. First, what counts as an epistemic benefit may vary. One might say that adopting a delusion is epistemically beneficial if it contributes to the acquisition or retention of true beliefs, if it promotes the agent's intellectual virtues, or if it is something an agent should be praised and not blamed for. One's commitments in epistemology will affect the way in which the epistemic benefits are identified and described. In the case of depressive delusions, the main benefit seems to be the preservation of a coherent self-representation.

Second, different notions and degrees of unavailability can explain the failure to adopt a less epistemically costly hypothesis. This spectrum of possibilities reflects the nature of the limitations that the agent experiences in the relevant context, ranging from standard reasoning limitations affecting all human agents to deficits of perception, inference, or memory that may apply in clinical settings. For instance, with respect to delusions in schizophrenia, one may suggest that in the person who adopts a delusional hypothesis there is an impairment in the capacity to evaluate hypotheses on the basis of their plausibility before adopting them as beliefs (this is an idea developed in the context of the two-factor theory of delusion formation, as in Davies et al., 2001). Alternatively, one may suggest that the person is so overwhelmed by the delusional hypothesis that she does not even consider alternative interpretations of her unusual experience (as in Freeman et al., 2004). In the case of depressive delusions, the unavailability of alternative hypotheses is driven by the process of negatively-biased learning we described earlier: people have long ignored positive information about themselves or re-interpreted it with a negative spin, and this has not been integrated in their self-schemata.

Third, epistemic innocence applies to the adoption, not the prolonged maintenance, of delusional beliefs. The benefit consists in avoiding a problem that presents itself when the unusual experience or the new evidence is not yet made sense of, and can generate anxiety, stress, tension. Delusions appear as a response to a critically high point (a 'tipping point') of cognitive imbalance (or, quoting Jaspers, a 'limit situation'), and their function is to reinstate the balance that has been lost. From an epistemic standpoint, by reducing dissonance and preventing the disintegration of the self, depressive delusions help restore the person's narrative identity. With reference to our previous example, John can preserve a concept of himself as a bad father, despite the reassurances of his wife and the gratitude expressed by his children, by distorting evidence that he is a good, highly appreciated, father. For the person who seeks consistency between her self-related beliefs and feelings and newly acquired information, the depressive delusion offers a solution. But the benefit is temporary. When the delusion becomes entrenched, as we showed both in the case of schizophrenic and depressive delusions, it becomes a new source of stress, anxiety, and tension.

To sum up, the most important function of depressive delusions seems to be that they restore the equilibrium between the cognitive processes responsible for adaptation. Depressive delusions contribute to the agent's narrative identity by validating prior self-related beliefs and feelings that happen to be negatively biased. They can be considered as epistemically innocent, which means that they deliver significant epistemic benefits which could not be obtained otherwise.

4.5 SUMMARY

In this chapter I asked what depressive delusions are and whether they have the potential for psychological and epistemic benefits. I argued that depressive delusions emerge as a result of the attempt to eliminate the inconsistency between self-schemata formed via a biased process of learning, and new conflicting information. Their function is to restore the equilibrium of the cognitive processes of adaptation, assimilation, and accommodation. New information is distorted in order to be assimilated and integrated in previously acquired self-schemata, which consist of negatively biased self-related beliefs and feelings. Due to their reducing dissonance and providing the basis for a unified narrative self, depressive delusions have the potential to deliver both psychological and epistemic benefits by relieving dissonance-induced anxiety and preserving a coherent self-concept. But in the long run, their distressing content causes serious psychological harm, and the mounting evidence against the self-schemata they are designed to preserve is destined to compromise the person's delicate cognitive balance.

I have not offered an exhaustive account of delusions in depression, but highlighted the need for more research into this fascinating and under-studied phenomenon. My preliminary consideration of the literature suggests that the experience of depressive delusions is on a spectrum with everyday experiences of attempting to maintain a previously acquired belief by reinterpreting new evidence that conflicts with it, and thus makes the cognitive mechanisms responsible for depressive delusions continuous with those underlying non-pathological beliefs. A better understanding of depressive delusions can offer some insights into the challenges faced by a person with a major depressive episode accompanied by psychotic

symptoms, and pave the way for interventions that respect the complexity of the delusional experience, both its highly distressing long-term effects and its temporary adaptive features.

CHAPTER 5: EMPATHY

Following the investigation into the links between depression and its possible benefits, this chapter focuses on the relationship between depression and empathy. More specifically, I address the question of how people who suffer from depressive symptoms respond to the painful experience of others and whether depression-bound empathy is linked to any particular costs and benefits for the subject.

Here is the plan: in section 5.1 I review selected accounts of empathy as presented in both philosophy and empirical science and explain how I am going to understand empathy in this chapter. Not dissimilar from the accounts of empathy offered by David Hume and contemporary social psychology, empathy in this chapter is understood as a construct largely overlapping with the notion of *sympathy* and is explicated as cognitive and emotional comprehension of another's painful experience (Hume, 1978/1739; Wispe, 1991). In section 5.2 I examine the literature exploring the links between depression and empathy. Based on the evidence coming from empirical research (including developmental and clinical psychology and neuroscience) I show that people who experience symptoms of depression have significantly elevated levels of empathetic response to the suffering of others. However, I argue further, this enhanced empathy in depression is based on an erroneous belief of one's own guilt and has not been empirically linked to any pragmatic benefits. From the point of view of an agent, guilt-based empathy does not lead to any altruistic action but leads instead to negative consequences for both the subject and the object of such empathy (O'Connor et al., 2002; O'Connor et al., 2012); these costs are analysed in more detail in section 5.3.

In section 5.4 I ask whether an enhanced guilt-based empathetic response in depression might be beneficial for the subject despite the costs described earlier. I argue that, by fulfilling the need for social belonging and by decreasing experienced loneliness, guilt-based empathy might contribute to preventing psychotic symptoms and enhance psychological wellbeing.

I conclude that the relation between empathy, depression, and loneliness is very complex and that the hypothesis that guilt-based empathy has some benefits requires further examination.

5.1 EMPATHY IN PHILOSOPHY AND IN THE EMPIRICAL SCIENCES

What exactly is empathy? The phenomenon has attracted the attention of both philosophers and scientists and has been defined in a variety of ways. Below I present a selection of views, followed by the explication of the notion of empathy I adopt in this chapter.

Before I proceed to explore the philosophical context of empathy, a few brief historical reflections on empathy are in order. The term 'empathy' was introduced into the English language in 1909 by Edward Titchener as the translation of the German word 'Einfühlung' ('feeling into') (Titchener 1909, p. 21; see also Wispe, 1987). Throughout the 19th century, various philosophers discussed the human ability to 'feel into' works of arts and into nature (Stueber, 2010) making empathy largely a concept in aesthetics. However, Theodor Lipps (Lipps, 1979) presented it as a concept central to philosophical and psychological analysis. Lipps scrutinised empathy as the primary basis for recognising each other as minded creatures, for recognising other people's states of mind, and for making sense of their

behaviour in light of the causal powers of their mind (Stueber, 2010). For example, we may predict that another person will not decide to make a transatlantic journey by plane because she is afraid of flying. Our human ability to understand other people as minded creatures constitutes the psychological foundation for us being social beings and members of society. In contrast, the inability to read others' minds has been linked to difficulties in forming basic social bonds and would also be a clear disadvantage when the success of our action depends on the cooperation of other people.

How do we understand others' minds? This was one of the central philosophical questions in the late 19th century and still occupies philosophers up to this day. The controversial point is whether our epistemic access to other minds is structurally similar to, or radically different from, our access to other domains of knowledge (see for instance Hume, 1978/1739). The defenders of the view that the two forms of epistemic access are radically different argue that our understanding of other minds is unique, as we not only attribute mental states to other people from a third-person perspective but also conceive of ourselves as minded creatures from a first-person perspective (Stueber, 2010). In other words, we do not have to rely on knowledge of a psychological theory about other human beings to find out what is in their minds; for that purpose, we can use empathy as a most direct way of simulating or imitating others' mental processes.

In the last century, the above view of empathy as the fundamental method of gaining knowledge about other minds has lost its appeal to philosophers, who tend to regard empathy as epistemically naïve and incapable of providing an epistemically sound method of interpretation and explanation (see for instance Prinz, 2011a; Prinz, 2011b; Bloom, 2017).

Rather, a number of lively debates surround the ethical implications of empathy. For example, in his article ‘Is empathy necessary for morality?’ Jesse Prinz argues that empathy cannot be regarded as a reliable epistemic guide to, a foundation for the justification of, or the motivating force behind, our moral judgments (Prinz, 2011a) because - he claims - empathy is prone to biases that render it potentially harmful. In a follow-up paper, *Against Empathy*, Prinz goes even further and argues that “empathy is, by and large, bad for morality” (2011b, p. 216) as it can be easily manipulated (see also Tsoudis, 2002), as well as being subject to the so-called ‘similarity bias’ (the claim that people feel greater empathy for those who are similar to them; see Xu et al., 2009 for a full review).

In defence of empathy, a number of authors suggest that in spite of being vulnerable to biases, empathetic understanding nevertheless ought to be regarded as epistemically central for our appreciation of other agents, as well as necessary for moral judgements (e.g. Stueber, 2010; Masto, 2015). In her paper ‘Empathy and its role in morality' Meghan Masto argues that “empathizing with others can help motivate us to do the act that we recognize as right” (2015, p. 92) and that failing to comprehend the emotional states of others can cause us to downplay their importance. Masto proposes that one way to mitigate the biases that are problematic would be to become more aware of them as well as to be ‘more deliberate’ in the process of empathising itself. Denise Cummins, in turn, warns that when reason becomes unchained by empathy, it is just as likely to lead to tyranny and genocide as it is to lead to good judgment. Cummins argues that when compassion and reason are decoupled, morality is not improved. Instead, the door is opened to inhumane practices.

> “Human history is replete with examples of principle-based atrocities. The reasoning underlying genocide and "ethnic cleansing" seems perfectly logical to people who subscribe to

> a twisted belief system-bring about a "greater good" by "cleansing" the world of "bad" people-but it's empathetically bankrupt. What drives and sustains the suicide bomber? The belief in the purity of his principles, principles that require one to blind oneself to the suffering and carnage of the innocents at his mercy." (Cummins, 2013)

Unlike philosophers, social psychologists are more concerned with the practical implications of empathy than with the definition of the concept itself (Eisenberg and Strayer 1987; Davis 1994; Hoffman 2000). Psychological science does not investigate empathy as a specific cognitive mechanism of inner imitation for gaining knowledge of other minds. Instead, it attends to empathy as the psychological foundation for social relations and altruistic behaviour. For example, a widely used psychological questionnaire, Davis's Interpersonal Reactivity Index (IRI), is a tool that tries to scale one's empathetic responses on a variety of dimensions such as ''perspective taking'' or ''the tendency to spontaneously adopt the psychological view of others in everyday life''; ''empathetic concern'' or ''the tendency to experience feelings of sympathy or compassion for unfortunate others''; ''personal distress'' or ''the tendency to experience distress or discomfort in response to extreme distress in others''; and ''fantasy'' or ''the tendency to imaginatively transpose oneself into fictional situations'' (Davis 1994, pp. 55–57). Empathy research in social psychology merges the concept of empathy and its primarily cognitive concerns with the concept of sympathy within moral psychology dating back at least to David Hume and Adam Smith. David Hume in his *Treatise* (1978/1739) and *An Enquiry Concerning the Principle of Morals* (2006/1751), and Adam Smith in *The Theory of Moral Sentiments* (1966/1759), appealed to sympathy to explain how human beings, who are usually motivated by egoistic interests, could form a moral perspective and be motivated to act on the painful experience of other human beings. Hume's concept of sympathy shows the multidimensionality as the concept of empathy in social psychology. Our ability to sympathize with our fellow creatures refers to a rather diverse capacity to be influenced by, to fully grasp, and to be concerned with and moved by,

the mental states-passions and opinions-of other agents. Hume does not limit this form of contagion to affective mental states, but explicitly includes cognitive states in it, such as opinions and beliefs.

> Tis indeed evident, that when we sympathize with the passions and sentiments of others, these movements appear at first in our mind as mere ideas, and are conceived to belong to another person, as we conceive any other matter of fact. . . . No passion of another discovers itself immediately to the mind. We are only sensible to its causes or effects. *From these we infer the passion*: and consequently, these give rise to our sympathy. (Hume 1978/1739, pp. 319, 576, my emphasis).

Thus, for Hume, sympathy plays the role of transforming a mental-state attribution to another person from a detached theoretical exercise into a phenomenon that has practical significance for us (Hume, 1978/1739, pp. 319, 576; Wispe, 1991). For the purpose of my further investigation into the links between empathy and depression, Hume's approach would seem prima facie to be particularly relevant. By embracing both cognitive and emotional capacity in empathy, as well as by emphasising the fundamental role of sympathy for another being in subsequent practice, Hume's understanding of empathy constitutes a perfect bridge between the two worlds of philosophy and psychological science. It is in this Humean sense that I will understand the concept of empathy in this chapter.

In the next section, I proceed to address the question of whether there are any particular links between empathy and depression. Based on the available empirical evidence, I will argue that people who experience depressive symptoms have significantly increased levels of empathetic response to the suffering of others.

5.2 EMPATHY IN DEPRESSION

While depression has frequently been described as a 'disorder of the self', some authors argue it should be more accurately characterized as a disorder of 'concern for others' (O'Connor et al., 2007). This is because the vast majority of research exploring links between depression and empathy confirm that the ability to embrace other people's misfortune alters substantially as a result of the illness (e.g. Burns and Nolen-Hoeksema, 1992; O'Connor et al., 2007; Joiner and Timmons, 2008; Moran and Diamond, 2008; Cusi et al., 2011; Galvez et al., 2011; Thoma et al., 2011; Wolkenstein et al., 2011; Schreiter et al., 2013). What exactly is the character of this transition? Below I review the research on the links between empathy and depression in developmental psychology and neuroscience; next I look into the research on the phenomenon of guilt.

5.2.1 Empathy and depression in developmental psychology

The evidence coming from the studies in developmental psychology indicates that the links between empathetic response and subsequent depression often start in early stages of life. For example, Zahn-Waxler notes "the presence of an early developmental pathway where surfeits of empathy, as well as guilt, can place individuals at risk for later depression" (2000, p. 226). According to empirical research, as soon as one day after birth infants react to the distress cry of other newborns with higher intensity than to the cry of a 5-month-old baby, a white noise, a synthetic (artificial) cry, or a recording of their own distress cries (Sagi and Hoffman, 1976; Martin and Clark, 1982). A study by Zahn-Waxler and colleagues (1979) indicates that children between 12 and 18 months make own efforts to help others in need.

The studies relying on the observation of children and their mothers in both natural and laboratory settings provide data on the close associations between empathy, guilt and later proneness to depression, especially in females (Nolen-Hoeksema et al., 1999; Zahn-Waxler, 2000; Hay and Pawlby, 2003; O'Connor et al., 2007). For example, Hay and Pawlby (2003) found that children who scored high on the pro-social scale appeared more worried about their families' wellbeing than their less-worried peers; they also suffered more psychological distress than controls. The pro-social character of empathy highly correlates with depressive symptomatology here. Klimes-Dougan and Bolger (1998) note that high empathy in children is a risk factor for later depression if the children are socially over-involved, self-blaming and distressed. One especially interesting conclusion emerging from the developmental studies is that, on one hand, empathy has been empirically linked to prosocial and moral behaviour even among very young children. On the other hand, the children who have enhanced levels of such empathy have higher rates of depressive symptoms in later years.

What is the key to understanding such an intriguing set of correlations? One possible explanation of this phenomenon might be related to the way in which children-and possibly many adults-conceptualise their selves in relation to others' distress. I come back to this issue in the Section 4, where I analyse costs and benefits of empathy in depression.

5.2.2 Empathy and depression in neuroscience

The advances in clinical neuropsychology, including brain imaging, back up the studies in developmental psychology with regards to the links between depression and empathy. The limbic and paralimbic system structures found active in emotional empathy, automatic moral decision-making and guilt are found active or hyperactive in people suffering from depression

(Shin et al., 2000; Lange and Irle, 2004; O'Connor et al., 2007). In contrast, a deficit of empathy has been found in disorders such as psychopathy (Blair, 1997), sociopathy, autism, certain psychotic disorders or in physical brain damage.

Lange and Irle (2004) found abnormal activation in limbic structures, including enlarged amygdalae in patients with recent major depression. Other studies of depressed patients similarly found unusual activation of the amygdala, (underactive in psychopathy), characterized by the absence of 'normal' capability of moral decision-making and by the feelings of guilt. Pagani and colleagues (2004) observed increased cerebral blood flow in the anterior temporal lobe of depressed patients, also a focus of activity in feelings of guilt. Dysfunctional limbic and paralimbic system activity has also been observed in people with major depression and returned to normal with successful antidepressant treatment (Shin et al., 2000). Neumeister and colleagues (2004) reported that people with a history of depression demonstrated chronic overactivity in the brain circuit central to emotion regulation. The hyperactivity was observed even when the patients were in remission, suggesting that abnormalities in emotion regulation exposed in this study may be genetic. What was especially intriguing was that the same hyperactivity of limbic and paralimbic structures was associated with moral behaviours and empathy. This confirms findings in developmental psychology showing strong links between high levels of empathy and depression.

To sum up, the evidence coming from neuroscience lends a substantial and measurable basis for the claims made in other areas of psychology. The lesson we learn from these data is that there must be something common in both depression and enhanced empathy that is reflected in the hyperactivity of the same areas of the central nervous system. What might this be?

What could be the bridge connecting high levels of empathy with depression? One of the possible answers lies in the data coming from the studies in clinical psychology concerning the phenomenon of guilt.

5.2.3 Empathy, depression, and guilt

The association between guilt and depression has been long acknowledged in psychology. Indeed, a feeling of guilt is a criterion for major depressive disorder in the DSM5 (American Psychiatric Association, 2013). However, not much has yet been said about the connection between guilt and empathy. In psychoanalytic theory, guilt is viewed as a manifestation of unconscious hostility and rivalry, which begins with the child's desire to kill her/his same-sex parent in the oedipal struggle (O'Connor et al., 2007). The Freudian idea, so widespread in the middle to late twentieth century, is being gradually replaced by more recent concepts. Current research refers to guilt as a prosocial emotion tied to empathy and to the desire to maintain social bonds (Cunningham et al., 1980; Tangney, 1992; Miceli, 1992; Baumeister et al., 1994; Baumeister and Leary, 1995; Jones et al., 1995; O'Connor, 2000). For example, Baumeister and Leary (1995) argue that the need to maintain social bonds (the need to which the authors refer to as 'belongingness') is actually the most fundamental human desire; unfulfilled, it leads to a number of negative emotions with guilt as one of the most prominent. Empirical studies of how people induce guilt in others have found that such inductions are most frequently confined to close interpersonal relationships. A major reason for inducing guilt is to cause one's partner to exert himself or herself more to maintain the interpersonal relationship (Vangelisti et al., 1991; Baumeister et al., 1994). Many episodes of guilt can thus be understood as responses to disturbances or threats to interpersonal attachments. Possibly the best example of an inexplicable connection between empathy, guilt, and depression comes

from the phenomenon of ‘survivor guilt', observed initially by Niederland (1961) who studied the severe depression and anxiety in survivors of Nazi concentration camps. He discovered that people suffered from severe guilt simply for being alive while their families had been killed by the Nazis. The survivors felt guilty as if their own survival had somehow caused the death of their families, although that certainly was not true. Based on Neiderland’s research, Modell (1971) expanded the construct to include the guilt people feel when they believe they are harming others by being happy or successful. He observed that individuals with the symptoms of depression frequently believe that if they were successful, happy or simply lucky, it would be at the expense of others; the less fortunate friends or family members would suffer as a result, because -as people with depression believed-there must be a limit on how much ‘good' can be had.

In more recent studies O'Connor and colleagues (1997) found significant associations between survivor guilt, empathy, and depression. The researchers argue that survivor guilt is an empathic emotion often occurring with conscious awareness. For example, people may experience this type of guilt when they get their paper accepted for publication, while a friend's article has just been rejected. Similarly, we may feel guilty when we are healthy and we hear that our friend has been diagnosed with cancer. Furthermore, the presence of survivor guilt is often marked by submissive behaviour: we may act as if we are lower in status (or less healthy or less fortunate) than the person for whom we feel sorry. The destructive effect of survivor guilt may come to our attention only after we experience serious costs (such as, for example, depression), in an effort to ‘make things fair'.

In sum, the available empirical evidence seems to suggest that there is indeed a link between empathy and depression: people who experience the symptoms of depression show enhanced levels of empathy. Although there is no definite indication of what would be the causal direction of such relation, researchers suggest that guilt, more than any other factors, is responsible for enhanced levels of empathy in depression. The hypothesis is such that people suffering from depression show more empathy towards the pain of others because they feel guilty; they feel guilty because they implicitly perceive other people's misfortune as their own 'fault'.

This perpetual relation between guilt, depression, and empathy seems to be a vicious circle: one feels guilty for other's misfortune because one has depression; but, at the same time, the guilt-motivated empathy increases one's depressive symptoms. Even more interestingly, this conclusion might be hiding a possible answer to an old paradox of depression, explicated in the fact that the illness makes the person increasingly focused on herself (indeed people with depression are often labelled as 'selfish' or 'egoistic'), but it enhances the person's levels of empathy towards others. Could *guilt* be the key to this apparent tension? In other words, is it possible that the enhanced empathy observed in depression is not shaped by one's genuine concern about others, but – rather sadly – it comes as yet another mean of self-focused concern? By perceiving another person's pain as one's *own* fault, one directs one's worry towards oneself, becoming once again the protagonist of the story. That which is seen as empathy by an observer (and indeed the same neuropsychological patterns are observed in the presence of empathy), might, in fact, constitute a mere rumination of a self-themed fantasy. In the next section, I develop this idea further, based on research on different types of self-conceptualisation in empathy.

5.3 THE COSTS OF GUILT-BASED EMPATHY

In the previous section, I reviewed some evidence in support of the claim that enhanced empathy and depression are closely related. The studies report that people often feel guilty when they realise that they are better, happier or healthier than others; this guilt might-to some extent-motivate them to help others, but at the same time it contributes to their depressive symptoms.

Here I would like to ask: are there any benefits of guilt-based empathy? One may argue that in spite of its negative consequences for the subject, guilt may nevertheless constitute a good base for an altruistic action. For example, feeling guilty for our better health, we may be willing to help a terminally ill friend. Or, experiencing guilt related to the fact that we possess more wealth than another, we might be inclined to offer some money to a charity. According to the empirical research, the practical reality of guilt-based altruism does not look like that. O'Connor and colleagues (2007) argue that the net result is a self-destructive but common cycle. The guilt-motivated attempt to help someone less fortunate may-to some extent-reduce guilt, but at the same time the nature of such interaction is emotionally dysregulating and may enhance other symptoms of depression or set off a depressive episode in a vulnerable person. This is because the show of submissive behaviour often elicits negative reactions from other people, who then re-evaluate the social ranking of the 'helper'. "As witnesses look down on people who respond to survivor guilt with submission, they treat them as inferior' (…) 'Thus, people who become submissive in an effort to help others often unwittingly become altruistic martyrs" (O'Connor et al., 2007, p. 58). In their very interesting book chapter entitled "Empathy-based pathogenic guilt, pathological altruism, and psychopathology" O'Connor

and colleagues argue that empathy resulting from guilt is pathological and based on false assumptions.

> Empathy-based guilt often hovers behind *pathological acts* of altruism, generating the considerable energy spent in sometimes futile and often self-and other-destructive efforts to help (…). When people who feel empathy at witnessing another's misfortunes *falsely* believe that they caused the other's problems, or *falsely* believe that they have the means to relieve the person of suffering, *they have erred* in their analysis of the situation (2012, p. 11, my emphasis).

The authors argue that upon witnessing someone in distress, people tend to react empathically and feel the distress as if it were their own. In some cases, people implicitly feel pathogenic guilt: they erroneously believe that it is them who caused the distress and that they have the power to relieve it. Based on this false belief of causality, they may then engage in pathological acts of altruism, failing to help, or even harming the person in distress as well as themselves. For example, the abused wife falsely believes that she is responsible for her partner's violent behaviour and that if she were to leave him, he might commit suicide. In an effort to save his life, she stays in the abusive relationship. Similarly, the person with recurring depression and relapses in alcoholism falsely believes that if she killed herself, she would cease being a burden to her family members. As a result, she commits suicide. In another example, the man who is happily married and wealthy believes that his happiness is making his less fortunate brother feel inadequate and worse by comparison. In an effort to make things more equal, he begins fighting with his wife for no apparent reason as well as deciding not to go on luxury family holidays (see more relevant examples in O'Connor et al., 2012, p. 15).

In each situation, neither empathy nor altruistic motivation is inherently problematic; pathology begins when people implicitly and erroneously believe that they are the source of

someone else's problems and that they have the ability to relieve the difficulties. The self-destructive actions that follow are acts of pathological altruism, driven by pathogenic guilt.

It is important to mention that the phenomenon of guilt-based empathy is not limited to people suffering from depression. Whilst discussing the subject, O'Connor and colleagues point at depression as merely one of many possible related psychological problems. Here we can find an example of a woman, an OCD (Obsessive-Compulsive Disorder) sufferer and a hoarder, who continuously picks up papers from the floor of the supermarket believing that if the papers were left on the floor, some old woman might slip on them and be lethally injured-all because she failed to pick up the pieces of paper. Similarly, war veterans suffering from PTSD (Posttraumatic Stress Disorder) are tormented by their memories of trauma related to closely witnessing sudden deaths. What turns these recollections into PTSD is-again-an erroneous causal attribution (O'Connor et al., 2012, p. 17).

The impact of guilt-based empathy on our overall mental health seems to be truly immense and the claims made by the authors deserve further examination. For our research into the links between depression and empathy, the presented evidence is particularly important. It is possible to see that the claims about guilt-based empathy made by O'Connor are convergent with the clinical data presented earlier. The data coming from neuroscience suggest that the brain processes related to guilt are frequently found in people with depression; the same processes have been observed in people with enhanced levels of empathetic response to the suffering of others.

Another interesting view on harmful forms of empathy comes from the research on self-conceptualisation in empathy by Stotland (1969), developed further by Batson and colleagues

(1997). The idea here is that when empathising with someone who is in pain, people tend to conceptualise their selves in one of two possible ways, which Batson and colleagues call 'imagine other' (IMO) and 'imagine self' (IMS) (1997, p. 751). IMO is a process of *adopting the perspective* of another person, who undergoes an adverse experience. This process relies on one's ability to imagine what another may think or/and how they might feel. The adopted perspective is empirically evidenced to evoke empathy for others and has been linked to beneficial outcomes, such as altruism (Stotland, 1969; Davis, 1994; Batson et al., 1997). The phenomenon of IMO has been empirically conceived by Batson and colleagues and juxtaposed with the IMS where the process of imagining the situation of another person is replaced by the process of *feeling* her actual pain, either psychological or physical. In the IMO the stream of empathy takes another being as its focus of attention; I think about another person, about the way she might feel, I attempt to imagine her own perspective, her situation, her motives and other related circumstances. Another person becomes the protagonist of the story, which I create, and the object of my thoughts. The process of IMS, in turn, involves thinking about *myself* being placed in another's shoes; I imagine *myself* going through the same circumstances and I experience the same kind of psychological or physical pain as another person. Here it is *myself* at the centre of a story, I become a protagonist being placed in the settings of another's misfortune.

In order to better understand Batson's account of different types of empathy let us take a look at one of his empirical studies (Batson et al., 1997). The authors asked participants to listen to an interview with a young woman in serious need. One-third of the participants were instructed to remain objective whilst listening (Group 1), one-third were asked to imagine how the woman felt (Group 2), and one-third were instructed to imagine how <u>they</u> would feel

in her situation (Group 3). As a result of the experiment, the researchers found that imagining how the other feels (Group 2) produced constructive, healthy empathy, leading to altruistic actions. However, people who were imagining how they would feel (Group 3) produced a kind of empathy related to personal distress and evoking egoistic motivation.

The participants who successfully took the distressed person's perspective (Group 2) not only were able to understand the stress she was going through, but they also expressed certain emotions, which were congruent with the situation presented, such as sympathy, compassion and tenderness. The researchers labeled this type of response *empathy*, to distinguish it from a self-oriented aversive emotional reaction, described as the *personal distress* implying that the process of IMS might not have much in common with empathy, after all. Such a conclusion would be convergent with the view of many other authors on empathy. For example, Meghan Masto (2015) calls the phenomenon of feeling another person's pain 'emotional contagion' and argues that it ought not to be considered empathy in the first place.

> Consider Sam who is writing an exam. Imagine that she glances up from the test booklet for a moment and notices a look of panic on a classmate's face. Suddenly Sam becomes nervous about her own performance on the exam. It seems wrong to claim that Sam has thereby empathized with her classmate, given the focus on herself (2015, p. 76).

Another argument against the 'emotionally contagious' type of empathy is-according to Masto-such that it is possible to 'get emotionally contagious' with large groups of people, whom we do not even know. For example, if I walk into a stadium filled with loud, happy, celebrating people-I might become happy too, even though I do not know what is being celebrated and do not even catch a glimpse of anyone's smile or other facial expressions. One can experience emotional contagion in this case without there being any individual person with whom one is empathizing (Masto, 2015, p. 76).

Batson’s discoveries are compatible with Stotland’s (1969) pioneering research on empathy. Stotland’s discovery was twofold: firstly, the two ‘imagine’ perspectives led to more physiological arousal than the objective perspective. This, in turn, speaks for more intense emotional expression in the ‘imagine’ perspectives than in the neutral one. Secondly, Stotland found that the two ‘imagine’ perspective also varied between one another with regards to the way they affect the subject. Participants who adopted the ‘imagine self’ perspective showed signs of intense distress in the form of palmar sweat. They also verbally reported feeling more tension and nervousness, which the author interpreted as evidence that their emotional reactions were more self-oriented (*how would **I** feel in that situation?*) and not quite so related to the experience of the model in distress.

If we now return to our investigation into the specification of empathetic responses found in depression, we come to see that it has more to do with the IMS or/and with ‘emotional contagion' rather than with a ‘healthy' type of empathy. People who are ‘depressed' seem to empathise in this way: they base their empathetic reaction on the feeling of guilt, involving ‘imagine selves' in the others' misfortunes and getting in a midst of emotional distress. These findings were further confirmed by Showalter (2010) who investigated associations between depression and compassion in individuals working in helping professions. The author found out that people with high levels of depressive symptoms show-what she calls-‘compassion fatigue’, explained as professional burn-out, loss of self-worth, diminished productivity, poor morale, and more. These symptoms, in turn, are linked to diminished capacity to help others in need. Not surprisingly, despite showing enhanced levels of emotional empathetic response

in the neuropsychological lab, people with depression do not seem to benefit from their empathy; at least not at the first glance.

5.4 THE BENEFITS OF GUILT-BASED EMPATHY

So far I showed that although people who suffer from depression exhibit significantly higher levels of empathy, they are psychologically worse-off as a result. Their empathetic response is largely based on experienced guilt and does not contribute to their wellbeing. What is more, this type of empathy is not linked to altruistic action, which implies that people with depression, although more empathetic, cannot be seen as better moral agents than 'healthy' individuals. For these reasons, even these philosophers who generally defend empathy as a factor motivating altruism, reject 'emotional contagion' as non-beneficial for right moral judgements. For example, mentioned ealier in this chapter Meghan Masto in her paper entitled "Empathy and its role in morality" (2015) defends the role of empathy as a moral compass, arguing against the opposite views of Prinz (2011a, 2011b). Masto claims that empathy is necessary for moral judgement and moral development; however, she does not consider 'emotional contagion' as a genuine kind of empathy. Masto's main argument against the genuity of 'emotional contagion' is such that this type of empathy does not require any particular subject-or object-to which the empathy is directed. One can experience 'emotionally contagion' because of 'catching' the mood of a crowd (for example, during a musical performance or a sport game), but her feeling is not directed into anyone in particular, therefore, it does not benefit anyone else than herself.

However, as I argue below, the guilt-based empathy in depression may carry important psychological benefits for the subject, alongside the associated psychological costs. One of them is preserving the unity of self in the face of depression-related severe loneliness.

5.4.1 Depression and the sense of loneliness

The concept of loneliness has been relatively unexplored in academia. It began to trend in the mid-1960s, and has become prominent only with Robert Weiss's all-important *Loneliness: The Experience of Emotional and Social Isolation* (1973). People may experience the symptoms of mental illness as a result of numerous social factors such as being discriminated against (Anglina et al., 2013), being bullied (Wolke et al., 2014), living in urban areas (Kelly et al., 2010), living alone (Morgan et al., 2008), being a migrant (Cantor-Graae and Selten, 2005), having low socioeconomic status (Boydell et al., 2013) and having a limited social network and support (Gayer-Anderson and Morgan, 2013). Two common components of these experiences have been argued to be social defeat (Selten et al., 2013) and perceived social isolation (Jaya et al., 2017), both likely to result in a sense of loneliness.

However, the experience of loneliness is not the same as social isolation. One may feel lonely even when surrounded by other people (Hawkley and Cacioppo, 2010). It is also different from solitude, which is a voluntary state (Cacioppo et al., 2010). Rather, loneliness can be described as a negative emotional state that results from the perceived discrepancy of a person's *need* for social relationships with their *actual* social relationships (Hawkley and Cacioppo, 2010; Jaya et al., 2017).

Although loneliness has been shown to be associated with a variety of psychological problems, its links seem to be the strongest with depression (Neeleman and Power, 1994; Meltzer et al., 2013; Jaya et al., 2017). For example, building on the research of Cacioppo (Cacioppo et al., 2010), Jaya and colleagues show that depression is a key factor mediating the relationship between loneliness and positive psychotic symptoms, such as delusions and hallucinations. The association between loneliness and depression has also been confirmed in the research conducted by Meltzer and colleagues (2013). Andrew Solomon, in turn, explicitly calls depression the 'disease of loneliness' and points out that "many untreated depressives lack friends because it saps the vitality that friendship requires and immures its victims in an impenetrable sheath, making it hard for them to speak or hear words of comfort" (2014).

People with depression often report feeling alienated, enclosed, 'dead' inside, unable to make or maintain social relationships, often with the closest family members (Russell et al., 1984). This state of extreme emotional detachment from other people is found to be a high-risk factor for psychosis (Borsboom and Cramer, 2013; Linscott and van Os, 2013; Zavos et al., 2014; Constantini et al., 2015) and other severe mental health problems (Weeks et al., 1980; Young, 1982; Neeleman and Power, 1994; Hagerty and Williams, 1999; Adams et al., 2004; Meltzer et al., 2013; Sündermann et al., 2014; Jaya et al., 2017). For example, Sündermann and colleagues (2014) examined the relationship between social networks, loneliness, and psychotic symptoms in a sample of 38 first-episode psychotic patients. They found that loneliness was correlated with positive and negative symptoms of psychosis and that the association between loneliness and paranoid symptoms was partially explained by anxiety. Given that the sample consisted of first-episode psychotic patients of whom one third did not

have a confidant, loneliness does not seem to be merely a consequence of the disorder. Rather, feelings of loneliness are likely to have preceded the disorder and possibly contributed to it.

Meanwhile, preserving consistency is a priority for human cognition (Festinger, 1957; Brehm and Cohen, 1962; Festinger, 1962; Abelson, 1968; Elliot and Devine, 1994; Goetzmann and Peles, 1997; Antrobus and Bortolotti, 2016). In order to avoid mental disintegration, a person needs at least a minimal personal attachment; an experience of being a part of something bigger than herself, a feeling of social belonging. Baumeister and Leary (1995) have proposed that as humans we possess a *need to belong*, which constitutes a fundamental motivation, driving our thoughts, emotions, and interpersonal behaviour. Fromm-Reichmann writes:

> The longing for interpersonal intimacy stays with every human being from infancy throughout life; and there is no human being who is not threatened by its loss… the human being is born with the need for contact and tenderness" (1959, p. 3).

I propose that guilt-based empathy plays this fundamental role for someone with depression. In particular, to empathise by 'imagine self' (as explained earlier in this Chapter in the works of Batson and colleagues, 1997) as experiencing another person's pain, makes us share their experience and, as a result, makes us feel less lonely. The guilt-based empathy, explicated by Batson as 'imagine self' in another person's shoes, enables us to transcend the limits of our selves, opening us for an experience different to our own misery. For example, when a person with depression cries as a reaction to the news showing a dead refugee toddler having been washed out on the shore, she certainly feels a deep distress. She imagines herself being in the same boat as a child or perhaps even being a child itself. She also feels immensely and personally responsible for the tragedy, trying to figure out why she had not been able to

prevent it in the first place and ruminates the actions she could possibly take to help other children in need. These reactions are typical in cases of guilt-based empathy and were analysed earlier in this chapter. However, at the same time, she feels as if she relates to an important cause; by mentally stepping into other people's situations, her self is no longer detached from the environment. In this sense, the guilt-based empathy offers relief from extreme loneliness and might prevent psychotic disintegration of personality.

To sum up, to feel empathy, even if in a form of pure 'negative emotional contagion' and even in a case when it does not lead to an altruistic action, offers a vulnerable person one possible way to fulfilling the fundamental need to belong. The feeling of 'belonging', in turn, plays crucial role in preserving the unity of the self in face of severe distress; it offers relief from the experience of loneliness and mental disintegration that follows. For that reason, the guilt-based empathy ought not to be discredited as a non-virtuous or exclusively harmful. A better understanding of empathy and its relation to loneliness may offer some insight into the way in which people attempt to overcome their mental struggle.

Can guilt-based empathy offer any epistemic benefits to the subject? As the very process of empathising involves 'imagining self' in somebody else's shoes, we may hypothesise that it could be associated with acquiring better knowledge about their personal situation and life circumstances. For example, when I empathise with my ill friend by imagining myself going through the same terminal illness, do I gain any better knowledge about her experience or about other aspects of her situation? No research available today addresses this question. However, given that, in such a process, I am a protagonist of my own story and, as I showed earlier in this chapter, my attention is focused on my own experience of another person's

situation rather than on that situation per se, a benefit of expanding knowledge about other people seems unlikely. Further research is required to explore this question in more detail.

5.5 SUMMARY

This chapter asks what the relation between depression and empathy is. Based on empirical evidence I argued that people who suffer from depression have elevated levels of empathetic response to the suffering of others. Next, I showed that the type of empathy found in depression is based on one's feeling of guilt and, as such, does not lead to altruistic action, but, instead, has been linked to increased personal distress. Finally, I asked whether the guilt-based empathy might be linked to any benefits to the subject. I argued that by offering temporary relief from loneliness and strengthening the feeling of social belonging, the guilt-based empathy might protect the subject from developing psychotic symptoms. I concluded that further research is needed to confirm this hypothesis.

CHAPTER 6: CREATIVITY

> What distinguishes the poet or, quite generally, the artist from other human beings, therefore, is not his skill, his mastery, but the intensity of his feeling; and it is this intensity alone which really matters. A work of art produced without feeling, in cold blood, is really a fake; it is dishonest and immoral, for the public is deceived if a poet writes of a love he did not really feel in his heart. (Gombrich, 1980, p. 148)

Creativity is a fundamental activity of human information processing (Boden, 1998; Dietrich, 2004). Researchers investigating creativity largely agree on including two defining characteristics: the ability to produce work that is both novel (i.e., original, unexpected) and appropriate (i.e., useful, adaptive concerning task constraints) (Sternberg and Lubart, 1999, p. 3). Much has been written about creativity from social, psychological, developmental, cognitive, and historical perspectives, and a number of theories have been proposed from those viewpoints (Guilford, 1950; Mednick, 1962; Gruber, 1981; Wertheimer, 1982; Amabile, 1983; Simonton, 1988; Eysenck, 1993; Gardner, 1993; Martindale, 1995; Sternberg and Lubart, 1995; Csikszentmihalyi, 1996; Ward, Smith and Finke, 1999). However, still not much is known about its associations with mental illness, and specifically with depression.

Meanwhile, it would not be an overstatement to say that the question of whether creativity is linked to mental illness constitutes one of the most interesting and controversial topics both in the philosophy of psychiatry and in modern research on creativity. Although the big picture consensus appears to be the same: artists suffer from elevated rates of mental disturbance compared to the general population (Ludwig, 1992; Jamison, 1993; Ludwig, 1995) - the details of this mysterious relation are complex and inconclusive: a large number of

possibilities suggests that the reply is: ‘it's complicated!' Both creativity and mental illness are abstract and complex concepts; there are many psychiatric disorders and there are countless domains of creativity, with divergent thinking, musical, artistic and linguistic skills making only a small sample. As the growing body of evidence suggests that creativity is domain specific (e.g. Baer, 1999), crossing the different mental disorders with the different creative domains produces an enormous 'Disorder by Creativity' matrix (Silvia and Kimbrel, 2010). Furthermore, if we accept that both mental health and creativity vary in degree, not just in kind, this complex network of mutual relations is multiplied. For these reasons, Silvia and Kaufman (2010) suggest that in order to find out how both phenomena intersect (if at all) we ought to narrow the research to specific mental disorders, specific creativity domains, human developmental periods and levels.

In the past, schizophrenia and depression were perceived as the main sources of creativity (Ludwig, 1995), whilst more recent research has emphasized the role of depression and bipolar disorder in bringing about creativity. Being aware of the fact that frequently the diagnostic borderline between bipolar and unipolar depression is not sharp (in fact, it is often the case that major depression precedes a later manic/hypomanic episode), I will focus on the evidence of creative traits in people experiencing major depression. Most of those studies advocating for positive links between ‘mood disorders’ and creativity point at the symptoms related to manic/hypomanic phases of the illness, such as the elevation of mood, cognitive fluidity, openness to new experiences, neglecting instead the opposite spectrum of the illness. In this chapter, as in the whole thesis, I am more interested in acquiring knowledge about the benefits of those mental states where cognitive activity is slowed down rather than accelerated and where melancholy replaces euphoria. The relationship between hypomania and creativity

is worth investigating because unipolar depression is commonly perceived as a debilitating and painful disorder. Its defining symptoms include diminished interest in all activities, loss of energy, indecisiveness, and lack of concentration - these symptoms are not usually associated with creative behaviour. Intuitively, any direct link between the symptoms of unipolar depression and creativity sounds unlikely. However, as I will show here, the association in question is very complex and has been repeatedly supported by evidence.

Despite its widespread occurrence, major depression has attracted relatively little interest from researchers investigating the links between creativity and mental illness (Weisberg, 2006; Kaufman, 2009; Silvia and Kaufman, 2010; Simonton, 2014a, 2014b). The majority of studies in the field focus on the dimensions associated with disorders of thought and mood, such as schizophrenia and manic/hypomanic states (for example Jamison, 1989; Goodwin and Jamison, 1990; Jamison, 1993; Richards, 1994; Janka, 2004; Andreasen, 2005; Kinney and Richards, 2007; Batey and Furnham, 2008; Murray and Johnson, 2010; Johnson et al., 2012), even though these disorders are much less frequent in the general population (Kessler et al., 1994; American Psychiatric Association, 2013). To investigate possible links between depression and creativity is, therefore, vital in order to achieve a more complex picture of the illness itself as well as expanding our knowledge of the phenomenon of creativity.

Here is the plan of this Chapter: In section 6.1 I review a selection of available theories and empirical studies both supporting and opposing the hypothesis of a link between creativity and depression. I argue that, based on the reviewed evidence, creativity is proven to be linked to depression, predominantly in the population of eminent artists, with poets being the most vulnerable group. In the search for a plausible explanation for this finding, in section 6.2 I

look into the empirical data from neuropsychology and argue that a specific type of creative act, namely spontaneous/emotional creativity, is both typical in eminent artists and, at the same time, biologically linked to depression. In section 6.3 I analyse the findings in more detail and propose that in the population of eminent artists creativity may constitute an epistemic benefit of depression. By supporting the act of spontaneous/emotional creativity, depression enables artists to produce works of the highest value. In section 6.4 I draw my conclusions.

6.1 MAD GENIUS?

The topic of this chapter constitutes one of the oldest questions in philosophical and psychological thought. Two millennia ago Aristotle asked: 'Why is it that all those who have become eminent in philosophy or politics or poetry or the arts are clearly melancholics and some of them to such an extent as to be affected by diseases caused by black bile?' (*Problemata* XXX.1 953a10-14). The 'mad genius' might sound like a recurring stereotype of contemporary cultural expression, nevertheless – beginning with Lombroso's 1891 exploration of genius and madness, a vast amount of empirical research points at the close association between creativity and depression. Still the results of the studies are largely inconclusive and the support for such relation rather unconvincing. There are at least two main reasons for such an ambiguous outcome, both rooted in methodological inconsistencies: firstly, both the term 'depression' and the term 'creativity' have become umbrella terms for many, often significantly different, phenomena in the centre of the research focus. Those who talk about 'depression' usually mean a variety of mood disorders, in general. The studies

conducted often measure as diverse entities as bipolar disorder, temporarily induced low mood, anxiety disorders, post-traumatic stress disorder (PTSD), grief and bereavement. Similarly, by exploring ‘creativity' researchers seem to focus on various, not always related, phenomena, such as divergent thinking, artistic productivity of many kinds, problem-solving skills, an ability to create word associations, etc.

The second methodological discrepancy is evident in the fact that most of the studies exploring the association between creativity and depression rely strictly on biographical data and/or small samples of participants. This is problematic because, whereas offering some interesting facts about famous artists or about specific groups, such results do not enable us to draw any far-reaching conclusions about the creativity-depression relation in the wider population.

It is not my intention in this chapter to explore at length all the available data regarding the relation in question, nor to provide a final and ultimate solution to an old dilemma. This would be an impossible task, given the above assertions. My intention here is to look critically at the selection of available studies exploring links between creativity and depression and to clarify a possible relationship between them.

6.1.1 The evidence supporting the links between depression and creativity

Is the alleged link between depression and creativity more than anecdotal? To a large extent, the serious academic interest in this dilemma was prompted by the results of a landmark study conducted by Nancy Andreasen and Arthur Canter of 30 writers (27 men and 3 women) attending the University of Iowa Writers Workshop (Andreasen and Canter, 1974). The

results revealed that 80% of these writers, compared to 30% of those in control group, reported suffering from some type of mood disorder, with major depression being the most common condition.

Volumes of literature burst with countless examples of artists who suffered from depression. These include famous writers (e.g. Emily Dickinson, Edgar Allan Poe or Sylvia Plath), painters (e.g. Vincent Van Gogh, Edward Munch, Francisco Goya) and musicians (e.g. Ludwig van Beethoven, Robert Schumann or Pyotr Tchaikovsky) (Thomas and Duke, 2007). Kay Jamison, one of the most renowned investigators of the links between creativity and psychopathology, provided much evidence in support of the thesis that depression is indeed closely tied to creative traits of personality. Although Jamison was primarily interested in bipolar disorder, her extensive research on the topic of creativity provides some interesting data with regards to unipolar depression. For example, the author claims that the prevalence rate of major depressive disorder in artists is eight to ten times higher than the rate in the general population (Jamison, 1993). Moreover, artists are eighteen times more likely to commit suicide than their general population counterparts (Jamison, 1993, p. 88). Other studies mirror these findings. A study of a sample of 59 female writers shows that the rate of depression is as much as seven times higher than that in a control group. The authors suggest that this effect is mostly related to the fact that a substantially higher percentage of writers than members of the comparison group reported being physically or sexually abused as children and that those who allegedly were abused were far more likely to suffer from mental illness than those who were not (Ludwig, 1994, p. 1654).

This conclusion, if true, could shed a completely new light on the issue of creativity and its links with depression. We could hypothesise that childhood trauma might be linked to depression (this indeed has been repeatedly confirmed by a number of recent studies, for instance, Hill, 2003; Nemeroff et al., 2003; Heim et al., 2008; Cattaneo et al., 2015) but also that it might be associated with enhanced creativity. This, in turn, could mean that it is not necessarily depression *as such* that elevates the level of creative spirit, but that it is a significant suffering experienced in the past.

This claim might sound bold at first; it has received, however, certain attention from researchers. Psychologist, psychoanalyst, and writer Alice Miller investigates such a possibility in one of her books *The Untouched Key: Tracing Childhood Trauma in Creativity and Destructiveness* (2012). Miller asks what it takes to turn the painful experience of childhood trauma into immense works of art in some cases and into self-destructive behaviour in others. In order to find the answers, Miller analyses the life and work of such renowned artists and intellectuals as Picasso and Nietzsche, attempting to interpret their achievements in the light of their disturbed past.

Although Miller provides a fascinating reading woven with excellent questions, she does not present any hard empirical data, nor does she offer any final conclusions. However, some more recent research provides evidence to support the thesis that childhood trauma and creative traits of personality are associated. In their interesting experiment, Allen and Lauterbach (2007) investigated whether childhood trauma might be linked to specific characteristics of personality. The authors hypothesised that people who had experienced prolonged, repeated trauma as children, would be subjected to significantly more personality

disruptions than individuals who had experienced a single, one-time traumatic event or who had not experienced any trauma at all. The researchers used both clinical interviews and scales (e.g. the Kessler's National Comorbidity Survey, NCS) to select their sample as well as to assess the participants' trauma exposure. Traumatic events were grouped into 10 different categories, starting from "direct combat experience in a war", to "physical abuse as a child" to "sexual molestation" (Allen and Lauterbach, 2007) and placed on a scale of frequency of occurrence. The authors found that participants who self-reported being exposed to either single or repeated childhood trauma present higher levels of neuroticism and openness to new experiences (personality traits usually associated with creativity) than those who did not have such experiences. The researchers suggest that child trauma victims are also likely to have higher levels of such traits as curiosity, open-mindedness and cleverness (Allen and Lauterbach, 2007, p. 592). Whilst discussing their findings, the authors emphasise that

> Although it is, of course, impossible to make causal statements based on retrospective, cross-sectional data, these findings point to the possibility that *some level of posttraumatic growth* may occur following some types of childhood trauma (2007, p. 593, my emphasis).

In addition, rather importantly, the authors point out that the results of their study re-affirm the need of new, dimensional structure of human mental health classification, based on a continuum of personality traits rather than on a taxonomic 'present vs. absent' diagnosis in psychiatry.

Allen and Lauterbach's study provide an excellent argument for the view endorsed in this thesis that human mental health ought to be understood as the continuum of diverse dimensions. Painful experiences such as childhood trauma have the capacity to intensify one's suffering and lead to a mental breakdown; at the same time, they are evidenced to offer the

capacity for personal growth and positive character traits. This conclusion points, rather importantly, to the possibility that there might be more than one causal direction between depression and traits of creativity. Although a vast number of studies explore the question of whether people who score high on depression scales show enhanced creativity, the opposite direction of such a link is also likely. More specifically, it is plausible to think that people who are highly creative are prone to depression or other mental illness. The common ground for both phenomena, depression and creativity, could lie in specific personality traits (such as neuroticism and openness to new experiences) and these, in turn, could result from difficult events experienced in one's childhood.

Additional research has suggested possible ways in which depression enhances creative productivity. In a study paralleling Ludwig's (1995) in scope, Kaufman (2001) took a closer look at gender whilst investigating the interplay between mental illness and creative writing. He examined the psychobiographies of 1629 male and female poets, novelists, playwrights, and nonfiction authors. Female poets were found to show significantly higher rates of depression than all other groups of writers. Kaufman coined his finding 'The Sylvia Plath Effect', after one of the most highly acclaimed female poets of the 20th century, who died by suicide at age 31.

Not only do poets and writers suffer from the highest rates of depressive disorders, but research also suggests they have higher rates of suicide and early death. As Kaufman (2003) simply puts it, "writers die young" (Kaufman, 2003, p. 814). Kaufman found writers to have a shorter lifespan than individuals in other artistic and non-artistic professions. Kay Jamison (1996) did not directly analyse differences in suicides between groups of artists in *Touched*

with Fire, but a quick glimpse at her appendix reveals that the number of suicides among famous poets equals the sum of suicides committed by prose writers, music composers, and other artists, combined.

Thomas and Duke (2007) in a very interesting study investigated whether work of authors with depression differs from control groups of writers in terms of cognitive distortions. The authors looked at the prevalence of seven cognitive distortions associated with depression: arbitrary inference (forming conclusions without supporting evidence or in the face of contrary evidence), selective abstraction (overemphasizing selected details in a situation while simultaneously ignoring other facts that are just as compelling), overgeneralization (developing a general rule on the basis of isolated events and then applying the rule indiscriminately across unrelated situations), magnification (when the significance of ordinary events is routinely distorted and exaggerated), minimization (when consequential events are trivialized or discounted), personalization (assuming personal responsibility for events over which the author has little or no control), and dichotomous thinking (describing things or events in all-or-none terms) in the works of prominent authors with and without depression. Beck's cognitive theory of depression assumes suicidal individuals possess the greatest degree of cognitive distortions of any population (Brown et al., 2000). Statistical analyses of the primary research questions found that works of the authors with depression exhibited more cognitive distortions than works of the control groups. Furthermore, as Thomas and Duke discovered, at an even greater level of significance, poets employed significantly more cognitive distortions than writers, with no significant differences in the exhibition of cognitive distortions in the works of female and male authors. What is the explanation for the phenomenon, evidenced in several empirical studies, that poets score higher on the scales

related to depression than other writers or, even more broadly, other types of artists? One explanation for this interesting association comes from the works of Kaufman and Sexton (2006). The authors propose that among many reasons, poets are likely to suffer from mental illness at a greater rate than other writers because they exhibit a significantly different writing style. As Kaufman and Baer (2002) note:

> … efforts to distinguish the thinking styles of nonfiction and creative writers (…) have received more attention than comparisons of the thinking styles of poetry and fiction writers, but one recurring theme is that poetry may be more expressive, emotional, and introspective than fiction. (Kaufman and Baer, 2002, p. 276)

In "The Art of the Novel", Milan Kundera (1988) points out vital distinctions between poets and novelists. He quotes Hegel, saying:

> The content of lyric poetry (…) is the poet himself; he gives voice to his inner world so as to stir in his audience the feelings, the states of mind he experiences. And even if the poet treats "objective" themes, external to his own life, 'the great lyric poet will very quickly move away from them and end up drawing the portrait of himself'. (Kundera, 1988, p. 40)

Thomas and Duke (2007) offer yet another explanation for the phenomenon of 'depressed' poets. In writing, they suggest, novelists generate people whereas poets generate emotions and ideas. Writers allow characters they create to control the narrative voice and guide their stories as the character unfolds (the writer can almost become a bystander of the characters and actions she/he creates). Poets, on the other hand, tend to maintain their own voice throughout their writing. For poets, their work is often their feelings. Novelists, on the other hand, must distance themselves from their feelings in order to do their work.

Two other theories briefly explain why poets might be more vulnerable to depression than other artists. The first theory proposes that the association is mediated by the age factor. The

finding that poets die younger than any other artistic group has been replicated (Simonton, 1984; Ludwig, 1995; Kaufman, 2003), suggesting a possible connection between age, depressive disorders, and writing medium. Poets have been reported to start their career much earlier than prose writers, producing twice as much of their total lifetime output in their twenties than writers (Simonton, 1984).

The second explanation deals with the locus of control, an important concept in cognitive psychology. A person's locus of control can either be internal, meaning that individuals tend to credit themselves for important events in their lives, or external, indicating the tendency to consider major events as being the result of outside forces (Rotter, 1966; Thomas and Duke, 2007). Research suggests that poets are more likely to attribute their works to a 'muse' than writers (Kaufman & Baer, 2002). This attribution could be viewed as poets being more likely to have an external locus of control, which consequently implies that they may have lower self-efficacy than prose writers. Whilst analysing Thomas and Duke's study it is important to note that its one significant limitation was that it failed to distinguish between unipolar depression and bipolar disorder, referring to both as depression. It is important because, as Jamison (1993) revealed, the prevalence of bipolar disorder was anywhere from 10 to 40 times higher among artists than in the general population (compared to 8 to 10 times higher for unipolar depression). Therefore, it is probable that a vast number of poets and writers analysed by Thomas and Duke suffered from bipolar disorder rather than unipolar depression.

A number of researchers aimed to verify which negative emotions, in particular, are associated with creativity in a most significant way. The evidence coming from these studies indicate that intense negative emotions can create powerful self-reflective thought and

perseverance, leading to increased creativity (Isen, 2000; Kaufman and Baer, 2002; Verhaeghen et al., 2005; Akinola and Mendes, 2008; De Dreu et al., 2008). A study conducted by Akinola and Mendes (2008) looked at the role of perceived social rejection (one of the experiences related to depression) in fostering creativity. The creative production (collage making) was assessed by a panel of artists (both professional artists and graduate art students). The authors found out that participants with the experience of social rejection produced more creative collages than controls and than the positive feedback group. This association was moderated by participants' biological vulnerability to depression measured by neuroendocrine test (DHEAS). It turned out that participants who were biologically vulnerable to depression and who were exposed to a situation that brings about intense negative emotion (social rejection), showed the most artistic creativity.

Some other researchers were interested in another depression-related phenomenon, self-reflective *thought rumination*, and its possible links with creativity. Thought rumination has been defined as "a class of conscious thoughts that revolve around a common instrumental theme and that recur in the absence of immediate environmental demands requiring the thought" (Martin and Tesser, 1996, p. 7). Self-reflective rumination (e.g. Nolen-Hoeksema et al., 1993; Treynor et al., 2003) uses the self, that is, one's inner feelings, memories, and so forth, as the recurrent theme (see also Verhaegen et al., 2005). According to Nolen-Hoeksema (1991), rumination is characterized by a style of thought rather than by its negative content. This implies that rumination by itself does not necessarily promote depression because even when healthy people show this style of thinking, they do not necessarily focus on negative affect or on negative personal attributes. However, a large body of literature suggests that a ruminative thinking style increases one's vulnerability to depression and maintains negative

affect when the focus is on negative life events or when the individual experiences frequent negative mood states (Verhaegen et al., 2005). In their analysis of the high prevalence rates of mental disorder in female poets, Kaufman and Baer (2002) proposed a link between rumination, depression, and poetry writing. They argued that the introspection and rumination that characterizes depression may also be involved in writing poetry and, in addition, that rumination and introspection may, in fact, increase instability in poets who are already vulnerable to mental disorder. Verhaeghen and colleagues (2005) mirrored these findings in their study and propose that self-reflective rumination prepares individuals to generate a larger number of ideas. This enhanced fluency, in turn, allows for the emergence of more creative ideas and for increased elaboration. The authors conclude that the relationship between depression and creativity is mediated entirely by ruminative tendencies and that depression on its own does not predict increased creativity.

6.1.2 The evidence against the links between depression and creativity

Although a lot of studies attempt to link depression with creativity, for a great number of researchers the generality and validity of the 'mad genius' hypothesis are nevertheless questionable (Baas et al., 2016). The validity of many archival and interview studies has been heavily criticized (see for instance Schlesinger, 2009). In addition, systematic study of the associations between (vulnerability to) psychopathology and creativity in both clinical and nonclinical populations has yielded mixed results (Kaufman, 2014). Despite growing evidence for the association between psychopathology and creativity, other authors obtained neutral results (e.g., Rothenberg, 1990; Lauronen et al., 2004; Simeonova et al., 2005; Santosa et al., 2007), or even negative relations (e.g., Crowe, 1996; Abraham et al., 2007). Similarly

mixed results come from the research looking into the links between creativity and depression.

In a broad study of creativity and subclinical spectrum traits, Schuldberg (2001) found evidence that depressive symptoms were negatively related to creativity. Small negative effects appeared for several of the creativity measures. Similarly, Santosa and colleagues (2007) found no differences between people diagnosed with major depression and people classified as "healthy controls" on the Barron-Welsh Art Scale, the figural and verbal components of the Torrance Tests, or the ACL creative personality scale. Silvia and Kimbrel (2010) investigated whether depression and anxiety predict high creativity. The authors assessed 189 university undergraduates for symptoms of depression and anxiety using the Depression Anxiety Stress Scale (DASS). Creativity was assessed across several domains including divergent thinking (participants were asked to generate unusual uses for a brick, a knife, and a box), creative self-concept (using Kaufman and Baer's (2004) 9-item Creativity Scale for Different Domains (CSDD) including self-reported levels of creativity), everyday creativity and creative achievement. Overall the authors found no effect of depression on any of the domains of creativity. It is crucial to note, though, that with the exception of the divergent thinking scale, all remaining domains of creativity were assessed merely by participants' self-report (participants did not engage in any creative tasks as part of the experiment). Whilst discussing their findings, Silvia and Kimbrel suggest that

> Creative behavior, viewed broadly, is appetitive and approach-oriented: creative people seek out people and activities that afford novel, unusual, and complex behaviors. People who find behavioral novelty and variability rewarding will have a motivational architecture that promotes approaching new, unusual things (Silvia, 2006). In contrast, depressive anhedonia essentially represents the absence of appetitive behavior, whereas anxiety and social anxiety would be expected to inhibit appetitive and novelty-seeking behavior (Kimbrel, 2008). Thus,

> from a motivational perspective, it is not surprising that anxiety and depression didn't predict higher levels of creative action. (Silvia and Kimbrel, 2010, p. 7)

Shapiro and Weisberg (1999) conducted a similar study of the relationship between affective disorders and creativity in an undergraduate sample. The study also relied on participants' self-reported assessment of creative behaviour. No evidence has been found that predominantly depressive symptomatology was related to increased creativity. The only group showing enhanced levels of creativity consisted of self-reported frequent episodes of hypomania without accompanying symptoms of depression. Shapiro and Weisberg's results mirror a suggestion made by Isen (1987) that it is primarily *positive* affect that may be tied to enhanced creativity.

A study by DeMoss and colleagues (1993) was designed to examine the relationship between creativity and affective symptoms among high-achieving adolescents. Although *figural creativity* (a test which involved presenting individuals with various shapes and asking them to create designs) was associated with a depressive attributional style for both males and females, a different pattern emerged for *verbal creativity* (involves several sections designed to elicit a number of different possible solutions to problems). More specifically, for females, verbal creativity was associated with a positive attributional style and low levels of depression-related symptoms. Whilst discussing their results, the authors suggest a few possible explanations. Firstly, low levels of depression may allow the females to generate more verbally creative responses. Alternatively, verbal creativity may serve for women as a protective factor against depressive feelings. Along these lines, it may be that verbally gifted females are highly valued by parents and teachers, and may meet their need for self-esteem through verbally creative outlets (DeMoss et al., 1993). It is interesting at this point to recall

the classic study by Andreasen (1987) who found a link between creative writers and affective disorder. As Andreasen's population was overwhelmingly (90%) male, one might speculate, based on the findings by DeMoss and colleagues, that a similar link does not exist for females.

Baas and colleagues (2016) conducted a broad review of the empirical literature examining the link between depressive mood and creativity and identified 39 independent studies, covering a total of 7,391 participants. Results did show that whereas the relation between depressive mood and creativity was negative for lay people (the higher levels of depression, the lower levels of creativity) it was positive in artistic populations (creativity levels grow together with depression). Although the latter result was based on only three studies, including 186 participants, it suggests that the nature of the relationship between depression and creativity may be domain-specific (Baas et al., 2016). This is in line with archival studies on eminent people by Simonton (2014b), who observed that rates and intensities of mental disorders varied across domains of creative achievement. For example, whereas eminent scientists have a low probability of severe psychopathology, famous thinkers, writers, and artists had higher risks of such mental problems. Similar differential relations have been observed with regards to non-eminent creativity, with acts of artistic creativity being more strongly related to diagnosed psychopathology than acts of everyday creativity. In a study exploring relations between artistic and non-artistic (everyday) creativity and psychological traits, Ivcevic (2007) found out that artistic creativity was related to psychopathology (diagnoses of psychological disorders, taking psychotropic drugs, and being in therapy), while everyday creativity was related to personal growth, a component of psychological wellbeing. Artistic creativity can be inspired by experiences related to a psychological disorder and it can

provide an avenue to express distress in a productive and socially valued way (see also Walker et al., 1995). On the other hand, everyday creativity can be facilitated by the need or desire to enrich one's daily experience and solve problems of daily living and might be inspired by one's perception of a need to create a change in the existing environment (see also Runco, 2004).

This conclusion facilitates yet another understanding of the results by Jamison (1993), discussed earlier. It seems possible that depression and other affective disorders explored in her study might not be actually related to creativity as a general personality trait, but rather to creative productivity in a specific group of people, that is in prominent artists, and specifically, as we remember the data, in poets. Repeatedly, the research exploring creative traits in non-artistic populations does not result in the same strong and conclusive data as its does in those groups; in certain cases, as we could see above, the correlation between creativity and depression is negative, indicating that in many cases the experience of depression stands in the way of creative expression.

To sum up, having analysed the data it becomes clear that the link between depression and creativity indeed exists, although it is more complex than the anecdotal 'mad genius' stereotype suggests. The majority of results indicate that the lifetime prevalence of depression is higher among people engaged in professional creative pursuits, particularly for well-known figures. Among these, in turn, male poets seem to be at highest risk of the illness. Further evidence suggests that certain symptoms of depression (such as experience of social rejection or self-reflective rumination), but not others, may be tied to increased creativity.

At the same time, a number of studies investigating possible links between creativity and depression in the general (rather than artistic) population have failed to uncover any such relationship. One possible explanation for this effect is that certain authors (e.g. Shapiro and Weisberg, 1999; Silvia and Kimbrel, 2010) relied predominantly on participants' self-reported creativity rather than on its direct measures. However, this explanation does not seem completely convincing. First, similar results of no link (or of a weak negative link) between creativity and depression come from the studies which use other measures than self-reported creativity (see Ivcevic, 2007; Baas et al., 2016). Secondly, a hypothesis that one's self-report is less reliable or trustworthy than a laboratory design creativity task does not have much support. The construct of creativity itself is multi-dimensional and covers a broad range of cognitive and behavioural factors as well as skills and behaviours. An insightful self-report might be in these circumstances an advantageous method when compared with a general creativity task constructed as a part of laboratory experiment. One may be excellent in, for instance, finding novel use for everyday objects, but if the task consists of creative writing, s/he may fail it entirely.

Can there be any more plausible explanation for the links between creativity and depression in artists that have been repeatedly shown and for the lack of such an association in the general population? I address this question in the next section, where I discuss one possible explanation, pose some resulting questions and propose directions for further research.

6.2 EMINENT ARTISTS AND DEPRESSION: NEUROCOGNITIVE ARGUMENT

Having reviewed a selection of empirical studies investigating whether creativity is linked to depression, we arrived at the conclusion that whilst such an association manifests in eminent artists, the same result is not observed among people from the general population. A review of neurocognitive research concerning creativity offers a possible explanation of this fascinating phenomenon.

In his article "The Neuroscience of Creativity" Arne Dietrich (2004) suggests that every creative production predominantly occurs in a subject's emotional structures or in their cognitive structures, crossing the type of information with the two modes of processing: deliberate or spontaneous. As a result, there are four possible combinations of the process of creating: 1. emotional and deliberate, 2. emotional and spontaneous, 3. cognitive and deliberate, 4. cognitive and spontaneous. Dietrich stresses, however, that a given creative act should not be understood as the manifestation of one of these types in pure form. Just as any behavioural act is the result of a combination of normative cognition and emotion, the four types of creativity are basic elements of information processing, and creative behaviour is ultimately the result of a combination of these basic psychological processes (Dietrich, 2004). As a consequence, different types of creativity will have different characteristics, depending on the proportions of each of the four types in each combination. On this picture, I suggest that eminent professional artists are more likely to engage their emotional (rather than cognitive) mental processes and are more likely to work in a spontaneous (rather than deliberate) mode. A majority of professional, especially eminent artists, use the act of creativity in a spontaneous way, which means that they do not need to focus their attention on

the technical side of the act itself, such as, for instance, following instructions on how to mix oil paints, thinking about how to use perspective or how many lines should they write in order to create a poem. They create their work half, or even entirely, spontaneously, and the very aim of their creation is as much a physical end-result, as it is, often primarily, to express their mental state through the very act of creating. Colloquially, we would say, that the very good artists are 'lost' in their work or that they 'do not see the world around them'. Such a spontaneous act of creation involves predominantly implicit emotional processes.

Everyday creativity, on the other hand, is related predominantly to deliberate and methodical problem solving (e.g. Guilford, 1982; Boden, 1998; Weisberg, 1993; Sternberg and Lubart, 1999). In other words, non-artists approaching a creative task, focus their attention on the task itself rather than on expressing their emotional states, as well as work deliberately, that is, engage their executive cognitive control over the process. Similar distinctions between modes of thinking, for instance, intuition and analysis or explicit and implicit, have been made previously (Simonton, 1975; Shirley and Langan-Fox, 1996; Ashby et al., 1999). Many other authors have pointed out that artistic creative insights are marked by *sudden realizations* that tend to occur in a mental state characterized by *defocused attention* (Bransford and Stein, 1984; Eysenck, 1995; Martindale, 1999), in other words, spontaneous and anecdotal reports in the arts and sciences frequently describe the artistic creative process as, to large extent, 'automatic' and 'effortless' (Dietrich, 2004). According to empirical evidence coming from neuroscience, both described types of creative processes also differ on a neuropsychological level:

> While *deliberate creativity* is instigated by circuits in the prefrontal cortex and thus tend to be *structured, rational, and conforming* to internalized values and belief systems, *spontaneous*

> *insights* occur when the attentional system does not actively select the content of consciousness, allowing unconscious thoughts that are comparatively more *random, unfiltered, and bizarre* to be represented in working memory." (Dietrich, 2004, p. 1016, my emphasis).

A discovery most important for this debate, however, is such that, according to the data coming from neuroscience, both spontaneous/emotional creativity and depression are linked to hyperactivity in the same region of the human brain (Dietrich, 2004). More specifically, it has been observed that spontaneous and emotional creativity relates to unusual alterations in the ventromedial part of the prefrontal cortex (VMPFC) and, at the same time, might be associated with depressive symptoms such as impaired social function.

> Depression might be particularly interesting because research shows that it is associated with hyperactivity in the VMPFC region but hypoactivity in the DLPFC region (see Mayberg, 1997). The present framework not only predicts that creative ability is altered in those individuals but can make precise predictions in what direction, and for what type of creativity. If this is the case, the link between mental illness and creativity can be described more precisely, as this connection is only reported for artists, writers, and musicians, but not scientists. (Dietrich, 2004, p. 1022)

Adrienne Sussman (2007), researching creativity and mental illness, links the hyperactivity in the frontal lobe both to creativity and to depression. This association is empirically evidenced in high levels of norepinephrine (whilst its low levels result in the symptoms characteristic for mania or hypomania). The author reflects that

> It is not hard to see how these symptoms might be loosely analogous to creative processes-drawing unusual connections or thinking in a unique way are hallmarks of the artistic mind. But the traits of creativity are not only descriptively similar to some of the side-effects of mental illness-the neurological brain states are actually the same. (Sussman, 2007, p. 22)

and

> More than the same brain region, the same neurotransmitters in that region seem to be responsible in both mental illness and creativity. (Sussman, 2007, p. 23)

The neuropsychological model of the links between depression and creativity presented has several limitations. The link between spontaneous/emotional mode of creativity and depression proposed in this chapter does not licence any claims about the causality. The research shows a possible correlation (co-occurrence) of the phenomena, without refining what could be the way in which both, creativity and depression, influence one another. As with limited data related to this question, finding the correct answer might be a matter of a rather distant future.

Taking into account the complexity and the mystery of the human brain and of the human mind, the model is merely a great simplification of the unlimited number of possible combinations between types of creativity, experiences of depression, modes of creative acts, and so on. Both notions, that of creativity and that of mental illness, are probably among the most complex and multidimensional phenomena; both contain, I believe, an astonishing potential for advanced, exciting, multidisciplinary research.

6.3 CREATIVITY AS AN EPISTEMIC BENEFIT OF DEPRESSION

Thus far, I have shown that depression or the experiences related to depressive illness such as social isolation or suicidal thoughts are more prevalent among eminent artists than in the general population. From the neurological point of view, depression shares similarities with the biology of a spontaneous, emotional act of creating. In short, it is possible that the

experience of depression could indeed contribute to spontaneous creativity, or perhaps that an act of creativity that is free of cognitive focus may somehow enhance certain depressive symptoms.

Having accepted that this connection is empirically supported and that its causality remains unclear, I propose to see the spontaneous/emotional creativity as an epistemic benefit of depression in the population of eminent artists. Intense emotional experiences create a strong need for creative expression (Torrance, 1988). Classical examples of spontaneous/emotional creativity include artistic expressions such as Picasso's *Guernica* or Coleridge's poem "Kublai Khan" (Dietrich, 2004), the works contributing to the world's cultural heritage and to countless personal insights, the works enriching human knowledge on both phenomenal and personal levels.

It might be argued that since creative emotional insights do not require specialized knowledge from the artists, the epistemic value of their art might be questionable. Addressing such a worry, Dietrich (2004) argues that whilst the artist's knowledge might indeed not be specialised, the expression of his/her emotional insights does require exceptional skill.

> …*Guernica* was inspired when Picasso witnessed the Condor Legion brutally destroying the town of Guernica in the Spanish Civil War. Picasso's work is not based on any historic, military, or other knowledge that can be acquired by formal education. It is based on understanding human suffering, injustice, and fear. It is likely that other witnesses to the event had similar experiences of empathy, but Picasso had a special way of expressing it. Similar arguments can be made for other creative arts. Modern popular music requires little formal knowledge, often as little as a few simple chords, but few people would argue that the Beatles were not creative. Equally, creativity in literature and poetry is not based on special knowledge of grammar or a degree in comparative literature. Once the specific mechanics of expression are mastered, creativity in the various arts is based on emotional reactions to environmental stimuli. (Dietrich, 2004, pp. 1020-1021)

What is it about these prominent works of art that make them so precious and valuable? According to Ramachandran (2003) who has studied the neurological impact of art for years, the key factor of an ingenious work of art is its *novelty*. However, as the author emphasises, for an artist, novelty can be very difficult to achieve. In this sense, then, depression may be an advantage, allowing the artist access to experiences that others find difficult to imagine.

While there is no doubt that for the eminent artists as for the general population depression is associated with psychological and epistemic costs such as emotional pain, self-destructive behaviour, cognitive malfunctioning or significantly diminished focus of attention, the very idea that it may be simultaneously related to certain epistemic benefits is usually left unexplored. Meanwhile, as I hope I have shown in this chapter, in certain circumstances, symptoms of depression might carry the potential of a unique epistemic value. By enabling an artist to find novel ideas and novel ways of expression, depression might be seen as a medium of genius for many artists and contribute to the expansion of knowledge. In this sense, depression-related experiences may be seen as epistemic benefits both for the artists and for us, the recipients of their work.

Certainly, not every artist needs depression, or mental illness in general, in order to create a valuable work, but this is not the claim I try to make here. Many wonderful works of art have been created in a 'healthy' state of mind and the creative process itself was less 'spontaneous' than 'deliberate' and with a great part of cognitive control from the author. However, I hope that taking a careful a look at the long stream of empirical data helped us realise that the role of mental suffering in the famous works of artists is indeed significant.

As with regards to the general population, the links between creativity and depression have not been confirmed. In some cases, the correlation appeared to be slightly negative, which implies that the symptoms of depression stood in the way of the successful creative process. This result is equally interesting; it indicates that the creative process in people who are not professional artists might be relying less on a spontaneous and emotional act and more on deliberate, cognitive processes. This hypothesis, together with the results suggesting a negative link between depressive symptoms and creativity in the general population, offers a possibility that in certain circumstances deliberate and focused creativity could play a therapeutic role for people suffering from depression. By activating one's focus of attention and supporting executive cognitive skills, art therapy is indeed practiced in many mental health facilities with proven success.

6.4 SUMMARY

This chapter investigates the status of the current debate on the possible links between creativity and depression. The review of a number of empirical studies concludes that the association between the two phenomena is very complex as both depression and creativity are multidimensional and operationally problematic mental constructs. After having analysed the available data I argued that the positive correlation between depression (or certain related symptoms) and creativity can be predominantly found in the population of eminent artists (especially poets) but not in the rest of the population. Drawing from the related research in neuropsychology it is proposed that it is a specific type of creating process, namely

spontaneous and emotional, that is linked to depression and related symptoms. Whilst the causality of the association remains unclear I suggested that in certain circumstances creativity may constitute an epistemic benefit of depression. This is more recognizable in the case of eminent artists, who have created marvellous works of art whilst suffering from the illness.

CHAPTER 7: SPIRITUALITY AND RELIGIOSITY

In this chapter, I explore possible associations between spirituality/religiosity and depression. Some authors researching affective disorders proposed such a link (for example Galvez and colleagues (2011) have listed spirituality as one of the possible benefits of bipolar disorder), although the nature and direction of the alleged relation remain unclear.

Numerous empirical studies indicate the strong correlation between the phenomena of spirituality, religiosity, and depression (e.g. Cotton et al., 2005; Dalmida, 2006; McCoubrie and Davies, 2006; Sorajjakool et al., 2008; Perez et al., 2009; Galvez et al., 2011). Researchers attempt to address questions such as: (a) How does depression affect spirituality? (b) Can spirituality and/or religiosity function as a tool in coping with depression? (c) How does one define meaning in the presence of melancholia? (Sorajjakool et al., 2008). This chapter seeks to explore some of these questions by examining the related empirical findings. Here is the plan: I begin in section 7.1 with definitions of *spirituality*, *religiosity*, and *religion*, emphasizing differences between the three concepts. In section 7.2 I ask whether being religious and/or spiritual may have an impact on the outcome of depression. More specifically, I explore whether spirituality or religiosity have the potential for one's faster recovery from depression, or, on the opposite, perhaps being spiritual or having religious beliefs aggravates one's depressive symptoms? Based on empirical findings, I argue that the levels of spirituality (and spiritually fuelled religiosity) are inversely associated with depression: people who are spiritual exhibit lower levels of depression than non-spiritual controls. Singled-out religiosity, however, turns out to be positively associated with depression in certain cases. More specifically, people who routinely follow religious practices

but do not consider themselves deeply spiritual, exhibit higher levels of depression than controls. In section 7.3 I investigate possible explanations for the empirical findings presented and argue that by offering one's life *meaning*, spirituality enhances psychological health. Finally, in section 7.4 I conclude that further multidisciplinary research is needed in order to clarify the beneficial impact of spirituality on mental health.

7.1 SPIRITUALITY, RELIGIOSITY, AND RELIGION

There seems to be little consensus about the meaning of the terms religion, religiosity, and spirituality in the empirical literature. One major contributor to the difficulties encountered in differentiating spirituality from religion and religiosity is the fact that these terms tended to be used interchangeably prior to recent times (George et al., 2000). Nevertheless, it is important to identify how these terms are conceived in this chapter before further examination of related research.

For the purpose of simplicity, the concepts of spirituality and religiosity are referring to distinct, although related phenomena, of which spirituality (deriving from the Latin word *spirare*, meaning 'to breathe') is treated as a broader and more inclusive one (see for example Cotton et al., 2004; Saslow et al., 2013). Spirituality is usually understood as referring to the personal and emotional aspects of religion, often defined as an emotional connection with something transcendent or sacred (Dalmida, 2006), however, it may also be applied to a secular, that is non-religious, context (Bash, 2004). This is because, unlike religiosity, spirituality does not require being rooted in any particular rituals, practices or beliefs. It is

conceived to refer to “the human dimension that transcends the biological, psychological, and social aspects of living” (Mauritzen, 1988, p. 118) and “…whatever people do to attain a variety of goals, such as meaning in life, wholeness, interconnections with others, truth, and one’s own inner potential.” (Zinnbauer et al.,1999, p. 902).

William James (1902) described spirituality as the first-hand, emotional experience of religion, whilst the Dalai Lama speaks of spirituality as the quality that is “concerned with love and compassion, patience, tolerance, forgiveness, contentment, a sense of responsibility, a sense of harmony.” (Saslow et al., 2013, p. 201).

Religiosity, on the other hand, has been described as an organised system of beliefs guided by values, rituals, or a code of conduct (Mohr, 2006; Sorajjakool et al., 2008). Being religious can be manifested in the context of a traditional religious institution (Jewish, Catholic, Islamic, and so forth), New Religious Movements, as well as highly individualised and diverse religious practices related to core personal beliefs and values (Ingersoll, 1994; Hodges, 2002). Genia and Shaw (1991) propose that one may express spirituality in a religious context but one’s religiosity does not have to constitute a result of spirituality. People are known to identify with the terms ‘religious’ and ‘spiritual’ in distinct ways, with some describing themselves as being ‘religious but not spiritual’, others as ‘spiritual but not religious’, and still others as ‘religious and spiritual’ (Zinnbauer et al., 1997). These contrasting self-descriptions reflect divergent religious/spiritual beliefs, attitudes and practices (Zinnbauer et al., 1997; Zinnbauer et al., 1999; Taylor et al., 2000).

Swinton (2001) argues that whilst institutionalised religion in Western countries seems to be decreasing, there has been a dramatic rise in a quest for spirituality in other forms, such as an interest in Eastern religion, transcendental meditation, new age literature and so on. The number of people in Western societies who claim to 'remain spiritual, but not religious' is growing systematically (De Castella, 2013). This, in turn, suggests that although the difference between spirituality and religion in the area of philosophical research might have been muted, it nevertheless continues to exist, with a bigger than ever impact on our understanding of human beliefs in the supernatural.

Although most researchers support the opinion that there is a loose connection between the two concepts, it is important to note that certain authors argue for their closer association. For example, Puchalski (1999, p. 1) directly calls religion the "expression of spirituality". Similarly, Mohr and colleagues (2006) state that religion constitutes the platform for the expression of spirituality, and Mueller and colleagues (2001) argue that both concepts significantly overlap.

Finally, it is important to clarify the meaning of 'religion'. Unfortunately, the empirical literature uses the concept of religion interchangeably with that of 'religiosity', which adds to the overall conceptual confusion. Here I adopt Allport's (1960) understanding of 'religion' in a broad meaning, inclusive of both spirituality and religiosity and related practices, beliefs, and behaviours of related kinds. Allport's distinction between *extrinsic* and *intrinsic* forms of religion is significant in the context of this chapter and is discussed below.

In this chapter I take a view that one can be spiritual without following any particular organised system of religious beliefs; consequently, one can follow the rules of institutional church but not feel particularly connected to any spiritual 'power'. In the context of this thesis, I am interested in acquiring an answer to the question of whether there may be any specific link between any of these phenomena and depression?

Researchers in psychology have been predominantly focusing on exploring spirituality and religiosity (often with no conceptual distinction between the two) in people suffering from depression. The questions that they were attempting to address related mainly to the possibility of spirituality/religiosity affecting the symptoms and the outcomes of depression. Does being spiritual make an impact on one's depressive symptoms? In the next section, I review some of the studies in order to shed some light on the links between the phenomena.

7.2. SPIRITUALITY, RELIGIOSITY, AND DEPRESSION

The question which is the focus of this section, attracted a moderate amount of research. Interpreting this evidence is fraught with difficulties, however, since close inspection reveals that the concepts of spirituality and religiosity have been largely blurred. George and colleagues (2000, p. 107) notice that much of the literature claiming to explore the impact of spirituality on health, in general, investigates religion (religiosity) rather than spirituality. As a consequence, it is not surprising that few studies have investigated spirituality and religiosity as two distinct phenomena.

Overall, available empirical studies have established a relationship between religion, as defined by the formal, institutional, and outward expression of the sacred (Koenig and Larson, 2001), and mental health risk behaviours (Wallace and Williams, 1997; Hodge et al., 2001; Bridges and Moore, 2002; Miller and Gur, 2002; Schapman and Inderbitzen-Nolan, 2002; Cotton et al., 2004). According to the findings, there is a small to moderate yet significant relationship between religious beliefs and depression. More specifically, some findings point out that people who believe in God and see religion as important in their lives show less depressive symptoms and less engagement in health risk behaviours (such as risky sexual behaviour or substance use) than less religious controls (Wright et al., 1993; Donahue and Benson, 1995; Lammers et al., 2000; McCree et al., 2003; Cotton et al., 2004). For example, in one of their studies, Cotton and colleagues (2004) examined spirituality as a meaningful construct in the lives of young people, exploring the ways in which spirituality and religiosity affect depressive symptoms and health-risk behaviours. A total of 134 teenagers completed a questionnaire assessing spirituality, religiosity, depressive symptoms and health-risk behaviours. The researchers found out that young people with higher levels of spiritual well-being had fewer depressive symptoms and fewer risk-taking behaviours. However, they also found that people who placed greater importance on religious rituals *per se*, without spiritual engagement, showed increased depressive symptoms when compared with controls. This is an interesting finding, pointing to the possibility that religious practices, if not coupled with deeper spiritual experience, might not be beneficial from the psychological point of view. Reflecting on the results, the authors concluded that the inclusion of spirituality in the promotion of mental health and resilience may encourage healthy adolescent development.

Other authors obtained similar results. Doolittle and Farrell (2004) examined the possible association between depression and spirituality in people living in urban areas. They discovered that the participants who scored higher on the spiritual assessment scales had fewer depressive symptoms than controls. At the same time, the authors noted that attending religious services did not have a significant impact on depression. Rather, characteristics related to spirituality, such as belief and trust in a higher power and prayer accounted for the difference between people with depression and controls.

It could be argued that low levels of spirituality (or, as Doolittle and colleagues say, "lack of faith" (2004, p. 116)) in people with depression may merely be another symptom of helplessness, hopelessness, and anhedonia that characterise the illness. In other words, it could be claimed that depression *causes* lack of faith on the same basis as it deprives us of other hopes and desires. A closer look at empirical research shows, however, that such a claim would be far from the truth. Some key studies in the field support the thesis that it is *the spirituality* that brings on mental health rather than 'lack of faith' being caused by depression. Martin Seligman (1990) observed that in the hermetic community of Amish people rates of depression were significantly lower than in Western society; among many differences in both Amish and general Western lifestyles, the author ascribed this phenomenon to the Amish spiritual way of living. Seligman suggests that spirituality may be seen as a factor protecting people against hopelessness and alienation seen in modern Western societies. In this sense, being spiritual may constitute an enhancing factor for mental health. Whilst such a claim may sound bold, it has been largely supported (e.g. Comstock, 1972; Zuckerman et al., 1984; Miller, 1985; Fehring et al., 1987; Idler, 1987; Pressman et al., 1990). For example, Richard Fehring and colleagues (1987), who investigated psychological and spiritual wellbeing in

college students, found out that the students who scored high on spirituality scales were in better psychological health than non-spiritual controls. Is there any plausible explanation for the link between low levels of depressive symptoms and spirituality? In the next section, I attempt to address this question and suggest that the answer lies in the phenomenon of *meaning.*

7.3 SPIRITUALITY, MEANING, AND MENTAL HEALTH

On the analysis of presented data, one wonders what might be an explanation for the intriguingly high correlation between spirituality and mental health? One possible answer comes from the research on the phenomena of *spiritual meaning* defined as "having a sense of purpose or calling, derived from beliefs about spiritual forces underlining or arching over life" (Mascaro and Rosen, 2006, p. 184). The idea here is that having a sense of purpose impacts positively one's life and strengthens one's resilience. Such a hypothesis has been confirmed by some empirical studies. For example, Wright and colleagues found that young people who had a sense of spiritual meaning in their lives experienced less depressive symptoms than non-spiritual peers (Wright et al., 1993). Olszewski (1994) obtained similar results, establishing a positive relation between life meaning and mental health. Sorajjakool and colleagues (2008) explored the impact of spirituality on coping with depression; the authors interviewed 15 individuals with clinical form of the illness. The participants were asked to describe whether being spiritual affected their mental health. The results obtained point at spirituality playing a significant role in coping with depression-related pain. Here is one example:

> The first time I went back to church was at the beginning of February and it was the first time I had felt peace in over a year. I did not feel my pain (in church). I want to commit suicide but the hope will come back when I read my Bible… it is a kind of tingling sensation [that] goes through my body. I can't explain it, but it is peace, joy, and love. All in one unconditionally… Sometimes I also get this overwhelming feeling, and I know that there is either somebody there that is watching me-whether it is my guiding angel or an angel… It starts through mystomach or my shoulders. It is a feeling like I have been touched. It is like somebody you love coming to touch you. (Sorajjakool et al., 2008, p. 526)

Other participants are quoted offering similar statements of the role which spirituality played in their battle with depression. Among other benefits, remaining spiritual offered them hope, brought comfort, prevented suicide, and provided crucial support during difficult times in their lives (Sorajjakool et al., 2008).

Interestingly, whilst it could be argued that being spiritual may offer psychological benefits in the circumstances of literally any adverse experience, Sorajjakool and colleagues propose that individuals with depression have particularly intense desire to *make sense* of their experience. They want to *know* why they have to go through such intense suffering and have a particular need to find a purpose attached to their experience. One of the students quoted in the study says “depression makes me who I am and I will not be the way I am without it. Once you come out of depression, you can realize how it *helps you with perspective* in life” (Sorajjakool et al., 2008, p. 527, my emphasis)

It may subsequently be argued that in order to benefit someone with depression a meaning does not have to be rooted specifically in spirituality. Perhaps a personal meaning (or, in fact, any meaning) may potentially contribute to positive mental health outcome? Whilst such a possibility cannot be rejected, some authors argue that the meaning which is rooted in spirituality has a special role to play in our life. Carl Jung is one of the classic authors who

argued for a unique role of spirituality. He proposed that without an “inner transcendent experience humans lack the resources to withstand the ‘blandishments of the world’” (Jung, 1958, p. 24). Jung believed that intellectual or moral insights, although important, are insufficient in this matter and articulated this principle way ahead of his time, suggesting that psychology should interpret the spiritual experience of people as valid expressions of their psyche (Jung, 1933).

Other authors expressed similar ideas: Erikson (1969) emphasized that spiritual development is a natural process in humans and Allport (1960) asked: "Does a person ever really attain integration until he (she) has signed and sealed a treaty with the cosmos?" (Allport, 1960, p. 90). For Victor Frankl (1978), the greatest problem of the modern era was what he called the “existential vacuum”, or meaninglessness; people do not seek spiritual development. Based on this claim, Frankl developed the unique form of therapy called ‘Logotherapy’, the process aiming to rediscover one’s personal values as well as to recognise the presence and work of a benevolent force (i.e. God) (Frankl, 1967).

For Maslow (1971) one of the central dimensions of human development is that of *transcendence,* which includes an awareness or belief in a power beyond ourselves and implies that the individual is a part of a more complex entity. Other related characteristics include a sense of selflessness, life purpose, a desire to help others, and an unconditional love that promotes working toward a greater good (Hodges, 2002). Maslow emphasises that transcendent development carries a spiritual significance, which includes an appreciation of beauty, truth, and unity as well as recognition of the sacred in life.

In sum, can spirituality function as a tool in coping with depression? Based on the studies reviewed above the answer seems to be positive. However, there are some exceptions from the rule. As Hills and colleagues found out in their interesting study (2005) this is no longer true for those people whose experience of spirituality is woven with negative emotions. The authors examined the phenomenon in older patients in palliative care and discovered that those who expressed anger at God or questioned the existence of 'higher power' showed more distress, confusion, and had more depressive symptoms than controls. These results confirm earlier findings by Koenig and colleagues (1988) who revealed that the quality of life in older medical patients who demonstrated negative feelings associated with God was significantly negatively affected.

One of the key questions arising from the analysis of empirical studies is as follows: Why does spirituality affect our mental health in a largely positive way, whilst religiosity in a form of following a set of institutional practices seems to be largely disadvantageous? One possible explanation comes from Allport's (1960) theory which differentiates between *immature* and *mature* forms of religion. According to Allport, mature religion serves an integrative and organising function in the personality, thereby producing a consistent morality. By contrast, immature forms of religion are explained as being absorbed with self-gratification, leading to a lack of integration of the personality and therefore a lack of self-reflective insight (Ventis, 1995). On this picture, we can understand spirituality as a mature form of religion, given its empirically evidenced links with previously described meaning, but also with compassion, altruism and personal development (Saslow et al., 2013). Allport's differentiation between mature and immature religion has led to the development of two brand new concepts in the psychology of religion, that is, *extrinsic* and *intrinsic* religion. Ventis (1995, p. 35) defines

extrinsic religion as the religion that is used to deliver certain types of external gratification to the person, such as an increase in their social status. Intrinsic religion, on the contrary, applies to those who treat their religion as the main motive in their lives and for whom religion is internalised and fully lived. Consistent with this theoretical framework, empirical studies measuring the impact of both types of religion on mental health have found out that extrinsic religion is negatively related, and intrinsic religion positively related, to mental health and social behaviour (see Ventis, 1995 for the full review).

An alternative explanation for the connection between spirituality and mental health comes from Bandura's social cognitive theory, grounded in a view of human agency that emphasises intentionality and forethought, self-regulation, and self-reflectiveness in adaptation and change (Bandura, 1986; Perez et al., 2009). The idea here is that religion and spirituality may foster personal agency in such a way that one's perceived relationship with a transcendental power (e.g. God) can empower one with the belief that one can achieve a certain goal. Such a belief constitutes an example of that which Bandura and colleagues (1999) call *perceived self-efficacy* and which builds the foundation of human agency in general. "Unless people believe they can produce desired effects by their actions, they have little incentive to act or to persevere in the face of difficulties." (Bandura et al., 1999, p. 258). A low sense of efficacy leads to feelings of futility and despondency later in life, making people vulnerable to depression. Other researchers support this claim, pointing out that spiritual beliefs are associated with personal agency beliefs and the sense of personal control (Strickland et al., 1971; Saudia et al., 2001). These, in turn, are evidenced to be inversely related to depression; in other words, the stronger beliefs in personal agency one holds, the less depressive symptoms one has (McFarlane et al., 1995).

Another possible explanation for the link between spirituality and depression has to do with (or is related to) coping behaviour. The research by Pargament (1997) demonstrates the direct effects of both positive and negative religious coping on health. The proposition here is that one's perceived personal relationship with God leads them to acknowledge stressful events as challenges to overcome rather than threats. This relates to a religious belief that with God's support, people are empowered to approach and fight obstacles. On this picture, religion can frame the way one thinks about problems and may be linked to more effective coping behaviour. This is an interesting conclusion, woven with practical consequences. Perez and colleagues (2009) reflect that if agency beliefs and coping behaviours constitute mechanisms by which spirituality and religion enhance immunity against depression, religious and mental health organisations could work together to foster people's resilience, mental health and wellbeing.

Yet another possible explanation for the link between spirituality and mental health lies in the phenomenon of *compassion*. A number of empirical studies argue that compassion (understood as motivated empathy) plays a key role in spirituality and that the phenomena are closely related. For example, Saslow and colleagues make a distinction between spirituality and religion and show that whilst the first construct has been linked to compassion, the later one has not shown a similar association (Saslow et al., 2013). In a series of repeated empirical studies comparing spirituality and religiosity, Saslow and colleagues obtained remarkable results. Individuals describing themselves as spiritual turned out to be significantly more altruistic and compassionate than those who classified themselves as religious. Religiosity, when detached from spirituality, did not lead to compassion. Moreover, the study revealed

another interesting relation: although both spiritual and religious individuals prayed or meditated, the first group (spiritual) was more likely to have transcendent experiences of feeling connected to the divine, whilst the second group (religious) was more likely to read holy books and to believe in a more fundamentalist form of religion (Saslow et al., 2013).

Interestingly, although the results of the majority of the studies presented point at the positive relation between spirituality and low levels of depression (but link religiosity with higher levels of depression), one study presents conflicting data. Baetz and colleagues (2004) used Canadian population data from 70,844 people aged 15 years and older to examine the links between spiritual and religious involvement and depressive symptoms. The researchers found that frequent worship attendance was significantly related to fewer symptoms of depression; on the contrary, those participants who considered themselves deeply spiritual showed significantly higher levels of depressive symptoms, even after controlling for potential mediating factors including age, income level, location, education, and so on.

What explanation could be offered for such strikingly diverse result? A close inspection of the study reveals at least three possibilities. The first and the second one are methodological: first, unlike other authors, Baetz and colleagues examined a non-clinical sample. In other words, people who were examined did not suffer from severe types of depression (nor from other mental disorders) but presented certain depression-related symptoms on the continuum of varied intensity. Second, the researchers' method was based on the review of previously attained ready data, which, additionally, consisted of a very large number of participants with no specified profile. Drawing valid conclusions based on such a divergent participant target is challenging, and errors can occur, due to possible interference with non-controlled variables

such as, for example, specific personality traits. Finally, it may be hypothesized that people who describe themselves as being highly religious but who do not attend organized worships, may have higher levels of depression-related symptoms, because they miss the connection with others; in a sense, they hold a need for religious expression, but they are unable to fulfil it; therefore, they feel psychologically worse.

As the final comment of this section I would like to point to the phenomenon of mindfulness as spiritually – bound practice aimed to enhance mental health. The concept of mindfulness is rooted in Buddhist and other contemplative traditions where conscious attention and awareness are actively cultivated (Brown and Ryan, 2003). Mindfulness is commonly defined as "the state of being attentive to and aware of what is taking place in the present" (p. 822). Much of psychological research has shown beneficial outcomes of mindfulness practice for one's wellbeing (e.g. Kabat-Zinn, 1990; Brazier, 1995; Martin, 1997; Shapiro et al., 1998; Ryan and Deci, 2000; Shonin et al., 2016; Jazaieri and Shapiro, 2017). For example, it has been evidenced that practising mindfulness helps people disengage from automatic thoughts, habits and unhealthy behavioural patterns (Ryan and Deci, 2000). From this point of view mindfulness can play an important role in combating depression: by enhancing the ability of conscious awareness in the present moment, the practice actively disengages the subject from cognitive and emotional 'anchoring' in dysfunctional, negative schemata (I discussed depressive schemata in the context of depressive delusions, see chapter 4).

7.4 SUMMARY

To sum up, the majority of research supports the claim that being spiritual plays an important role in maintaining mental health. The empirical evidence suggests that being spiritual offers people a unique kind of life meaning, which protects them from giving up in the face of difficulties, supports agency and coping behaviour. A certain amount of empirical data links religiosity, in a form of following religious rituals, to higher levels of depression. Unlike spirituality, such a form of religion has been called immature (Allport, 1960) and it has been evidenced that people who follow institutional rules without deeper spiritual involvement lack compassion (e.g. Saslow et al., 2013). Extended interdisciplinary research is needed to further clarify the character of the relation between religion and mental health; current on-going studies focusing on meditation as a way to prevent depression are promising.

CHAPTER 8: THESIS SUMMARY, CONCLUSIONS, AND SUGGESTIONS FOR FUTURE RESEARCH

The motivation for this thesis was to provide an alternative, more complex view of depression as a source of unique experiences associated not just with mental and physical harm, but also with certain short or long-term benefits of a cognitive, emotional, pragmatic and epistemic character. This was achieved through critical analysis of empirical data as well as by offering original arguments for and against the links between depression-related symptoms and selected beneficial traits. Here I summarise the main thesis of each chapter, address some questions that follow, and offer suggestions for further research.

8.1 SUMMARY OF THE KEY FINDINGS

In the first chapter I looked into the phenomenon of 'depressive realism'-the claim that people who suffer from depression make more accurate inferences about reality than 'healthy' people. The analysis of empirical data exploring this question led me to the conclusion that there is a limited number of circumstances in which depression-related experiences offer some epistemic benefits. Firstly, the majority of data shows that it is low mood, but not more severe symptoms of depression, which is linked to more accurate judgements. The judgements made by people suffering from clinical forms of depression are overly negative ('negativity bias'). Secondly, the accuracy of judgements made by people suffering from low mood seems the best in estimations about the self and self-related circumstances, rather than about other people and neutral events.

Having established the circumstances for epistemic benefits of depression – related symptoms, in chapter 2 I asked whether they can also deliver benefits of a psychological character. Here I challenged the so-called 'trade-off' view, according to which psychological wellbeing is the price which one has to pay in exchange for more realistic judgements. I examined the phenomena of low mood and low self-esteem and argued that both experiences, despite associated psychological costs, may relate to better wellbeing (as well as to better accuracy of judgements) by enabling certain psychological strategies combating anxiety. Although the advantages obtained may sometimes be only temporary and relate to specific circumstances, it is critical to recognise that the depression-related experiences offer more than just suffering.

In chapter 3 I provided further arguments against the trade-off view by exposing unrealistically positive views of oneself ('positive illusions') as psychologically costly. I challenged Taylor and Brown's (1988) account of PIs as advantageous for our mental health by showing that it is not (as they claim) departure from reality which makes these beliefs beneficial. Based on the empirical data I argued that beliefs which turn beneficial are rather based on a realistic evaluation of one's own capabilities and resources prior to deliberate focus on the positive aspects.

In chapter 4, I investigated the phenomenon of depressive delusions. I propose the hypothesis that delusions in depression emerge as a result of the attempt to eliminate the inconsistency between self-schemata formed via a biased process of learning, and new conflicting information. The function of depressive delusions is to restore the equilibrium of the cognitive processes of adaptation, assimilation and accommodation. Due to their role of

reducing dissonance and restoring unified narrative self, delusions have the potential to deliver both psychological and epistemic benefits by relieving anxiety and preserving a coherent self.

In chapter 5, I looked into the links between depression and empathy. Upon examination of the empirical data I argued that people who suffer from depression have elevated levels of empathetic response to the suffering of others. Next, I proceeded to investigate whether enhanced empathy in depression may constitute a source of psychological benefits for the subject. Based on psychological research I showed that empathy found in people suffering from depression is linked to feelings of guilt and leads to personal distress. However, I further argued that by offering a temporary relief from depression-related loneliness, such a kind of empathy may play a role in protecting people from developing more acute, psychotic symptoms.

In chapter 6, I was interested in acquiring an answer to the question of whether depression is linked to enhanced creativity. Upon analysis of the empirical research I argued that creativity is indeed evidenced to be associated with depression, predominantly in the population of eminent artists, particularly in poets. The neuropsychological research points to a specific mode of creation, namely spontaneous/emotional creativity, that is especially linked to depression. I propose that by contributing to work of the highest cultural and aesthetic value, creativity may be seen as an epistemic benefit of depression.

Chapter 7 presented an analysis of the alleged links between depression and spirituality and religiosity. Upon drawing a distinction between the concepts of spirituality, religiosity and

religion I asked whether being spiritual or/and religious may affect one's depressive symptoms. Based on the analysis of empirical evidence I argued that having spiritual beliefs contributes to better mental health and plays a role in preventing depression. However, in cases where people simply follow religious practices but do not consider themselves deeply spiritual, their levels of depression-related symptoms are higher than those of controls. What might be the nature of the link between spirituality and mental health? Based on psychological data I argued that by offering a meaning of life, spirituality enhances one's mental health and general wellbeing.

8.2 CONCLUSIONS AND LIMITATIONS

The main conclusion reached in this thesis is such that depression and related experiences, such as low mood, anxiety or low self-esteem can be seen as more than merely products (or by-products) of mental dysfunction. Undoubtedly, suffering comes as an inseparable part of depressive illness; the research aiming to reduce psychological costs of depression and to establish the most effective ways of treatment should not be underestimated. However, in order to bring on the best outcomes, such research ought to be based on the thorough and detailed understanding of the nature of the illness itself. Here is where this dissertation has a potential to make the best impact. Although there has been an enormous number of studies investigating the negative side of depressive experience as well as its countless harmful outcomes, not much has been said about the possibility of its more positive contribution to our mental experience. Meanwhile, as I showed in the subsequent chapters of this thesis, we have the grounds to believe that particular experiences related to depression come to our lives

not only as a result of our mental deficiencies or psychological trauma; they also come because they have an important role to play in our lives. Although they come disguised as clinical symptoms, the function they play in our lives seems to be much more sophisticated. To better understand the role which depression plays in one's life could mean to have the capacity to develop better tools for its treatment, but, more importantly, to develop new strategies of prevention.

Similarly to other studies, the current research also has several limitations. The most obvious one is such that only certain depression-related phenomena were taken into account when exploring potential benefits. I explored realism, pessimism, self-handicapping, delusions, empathy, creativity and spirituality, leaving a potentially long list of other factors behind, primarily due to consideration of the structural limits of this work. This is not to say that the phenomena I considered and analysed here are the only ones evidenced in science as linked to depression. The list of positive traits which one could attain together with (or because of) depression could be much longer as people's circumstances and life stories vary. The seven phenomena featured in this thesis are however those which are evidenced in the best way and are the most widespread in the empirical literature.

The key question which lies at the basis of my research: is depression related to anything positive? was originated in the countless psychological encounters I had with my clients, people who suffered from depression. It is them who have given me the inspiration to research further. What have I learnt throughout this journey? Whilst conducting the analysis of the empirical data related to my key question, one thing becomes especially apparent: whereas symptoms related to mild or moderate depression such as low mood, low self-esteem

or anxiety have the capacity to offer some benefits to the subject, more severe forms of the illness do not seem to offer such an advantage. Our low mood can make our self-related judgements more realistic; our anxiety, when harnessed, may play the key role in enhancing the success of a given task; our low self-esteem may constitute self-defence against more costly psychological damage, and so on. However, when the severity of depression reaches the heights (or rather, shall we say, the lows), when it becomes impossible to find the motivation to cope with everyday demands, searching for benefits most often ends up in a fiasco. Here the mental costs seemingly outweigh the potential benefits.

This conclusion supports the view that depression together with its associated experiences ought to be understood as a spectrum of mental events rather than the sudden outburst of an illness. Phenomena such as low mood, low self-esteem and anxiety are common in both clinical and non-clinical populations. They can be seen as part of our personality and/or patterns of behaviour but they also can be listed as the symptom of mental illness after reaching a certain level of severity. This leads us to a subsequent question: what could be done from a therapeutic point of view to support people who experience mild forms of depression in order to prevent the symptoms from escalating? Although there is a wide range of pharmacological and psychological treatment available for those who experience clinical forms of depression, not much attention has been paid to the ways in which the illness could be prevented. Meanwhile, as much of psychological evidence supports the hypothesis of the progressive cognitive alterations in vulnerable people (e.g. negative self-schemata described in more detail in chapter 4 of this thesis), early intervention for high-risk individuals ought to become a priority. The aim of such intervention could be, firstly, to make a person aware of their automatic negative thinking patterns and support the change in their habits and,

secondly, to support their personal agency. The latter factor seems especially important as, by its nature, rumination in depressive thought deprives us of the motivational force necessary to take an action (e.g. Bandura, 1989; Goodwin and Jamison, 1990). In his highly influential work 'Human agency in social cognitive theory' Albert Bandura writes:

> Depressive rumination not only impairs ability to initiate and sustain adaptive activities, but it further diminishes perceptions of personal efficacy… Much human depression is also cognitively generated by dejecting ruminative thoughts... Therefore, perceived self-inefficacy to exercise control over ruminative thought figures prominently in the occurrence, duration, and recurrence of depressive episodes. (Bandura, 1989, p. 1178)

In the context of current research, agency becomes an imperative in order to be able to acknowledge and utilise the benefits associated with the clinical symptoms. Without the action a person will not enter a social situation; with no social context, the symptoms may become a subject of ongoing psychological inflammation. Furthermore, the action becomes necessary for taking up a task (e.g. the cognitive-behavioural strategy of defensive pessimism), for joining spiritual (or any other) community, for expressing empathy or creating a work of art. Finally, at least minimal action is required to talk to a therapist. Inability to act significantly decreases one's chances of noticing and acknowledging the beneficial sides of depression and subsequently takes away one's opportunity for recovery. It is not a purpose of this thesis to argue for the best solution for depression, nor is it to advocate any particular treatment over the others. However, after having met many people going through depressive illness in its various stages, I have come to believe that whether one will or will not benefit from their own depressive symptoms, they firstly and most importantly ought to be offered a chance to examine it in their own capacity.

Another conclusion that can be drawn from the research presented is such that although more severe forms of depression do not seem to offer any immediate benefits to the subject, certain phenomena that occur at this stage, such as mood-congruent delusions, still may play an important role in the personal narrative. As I argued in chapter 4, the function of depressive delusions is to protect self-coherence, in other words, to prevent more serious psychological damage to occur, which might happen in the case of severe cognitive dissonance. Mood-congruent delusions, such as-for example-paranoid beliefs, not only bring obvious psychological suffering but also, by confirming the subject's severely negatively biased perception of events, re-affirm the coherence of her story. From this point of view, depressive delusions have an important epistemic role to play, even if they are woven with serious psychological costs.

8.3 FURTHER SUGGESTIONS

Based on the current findings, I believe that further research into the continuity of depressive symptoms in the clinical and non-clinical population could determine the most effective ways of depression prevention. What might such a study look like? First, it would further critically assess current accounts of ‘depressive symptoms’ in the clinical literature in order to move towards accounts which are sensitive to the potential epistemic, psychological and ethical benefits and to their role in supporting a unified and coherent sense of self and agency. Second, it would inform therapeutic interventions on people with depression and related disorders on the basis of the complex role of their experienced symptoms in the recovery and in the development of a self-narrative which supports their agency and wellbeing. Finally, it

would provide strong theoretical reasons to challenge the perceived discontinuity between ‘normal’ and ‘abnormal’ experiences related to depression such as feelings of sadness, low self-esteem, biased perception, negative self-evaluation, and mood-congruent delusions.

The most fundamental part of this study would be to develop a new theoretical framework of psychological intervention for depression and related problems. When does a ‘symptom’ have the potential to be used as a therapeutic tool in order to prevent mental decline or on the way to recovery? The central idea is that the support to shift one’s attention from psychological and epistemic costs of depression to accept and include its beneficial potential in a specific and personalized context will lead to a better sense of agency and cognitive control over the symptoms; eventually, this will result in a structured and accelerated way to recovery. Certainly, the full formulation of the framework needs rigorous analytical analysis and careful methodology.

Neglecting the possibility of epistemic, cognitive or ethical benefits of depression-related symptoms prevents us from understanding the complexity of the mental phenomena to be investigated and it precludes the development of a psychologically realistic picture of human nature as constantly developing in spite of constraints and limitations. Such a picture would easily support a more nuanced account of the distinction between the normal and the pathological. If the divide is between ‘feeling worried’ and ‘being paranoid’, then the divide appears to be sharp and clear. But if the divide is between beliefs or emotions that are affected by contextual factors (e.g. the loss of one’s job) and beliefs or emotions affected by contextual factors plus additional deficits associated with a psychiatric disorder (e.g. negativity bias or generalized anxiety), then the divide is no longer so clear. It becomes even

less sharp if both types of experiences, the normal one and the pathological one, have similar cognitive or epistemic benefits in spite of their costs. The study proposed here would aim to develop and expand this line of thought, widening its scope, and working out its wide-ranging implications. In the possible theoretical framework for psychological interventions, the beneficial features of depression-related symptoms are to be conducive to one's wellbeing given cognitive and emotional limitations.

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