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Parsing the Blues: What Depression Reveals About the Life Well-Lived

Ian Tully
Washington University in St. Louis

WASHINGTON UNIVERSITY IN ST. LOUIS

Division of Arts and Sciences

Department of Philosophy

Dissertation Examination Committee:
John Doris, Chair
Julia Driver
Dan Haybron
Charlie Kurth
Renee Thompson

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What Studying Depression Reveals about the Life Well-Lived

by

Ian Martin Tully

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Ian Martin Tully

Washington University in St. Louis

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For Martha Fox, who from the moment she saw me, knew that I would be a teacher.

ABSTRACT OF THE DISSERTATION

Parsing the Blues:

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by

Ian Tully

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Professor John Doris, Chair

This dissertation explores the way depression illuminates –and is illuminated by – certain aspects of moral philosophy. I begin by defending, in chapter one, a cognitive theory of one important subtype of depression. The subsequent chapters then investigate what depression can teach us about the nature of well- (and ill-) being, and about the nature of moral virtue. In chapter two I ask 'what makes depression bad for us?' and go on to argue that reflection upon this question shows that desire-based theories of welfare are false. Then, in the next chapter, I provide a (partial) answer to that question, arguing that a central harm of depression is its undermining of the values or cares that constitute the core of a person's self. This, in turn, vitiates effective agency and saps a person's life of subjective meaningfulness. Given the results from the previous three chapters, I then ask, in chapter 4, whether it is ever permissible to allow those suffering from depression to choose physician-assisted suicide, and answer in the affirmative. Finally, in chapter five I take up the relationship between depression and virtue. Though the virtuous should never seek to become clinically depressed, I contend that morally virtuous people ought to preferentially attend to what it is fitting to feel negative attitudes towards, and thus, that they should be unhappy.

πάθει μάθος (Suffer and learn.)

-- Aeschylus, *Agamemnon*

Chapter 1: What is Depression?

In this introductory chapter I provide an account of two broad debates concerning depression. The first is conceptual: what is depression, and how is it distinguished from related states like grief and healthy sadness? Here I argue for a 'contextual' account of the demarcation between depression-as-illness and normal sorrow: depression is an illness if and only if it is disproportionate to or untethered from any intelligible cause. Then I turn to the second debate: what is depression's etiology? I provide a cognitive account of depression, focusing in particular on the role of negative beliefs, cognitive biases, and rumination. These explanations of depression's nature and etiology then set up the chapters of the dissertation that are to follow.

1.1 Introduction

Depression is not a modern malady. What we would today recognize as depression was described by Hippocrates in the fifth century BCE (Solomon 2001; Horwitz 2015). Nor is depression confined to Western culture: though it may be expressed and interpreted in different ways around the world, the underlying malady is the same (Wolpert 1999: 31-38). Nor, for that matter, is depression especially rare; in fact, it is one of the most common illnesses in the world, and its prevalence is growing (WHO 2017).

But even though depression has been with us for as long as humans have been a distinct species – and longer, for depression is not just a *human* illness, either (Rottenberg 2014: 39-56) – its causes remain poorly understood and its treatments still troublingly ineffectual. Its general outlines, of course, are well known. Chief among them are depressed mood, lack of motivation, sleep and appetite disturbances, and thoughts of suicide. Yet a truly dizzying array of factors have been

implicated in the onset and maintenance of these symptoms, and a clear consensus on how the various factors relate to or influence one another remains elusive.

In this introductory chapter I aim to help shed a bit of light on the topic, explaining what we (think) we know about depression, and what is still obscure. The chapter is divided into two parts: the first deals with the *concept* of depression and is chiefly focused on defending a "contextual" account of the distinction between depression-as-disorder and normal sadness. The second part then turns to providing an account of the *science* of depression. Of course, research on depression – and mental illness generally – has exploded in the past fifty years, and I cannot synthesize every strand of this enormous literature. Still, I aim to provide what I think are the best running theories of depression's causes and treatments. Doing so will help situate the chapters to come.

It is plausible, however, that the term 'depression' does not pick out a single unified kind, and to allay this worry I will narrow my focus (in this paper and the dissertation as a whole) to a specific kind of depression**,** one that is caused and maintained by certain *cognitive* factors to be explained later.[1] In other words, I make no claims about having uncovered the nature of depression as such, or to have exhaustively catalogued its myriad causes. Nevertheless, I hope that by the end of this chapter readers will have a better handle on at least one of the (potentially many) things we mean to refer to using the term 'depression'.

1.2 The Concept of Depression: History and the Demarcation Problem

Before addressing the contemporary scientific literature on depression, some conceptual and

[1] My account of the science of depression will consist chiefly of explanations at the psychological level, rather than the neurobiological. As a result, I'll largely ignore, for instance, the controversy over the 'monoamine hypothesis,' according to which "some, if not all, depressions are associated with an absolute or relative deficiency of monoamines at functionally important receptor sites in the brain," (Willner, Scheel-Kruger, and Belzung 2013: 2). The ongoing controversy concerning the role of various neurotransmitters in depression's etiology is fascinating, but I have neither the space nor the relevant expertise to address it.

historical ground-clearing is in order. Depression is a mental illness, and with that label comes a great deal of conceptual confusion. I'll try to clear some of that up in what follows.

1.2.1 History

The Ancient Greeks were no strangers to depression. Or, rather, they were no strangers to *melancholia,* as depression was commonly known until the mid-nineteenth century (Solomon 285).[2] Hippocrates describes a condition involving "aversion to food, despondency, sleeplessness, irritability, restlessness," along with "sadness, anxiety, moral dejection," and "tendency to suicide" which he termed 'melancholia' after the Greek words for black bile (Hippocrates 1923: 185/Solomon 286). As is well known, Greek medical theory was based on the four humors – blood, phlegm, black bile and yellow bile – bodily fluids that were taken to be the fundamental causes of health and illness, and of temperament or character. Whenever these humors were out of equilibrium, trouble was the result: thus too much black bile was understood by Hippocrates to be the cause of melancholia. In the second century CE, Galen would extend Hippocrates's basic framework by adding the concepts of hot, cold, wet, and dry, and by relating each humor to one of the four elements (Solomon 291). Black bile was on Galen's picture understood to be cold and dry and was related to earth; individuals with a surfeit of this humor were melancholic by nature, prone to sadness, fear, and social withdrawal. We can see from this that for both Hippocrates and Galen – two of the most influential medical authorities in the ancient world – depression was both recognizably similar to today's MDD and was conceptualized as a medical complaint as opposed to a moral failing or mere 'problem in living.'[3]

[2] Andrew Solomon notes that the first instance of the term 'depression' being used in English "to describe low spirits" was in 1660. That this comparatively bloodless term has come to replace the more evocative 'melancholia' is to him, and to many others, lamentable. William Styron remarks, for instance, that the term prevents, "by its very insipidity, a general awareness of the horrible intensity of the disease when out of control" (Styron 1990: 37).

[3] It was with the advent of Christianity that the understanding of melancholia began to take on a moralized aspect. Here the relevant malady was known as *acedia*, a particular problem for monks of the early Christian period, who spent long

However, as was recognized by the ancients, depression-as-illness shades imperceptibly into states of normal sadness and despondency. How, then, to specify the precise *demarcation* between depression-as-illness and healthy or normal states of sadness? Here we can turn to another seminal figure in the history of Western thinking on depression: Robert Burton, whose *Anatomy of Melancholy,* published in 1621, attempts to provide a complete account of the nature of depression -- its causes, treatments, and philosophical significance. In Burton we find a clear and highly influential exposition of the distinction between healthy and unhealthy depression. In an oft-quoted passage he writes

> Melancholy, the subject of our present discourse, is either in disposition or in habit. In disposition, is that transitory Melancholy which goes and comes upon every small occasion of sorrow, need, sickness, trouble, fear, grief, passion, or perturbation of the mind, any manner of care, discontent, or thought, which causeth anguish, dullness, heaviness and vexation of spirit…. And from these melancholy dispositions no man living is free….Melancholy in this sense is the character of Mortality (Burton 1621/2001: 143-44).

In other words, experiencing the characteristic symptoms of depression in response to life's hardships is the common lot of all mankind, and not indicative of any illness. On the other hand, melancholic disease

> …is a habit, a serious ailment, a settled humour, as Aurelianus and others call it, not errant, but fixed: and as it was long increasing, so, now being (pleasant or painful) grown to a habit, it will hardly be removed (Burton 144).

Implicit in Burton's distinction between healthy or 'normal' depression and depressive illness is an appeal to *context*. Depression symptoms that are a proportional response to some identifiable stressor and which remit upon alleviation of that stressor (i.e., are "transitory"), are not indicative of illness. But when such symptoms become divorced from apparent causes, or persist long after those

hours in self-imposed solitude. Like melancholia, acedia involved feelings of despondency and a lack of motivation; however, unlike Hippocrates and Galen, the monks and other Christian authorities regarded this condition not as an illness to be treated but as a moral failing to be struggled against, seeing as it was "inimical to the joyful attitude befitting a Christian" (Radden 2009: 6). Not that overcoming acedia was thought to be easy; this was, after all, the infamous 'Noonday Demon,' arguably the most formidable of all the Christian monk's enemies (Bunge 2013). Nevertheless, to succumb to acedia was to give in to sin. This association between the symptoms of melancholia and the sins of sloths and ingratitude would persist in Christian thinking for centuries. It may be that we can hear echoes of these thoughts in the stigma that still accompanies depression today.

causes have gone away, or are out of all proportion to them, there one finds depressive illness. Call this the *Contextual* view.

1.2.2 Defending Contextualism

I'll argue that Burton had it right with respect to the demarcation between depression as a healthy state and depression as a mental disorder. It is worth noting before I begin that though my focus will be on the specific case of mood disorder, the account I'll defend can be extended to capture the demarcation between mental health and disorder more broadly, as has been demonstrated by Derek Bolton.[4] Bolton argues that "the mind is in good working order to the extent that its intentional objects and connections are appropriate," and conversely, that mental disorders are "failures of intentionality" (Bolton 2008: 186).[5] Thus, just as mood disorders are instances of inappropriate or inapt emotion, hallucinations and delusions are instances of inapt perception and belief. Among other advantages, Bolton's view captures both what is distinctively *mental* about mental disorder, while also providing an account of dysfunction or disorder which is not hostage to evolutionary psychological speculations about humanity's Pleistocene past -- as, for instance, Wakefield's (1992) 'harmful dysfunction' analysis is (Murphy and Woolfolk 2000).

So, then: when depression is untethered from appropriate cause – either in intensity or duration – it is a disorder. Unfortunately, this account has largely fallen out of favor in psychiatric practice, a development that has been extensively documented and criticized by the psychiatrists Allen Horwitz and Jerome Wakefield (2007, 2016). Four arguments have been raised against the

[4] It should be noted, however, that while I think that Bolton's account of mental disorder handles depression and many other cases nicely, I am ultimately skeptical that the concept of 'mental illness' admits of classical definition – i.e., one which specifies exhaustive necessary and sufficient conditions. That's because I'm skeptical that *most* concepts admit of classical definitions, as is evidenced by the long history failures to provide them.

[5] Bolton adds the further necessary condition that these failures of intentionality must be harmful or disabling in some way (Bolton 186). Thus "minor fluctuations in mood," for example, are not indicative of mental disorder.

Contextual approach to distinguishing normal and abnormal sadness; none of them, I argue, ought to persuade us to abandon it.

First, there are the familiar worries about the term 'appropriate.' Who or what decides what is or is not an appropriate response to the stresses of life? What one clinician deems an appropriate response to the loss of a parent or job might seem to another an over (or under) reaction. And for that matter what one culture deems appropriate may seem to another outlandish. Is the widow who undergoes three years of mourning overdoing it? On what basis are such decisions to be made?

Second, even assuming we can determine when depression is appropriate and when it is not, should we really withhold diagnosis -- and thereby possibly withhold *treatment* -- from the elderly man with terminal illness simply because his depression is 'appropriate' and thus not an illness? Depression is a miserable experience even when it is an expectable response to a person's circumstances. If we conclude that no diagnosis is appropriate in such cases, we may thereby prevent people from access to the best means to alleviate their suffering.

Third, there are epistemic worries. As Mario Maj notes, it can be extremely difficult – if not impossible – to identify the trigger (or set thereof) for a person's depressive symptoms, or to identify whether there even was any trigger at all. This is because "the presence of a depressive state" can both "lead to a significant increase in reports of recent stressful events" and can also "expose a person to adverse life events" (Maj 2012: 43-44). These problems threaten to make the Contextual approach useless in clinical contexts, for clinicians will not be able to confidently identify *the* trigger or set of triggers which precipitated the depressive symptoms (even assuming there were any).

Finally, and most significantly, the Contextual approach makes certain predictions which are alleged to have failed to hold up under empirical testing. In recent research, Kenneth Kendler, John Myers, and Lisa Halberstadt have put the Contextual approach to empirical test by formulating

several hypotheses they argue should follow from the approach (Kendler, Myers, and Halberstadt 2010, 2011). First, they hypothesized that if the Contextual approach is true, then individuals who develop depression in response to an identified stressor ought to score lower on various indices of liability to depression – for instance, certain genetic factors, level of neuroticism, and family history – than those whose depression arose 'out of the blue'. The thought is that if the Contextual approach is true, a person whose depression apparently arose spontaneously has 'real' depression – i.e., a mental illness -- and thus ought to score higher on liability to it than a person who has only a 'healthy' depressive response to stress. As the authors point out, if the Contextual approach is true, "we would not…expect such individuals [i.e., those whose depression arose as a result of an identifiable stressor] to have a liability to MD that is much greater than that expected in the general population" (Kendler, Myers, and Halberstadt 2010: 772). However, the authors found – contrary to the Contextual approach – that those whose depression arose from a stressor and those whose depression arose 'out of the blue' did not differ appreciably in liability to depression. Rather, both groups had much higher liability to depression that the non-depressed individuals in the population sample. In another study, the same authors compared the 'level of understandability' of different cases of depression (Kendler, Myers, and Halberstadt 2011). Those cases that were more 'understandable' were those in which patients reported causes for their depression that could serve as justifying reasons for it. As with the previous study, the authors contend that the Contextual approach should predict that individuals with highly understandable cases of depression should score lower on various indices for liability to depression. But again, this prediction was not borne out.

In response to the first set of worries, we can accept that some cases will be fuzzy and even that norms will be influenced by cultural expectations (and the idiosyncrasies of various clinicians) without abandoning psychiatry to total relativism. Many judgments can be expected to receive

universal (or at least near-universal) agreement: an otherwise well-off man who falls into a deep depression as a result of a dent in his car is not experiencing a fitting response to his circumstances, for example. His mood is disordered. A person who reacts the same way to the loss of her home and livelihood, however, *is* responding as she should. Of course, there is much work to be done here by philosophers (and social scientists) to work out a defensible account of the norms of sorrow (and the other emotions); nevertheless, as with moral norms, disagreement is often overblown.

As to the second set of worries, there is no reason why we cannot 'treat' responses that are healthy or appropriate. After all, we take Tylenol for fevers. What is at stake here is whether such appropriate responses constitute *disorders*, not whether they call for alleviation. Now, with that said it is true that withholding diagnosis will often mean withholding access to insurance coverage and thereby treatment; as a result, it is probably better for clinicians to adopt the least stringent set of criteria needed to make a diagnosis. But these lamentable features of our healthcare system are orthogonal to the issue of whether the Contextual approach correctly sorts disorder from non-disorder.

And neither are epistemic concerns relevant to the issue at hand. That clinicians will often be unable to tell whether a person's depression is a fitting response or not is not an objection to the claim that depression is a mental disorder if and only if it is not a fitting response to a person's circumstances. Perhaps our man with the dented car has fallen into despair as a result of cumulative little stresses, each of which has gone unremarked by him: the dent was simply the final straw. So, then, his depression really *is* a fitting response. Again, clinicians should probably err on the side of liberality here; hence, presumably, why the DSM carves an 'expectability' exception only in the case of the obvious and catastrophic stressor of bereavement. But what makes for good clinical practice does not necessarily make for good philosophical analysis.

The empirical challenge is most worrying; however, there are a number of reasons to be concerned about these studies. One problem is epistemological: as just noted, it can be extremely difficult to determine when a patient's MDD is the result of a particular cause and when it merely arose out of the blue. Perhaps many of those whose depression appears uncaused were forgetting important stressors; likewise, it is possible that some of those who identified a cause for their MDD were misattributing it. These worries make it difficult to interpret Kendler and colleagues' results. But more importantly, it does not necessarily follow from the Contextual view that we would expect to find fewer liability factors among those with MDD triggered by more severe stressors. The Contextual approach does not deny that depression can be the result of an identifiable stressor and *nevertheless be disordered.* That can be so when the response is disproportionate to the cause. As a result, there is no straightforward prediction from severity of stress to number of liability factors, because those experiencing high adversity may nevertheless – as a consequence of increased liability to MDD -- react in a disordered way. In other words, among Kendler and colleagues' sample may be many individuals whose MDD, though triggered by an identifiable stressor, nevertheless constitutes a disordered reaction to it, and these individuals would be predicted by the Contextual model to have an equal or higher liability to MDD than those whose depression was triggered by lesser adversity.[6]

Finally, what's the alternative? I can think of two competitors to the Contextual view, neither of which is adequate. First, one might adopt some kind of threshold approach: depression is pathological after a certain duration or at a certain level of severity. But while this approach will get many cases right, it produces certain highly counterintuitive results. For example, in "Melancholic

[6] Similarly, in a response to Kendler and colleagues, Patten (2010: 1757) notes that their findings are consistent with a "multiplicative risk model" of MDD, according to which "an exaggerated reactivity to minor life events may manifest as a multiplicative interaction between liability factors and stressful life events on MD risk," such that "the relative risk associated with the combined exposure equals the product of the individual relative risks."

Epistemology," George Graham provides the example of "Carl M, a forty-year-old Polish Jew" who has been "imprisoned in a Nazi concentration camp" (Graham 1994: 404). Carl's whole family has been murdered; he knows he is soon to follow. He sees nothing left of value in the time remaining to him, refuses his meager rations, and longs to die. Carl, by any standard, is severely depressed. Yet his depression is rational if any is. As such, it is not indicative of any disorder. A threshold view, however, would seem committed to regarding Carl as suffering from mental illness, for surely his depression is severe enough to meet any plausible threshold for pathology. Given that the threshold view is committed to implausible results like this, we should reject it.

Second, one might appeal to a view that identifies pathological depression with the presence of certain key symptoms, e.g., psychotic ideation or feelings of worthlessness. But such a view still gets cases wrong: it would, for instance, classify a severe, prolonged depression in response to a minor stressor which lacked any of the problematic symptoms as non-disordered. Besides, this approach can be easily accommodated by the Contextual view: psychotic ideation or feelings of worthlessness, for example, are simply never appropriate or proportional responses to adversity, and are therefore always indicative of disorder.

With all that said, a question remains: why should we even care? For one thing, I've divorced philosophy from clinical practice so much here that the issue seems 'academic' in the bad sense. What practical difference does it make where and how we draw the line between illness and normal functioning? Besides, suffering is suffering; whether it is rational or not might seem to make little difference as to whether we have reason to alleviate it. In fact, "medicalizing" suffering is a useful corrective against the notion that people should just 'toughen up' and stop complaining.

Nevertheless, I think we should care. There are practical problems stemming from over-diagnosis: diagnosing someone with depression has both financial costs (for the individual and for

society as a whole) and possible health costs, too – antidepressants, though generally safe, do come with side effects and other health risks (Andrews et al 2012). But those worries aside, blurring the lines between depressive illness and healthy sadness risks interfering with processes that are healthy and needed. Sometimes it is unwise to treat a fever, and the same may be true of psychological distress. For instance, a person who didn't grieve her lost loved ones might miss out on the important functions that grief provides. It is a matter of no small consequence, then, how we draw the line between normal and abnormal sorrow.

1.3 A Cognitive Theory of Depression

With these normative issues out of the way, I turn to an account of what causes depression. As noted above, I don't pretend that this is an exhaustive account; unlike, say, Huntington's disease, which has a single causal origin (viz., a particular gene variant) and therefore an *essence*, depression is a complex phenomenon with no single cause. Like many other psychiatric disorders, it is perhaps best characterized as a "mechanistic property-cluster," that is, as a "[set] of symptoms…connected through a system of causal relations" (Kendler, Zachar, and Craver 2011: 1148). In what follows, then, I'll sketch an account of some of the most common mechanisms underlying depressive illness.

1.3.1 The Science of Moods

Depression is, first and foremost, a *mood* disorder, and so understanding the function of moods should help us better understand when and why they malfunction. And since functional questions often call for evolutionary explanations (cf. Wright 1973), I'll begin with some hypotheses about the function of mood from evolutionary psychology.

Sadness is an emotion; depression is a mood. Psychologists treat emotions as "suites of cognitive, motivational, and physiological changes" brought about by an "appraisal" by an organism

of its environment – for example, that there is *danger* nearby (Nettle and Bateson 2012: 712). Now, appraisal theories of emotion are not without their share of critics.[7] Since I do not have the space to defend appraisal theories here, I am willing to be ecumenical: I believe the argument of this paper is compatible with any approach to emotions which allows for their having *some* sort of content, be it a full-blown propositional attitude or something more perceptual along the lines of Jesse Prinz's "embodied appraisal theory" (Prinz 2004). The only family of views incompatible with my argument are purely noncognitive approaches like the 'feeling' theory – but such views are implausible anyway, being unable to account for the fittingness of emotions.

Moods, on the other hand, "are longer lasting, and are detached from any immediate triggering stimulus" (Nettle and Bateson 713; cf. Gerrans and Scherer 2013: 255). In other words, moods, unlike emotions, necessarily involve "temporal spillover," meaning that a mood is an emotional state which persists beyond any triggering stimuli (713). Moods are like an emotional baseline: an organism spying a predator nearby is likely to experience fear, an emotion; an organism that repeatedly spies predators in the immediate vicinity will likely go on to develop anxiety, a mood, meaning that it will continue to experience some level of fear (and thus the motivational, cognitive, and physiological changes fear involves) even when no predators are present.

What are moods for? Or, rather, why is it advantageous for one's emotional states to persist at some level beyond the circumstances which first elicited them? The answer is that moods encode predictions about an organism's future environment. Whereas emotions are primarily *reactive*, moods

[7] In particular, opponents of these theories argue that appraisals are not necessary for the experience of an emotion. For one thing, both animals and small children are capable of experiencing emotions, but they may not be able to make appraisals (Deigh 1994). For another, Jesse Prinz (2004: 2) observes that "bodily changes can induce emotions" without "the mediation of anything like an appraisal judgment," noting in particular the effects of "facial feedback." It is worth noting that neither of the preceding objections is especially troubling. First, the "facial feedback hypothesis" does not enjoy strong empirical support: for example, one of the seminal studies purporting to have discovered the effect (Strack, Martin, and Stepper 1988) has failed numerous attempts to replicate (Acosta et al 2016). Second, nothing too cognitively demanding need be meant by an 'appraisal' – more specifically, appraisals needn't be (conscious) propositional attitudes. Accordingly, there is no reason to think small children and nonhuman animals wouldn't possess the capacities required.

are *proactive*. When a creature has had a run of encounters with dangerous predators, it makes good evolutionary sense for it to form the expectation that it will continue to do so. But it shouldn't just *predict* that it will; it should *be prepared*. And this involves ratcheting up behavioral, cognitive, and motivational systems to respond to the predicted threats. Thus, it ought to be anxious.

What goes for anxiety goes as well for depression. Here the relevant prediction is that the environment will continue to furnish few opportunities for reward (Nettle and Bateson 714). Sadness, as an emotion, represents reaction by an organism to (real or perceived) losses; depressed mood, on the other hand, represents the prediction that these losses are likely to continue in the current environment, or at least that opportunities to reverse them are likely to be scarce. Now, what is the most rational response for an organism to take when its environment is judged to be resource-poor and predicted to continue to be this way for some time? The answer proposed by numerous psychologists is to dial-back current reward-seeking behavior, hunker down, and become "more deliberate, skeptical, and careful" in how one processes information from one's current environment (Rottenberg 2014: 26; cf. Nesse 2000, Nettle and Bateson 2012). At the extreme, an organism ought to simply wait it out, ceasing reward-seeking behavior as much as possible. After all, given current circumstances, reward seeking is likely to be wasted effort. When a creature predicts future effort-expenditure will be futile, it makes little sense for it to engage in it anyway.

Thus, depressed mood, by engendering "pessimism and lack of motivation," plausibly provides adaptive benefits by inhibiting costly goal-pursuit (Nesse 2000: 14). Depressed mood is only beneficial, however, when it is an accurate reflection of an agent's circumstances, and thus when it remits when those circumstances no longer call for disengagement. Unfortunately, it is not infrequently the case that depression fails to meet these criteria. Quite often agents, as a result of certain vulnerabilities to be discussed below, get caught in a negative-reinforcement loop.

Accordingly, their depressed mood becomes untethered from facts about their environment. When this happens, a healthy depressive response has crossed into maladaptive clinical depression. But how is it that a healthy response to stress can take on a life of its own, becoming untethered from apparent cause? As a result of certain *vulnerabilities* which intensify or prolong it.

1.3.2 The Diathesis/Stress Model

Before discussing any specific vulnerabilities that lead from depressed mood into clinical depression, I need to discuss the stress/vulnerability framework in general (Monroe and Simmons 1991). Not every individual who experiences aversive circumstances will go on to develop clinical depression; thus, different individuals seem to have different vulnerabilities for developing the disorder. These vulnerabilities (or diatheses) alone do not cause depression, of course: for that their needs to be some trigger – i.e., stress -- either acute or chronic. Where an individual's vulnerability is low, a great deal of stress is needed to trigger a depressive episode; where it is high, little is required. Moreover, depression is a recurrent illness, and it is well-established that each episode of depressive raises a person's vulnerability to a subsequent one – a phenomenon referred to as 'kindling'. As this process repeats, a person's depression "becomes increasingly autonomous," requiring less and less stress in order to be activated (Willner et al 6).[8]

This model provides a framework for understanding why some individuals develop depression and others do not. There are many different kinds of vulnerabilities. Genetic factors, early childhood experiences like abuse or loss of a parent, and various personality factors – for example, a high degree of neuroticism – have all been found to increase depression susceptibility

[8] How does the model accommodate the phenomenon of 'endogenous depression', that is, depression that is (or appears to be) wholly divorced from negative circumstances? Such depression would seem to be the result of exceedingly high diathesis; in other words, such depression is 'autonomous' in the sense noted above.

(Willner, Scheel-Kruger, and Belzung 2013). Where these factors are present, depressive illness is more likely to develop in response to stress. And what of stress? It could be chronic, in the case of poverty, illness, relationship difficulties, or unemployment (Willner et al 7) or acute, as for example in the case of bereavement. All of these stresses represent losses (or likely losses) for an agent of various fitness-enhancing goods (health, employment, or social support). They indicate that in current circumstances the agent's goals are not being met. And for those with high vulnerability to depression, these setbacks are quickly translated into a confident prediction that current goals are not likely to be met in the future; thus, effort is heavily dialed-back.

1.3.3 Three Cognitive Vulnerabilities

Of particular interest from a philosophical standpoint are certain *cognitive* vulnerabilities, that is, various habits of thought and information processing that predispose a person to develop clinical depression. It is now widely accepted that there is "good evidence for the existence of cognitive diathesis for depression" (Willner et al 4). Here I will discuss three vulnerabilities: a tendency toward negative beliefs (Beck's 'negative cognitive triad'), cognitive biases, and rumination.

The Negative Cognitive Triad. At its most general, the *Cognitive Theory of Depression* pioneered by Aaron Beck (Beck 1974) identifies certain disordered patterns of thought and information processing as the cause of depression. Beck argued that depressed individuals' thoughts could be characterized by what he called the 'negative cognitive triad': negative thoughts about themselves, the world, and their futures. For instance, upon experiencing a setback a depressed person (or someone prone to develop depression) might attribute it to some immutable personal failing (e.g., I'm a lazy person) rather than to contingent external circumstances. In addition, they might predict further failures in the future and believe that they can expect no help from others (because, for example, they believe 'everyone hates me'). These disordered thought patterns turn stresses that

others are able to rebound from into long-term negative mood episodes and eventually into clinical depression. Evidence for these negative beliefs in depressed individuals comes from clinical observation as well as from the success of cognitive behavioral therapy (the development of which it catalyzed) – studies have shown that CBT is at least as effective as antidepressant medication and may be more effective at preventing relapses of depression (Hoffman et al 2012).

Cognitive Biases. Closely related to these negative thought patterns are biases in information processing and recall. The cognitive theory hypothesizes that depression can be caused or maintained by selective focus on and recall of negative information. Depressed individuals would accentuate the negative and play down or overlook the positive. These hypotheses have received extensive empirical support. According to a recent review of the evidence supporting cognitive theories of depression, "Preferential recall of negative compared to positive material is one of the most robust findings in the depression literature," (Gotlib and Joorman 2010: 7), and it has been repeatedly shown that depressed individuals have difficulty disengaging their attention from negative material (Gotlib and Joorman 13-15; cf. De Raedt and Koster 2010). In addition, evidence suggests that depressed individuals show biases in how they *interpret* information, displaying "a tendency to interpret emotionally ambiguous information in a negative manner" (Everaert, Koster, and Derakshan 2012: 4). Importantly, all of these cognitive biases can be found not merely in depressed samples but in at-risk and remitted ones as well, demonstrating that "these distorted cognitive processes are not merely mood-dependent correlates of the disorder" (Everaert et al 5).

Rumination. A great deal of research in depression focuses on the connection between the disorder and rumination, "a mode of responding to distress that involves repetitively and passively focusing on symptoms of distress and on the possible causes and consequences of these symptoms," (Hoeksema, Wisco, and Lyubomirsky 2008: 400). According to this research, a disposition to

ruminate (in a particular way – more on that later) is highly predictive of a person's likelihood to develop MDD (Hoeksema, Wisco, and Lyubomirsky 2008; Berman et al 2010; Lane and Northoff 2014). In fact, rumination "has been found to partially or fully mediate the relationship between depression" and other predictive factors like "neuroticism, negative inferential styles, dysfunctional attitudes, self-criticism, dependency, and neediness" (Hoeksema, Wisco, and Lyubomirsky 2008: 400).

Rumination causes and sustains the symptoms of depression by "enhancing negative thinking, impairing problem solving, interfering with instrumental behavior, and eroding social support" (Hoeksema, Wisco, and Lyubomirsky 2008: 401). Now, some researchers suggest that the obsessive rumination characteristic of depression is meant to provide the sort of contemplation needed to address the kinds of difficulties which have caused a person's distress. This so-called "analytic rumination hypothesis" is especially associated with the work of Paul Andrews and Andy Thomson. They contend that depressive rumination is an adaptation "whose function is to minimize disruption of rumination and sustain analysis of complex problems" (Andrews and Thomson 1). In other words, the very fact that depressed individuals find it difficult to stop obsessing about their problems is a feature, not a bug. They argue that this kind of continual, dogged contemplation and assessment of one's problems "helps people generate and evaluate potential solutions" and thus played a fitness-enhancing role in our ancestors (Andrews and Thomson 5). Rumination, though a fairly miserable experience insofar as it forcefully draws our attention to distressing thoughts about ourselves and the world around us, is ultimately a beneficial process, helping us see how things got to where they are, how we can get out of the bad situation, and how we can avoid it going forward.

But there is good reason to reject this hypothesis. Recent research suggests that there are in fact two distinct kinds of ruminative process – brooding and pondering – and that depressed

individuals primarily exhibit the former (Treynor et al 2003; Lane and Northoff 2014). Yet brooding is not helpful in solving problems; rather, it is narrowly self-focused, repetitive, and suffused with negative affect (Lane and Northoff 10). If depression really were a kind of problem-solving adaptation, we would expect to see depressed individuals engaged in the "concrete, process-focused" rumination characteristic of pondering, but we do not see this (Lane and Northoff 8). Instead, the kind of rumination depressed individuals engage in "does not lead to active problem solving to change circumstances surrounding these symptoms" (Hoeksema, Wisco, and Lyubomirsky 400). It makes problems worse by exacerbating negative affect and makes problem-solving harder – indeed, it makes suffers feel as though their problems are hopeless (Lyubormisky et al 1999).

1.3.4 "Faulty Prospection": The Key to A Predictive Model of Depression?

Finally, some interesting recent research builds on the burgeoning study of 'prospection' -- that is, the "mental representation and evaluation of possible futures" (cite) – in cognitive science to argue that depression is caused and sustained by "prospection gone awry" (Seligman and Roepke 2016). A recent trend in cognitive science focuses on the brain's ability to predict and evaluate various future possibilities, arguing that this capacity may be the key to providing a unified account of perception and action (Friston 2010; Clark 2013). This research paradigm has since been extended to account for various cases of psychopathology as well.

In the case of depression, Seligman and Roepke argue that depressed individuals engage in "dysfunctional if-then simulations of the future," and that this "faulty prospection" is "a core underlying process that drives depression" (Seligman and Roepke 2016: 25).[9] The thought is that

[9] Seligman and Roepke's theory is in many ways an updating of the "Hopelessness Theory of Depression" according to which to cause of depression is certain dysfunctional patterns of inference and attribution which serve to magnify the effects of stressors (Abramson, Metalsky, and Alloy 1989).

when depressed individuals simulate future scenarios, they tend to imagine "negative, and even catastrophic" outcomes (Seligman and Roepke 26). For example, a depressed spouse might imagine that talking with her partner about an issue in their relationship will only result in making matters worse, or even prompt her partner to leave her. Seligman and Roepke defend this account by noting numerous studies which confirm that depressed individuals "imagine fewer positive scenarios and…tend to imagine negative future scenarios more quickly and easily," and tend to evaluate future scenarios in deeply negative ways (26). In short, depressed individuals characteristically engage in highly pessimistic thinking, predicting that things will only get worse, perhaps significantly so. As a result of these pessimistic predictions, they experience diminished motivation (after all, why bother acting if it will only make matters worse?) and increased negative affect.

Seligman and Roepke hypothesize that their account may provide a unified framework which can incorporate the various cognitive vulnerabilities discusses above.[10] Thus, for example, they suggest that Beck's "entire cognitive triad may actually boil down to negative future thinking," observing that the belief that oneself or the world is "no good, but that this will change dramatically and for the better tomorrow," is not nearly so depressing as expecting that neither one's own failings or the world's will improve (25). In other words, negative expectations about future improvement are needed to really make depressive beliefs about self and world sting. A similar story might be told with respect to depressogenic cognitive biases. Biased interpretation, attention, and recall might affect mood most profoundly when applied to future scenarios. Biased recall might suggest that past

[10] Perhaps there is some underlying mechanism that could tie these related but distinct cognitive vulnerabilities together? Some recent work by Koster and colleagues suggests that there might be. According to their "Impaired Disengagement Hypothesis," difficulty disengaging one's attention (which is reflective of impaired cognitive control mechanisms) is "the central engine that puts individuals at risk for heightened levels of rumination and brooding in particular" (Koster et al 2011: 7). What is exciting about this work is that it can be easily extended to explain susceptibility to many of the other cognitive vulnerabilities discussed above. For example, impaired attentional control capacity explains – indeed, is partially constitutive of – the cognitive and attentional biases I've highlighted. It also perhaps explains the inability of depressed individuals to filter out negative material when simulating future scenarios. This research is still in its early stages; nevertheless, I find it highly promising.

experience predicts future failure, for example. And some of these predictions seem to be bearing out. In a recent study exploring the relationships between various "cognitive risk factors for depression," specifically "dysfunctional attitudes, hopelessness, and rumination," Marchetti and colleagues found "a dominant role [for] hopelessness in uniquely accounting for depressive symptoms" (Marchetti et al 2016: 11). In summarizing their findings, they write: "Altogether, these findings suggest that a detrimental and gloomy view of the future represents a powerful factor facilitating and, perhaps, maintaining depression," and they specifically connect these findings to Roepke and Seligman's work, concluding that "distorted future thinking plays a pivotal role in depression" (Marchetti et al 11). (Though they stop short of endorsing the view that faulty prospection is the "primary cause" of depression.) Of course, a great deal more empirical research is needed to make good on Seligman and Roepke's predictions, but the framework they have sketched is highly promising, especially in its ability to predict and explain the diminished motivation and hopelessness so characteristic of depression.

1.4 Conclusions

Though a predictive model of depression such as Seligman and Roepke sketch probably can't account for all features of depression, nevertheless it holds great promise, and from it we can take some insights which will structure the dissertation going forward. The key insight in Seligman and Roepke's model is that depression is, at its heart, a kind of systematic prediction bias, an expectation that things will continue to be bad, that the environment will continue to furnish little to no opportunity for reward, and so on. This in turn suggests a way of conceiving the central harm of depression, which, to telegraph the conclusions of the next two chapters, is what Viktor Frankl calls the "loss of a future" (Frankl 1986: 119). Depression makes future effort-expenditure seem pointless, and in so doing it robs us of our desires. These observations point the way toward

reconceiving ill-being, in particular raising issues for desire-based theories of welfare to which I'll turn now.

Chapter 2: Depression and the Problem of Absent Desires

In this chapter I argue that consideration of certain cases of severe depression reveals a problem for desire-based theories of welfare. I first show that depression can result in a person losing her desires, and then identify a case wherein it seems right to think that, as a result of very severe depression, the individuals described no longer have any desires whatsoever. I argue that the state these people are in is a state of profound ill-being: their lives are going very poorly for them. Yet desire theories get this case wrong. Because no desires are being frustrated, the desire theorist has no grounds for ascribing ill-being; indeed, because the individuals described seem utterly without desire, the desire theorist has no grounds for treating these people as subjects of welfare ascription at all. I argue that these results are unacceptable; therefore, we should reject desire-based theories of well-being and ill-being.

2.1 Introduction

In his essay "Depression, Too, is a Thing with Feathers," Andrew Solomon paints a particularly vivid picture of what it is like to suffer from depression:

> I didn't feel very excited or enthusiastic about any of the things that had previously filled me with joy and pleasure. I remember particularly that, coming home and listening to the messages on my answering machine, I would feel tired instead of being pleased to hear from my friends, and I'd think, 'That's an awful lot of people to have to call back.' I was publishing my first novel at the time, and it came out to rather nice reviews. I simply didn't care. All my life I had dreamed of publishing a novel, and now here it was, but all I felt was nullity. That went on for quite a while.
>
> Then the sense of life's being effortful kicked in. Everything began to seem like such an enormous, overwhelming effort. I would think to myself, Oh, I should have some lunch. And then I would think, 'But I have to get the food out. And put it on a plate. And cut it up.

> And chew it. And swallow it.' And it all began to seem like the Stations of the Cross (Solomon 2008).

It is plain that Solomon's life, when suffering from depression, is going very badly for him. Yet surprisingly depression – a paradigmatic state of *ill-being* – has not been much investigated by philosophers thinking about welfare. In part, this may be because theories of ill-being have received less attention from philosophers than theories of well-being have (Kagan 2015). But whatever its explanation, this lacuna in the literature is unfortunate, for depression has much to teach us about what makes our lives go well – and poorly. In fact, I argue that certain cases of severe depression provide a counterexample to desire-based theories of welfare. A desire-based theory of welfare (which I will also refer to as 'the desire view' or 'the desire theory') cannot explain why severe depression is bad for us; instead, such a theory implies, implausibly, that certain severely depressed individuals are no longer even subjects of welfare. For these reasons, desire-based theories of welfare should be rejected.

In order to demonstrate this, I first show that the cases of severe depression I highlight pose a problem for a simple version of the desire theory (what I will call 'the Simple View'), which I characterize in section 2. After explaining why severe depression is a problem for the Simple View, I go on, in section 4, to consider more sophisticated versions of the desire theory which one might hope could avoid the problem I have identified. However, either these modified accounts fail to solve the problem, or else they generate other objections which render them unacceptable. As a result, no version of the desire theory is found to be acceptable.

This result is both surprising and important. The desire-satisfaction theory is often seen as the "theory to beat" in the well-being literature (Haybron 2008: 3). Moreover, though many objections have been leveled against desire-based accounts of welfare, the problem discussed in this paper is, to my knowledge, a novel one. My conclusion, if true, also points to a more general moral -

- one stressed recently by Shelly Kagan -- that philosophers interested in well-being would do well to also attend to instances of our lives going poorly.

2.2 Desire-Based Theories of Welfare

Desire-based theories of well-being have a long history and numerous defenders (Hobbes 1651/1994; Brandt 1966; Singer 1979; Heathwood 2006, 2011). Chris Heathwood describes their core commitments as follows:

> The desire-fulfillment theory…holds, in its simplest form, that what is good in itself for people and other subjects of welfare is their getting what they want, or the fulfillment of their desires, and what is bad in itself for them is their not getting what they want, or the frustration of their desires (Heathwood 2015: 135).

Thus, for instance, if I want my favorite song to come on the radio and it does, my life goes better for me. Conversely, if I desire to see my favorite band in concert but their show is sold out, it goes worse.

The simplest version of the desire theory that I will be working with in this paper – i.e., the 'Simple View' -- has the following three features.[11] First, on this view, it is only the satisfaction or frustration of a person's *actual* desires which affect her well-being, as opposed to some *idealized* set of those desires – for example, only her fully informed desires. Second, on the Simple View, it is only the satisfaction or frustration of those desires a person *currently holds* which makes his life go better or worse for him. In other words, the Simple View incorporates a "*temporal concurrence* requirement" (Lin 2016: 105). What this requirement means is that if I desire to have a baked potato now, but have ceased to desire it by the time it is done, then eating the potato will no longer improve my well-

[11] A further complication concerns the choice between an 'objective' and a 'subjective' formulation of the desire view (Lin 2016: 104-105). According to the 'objective' account what is basically good for us are desire satisfactions, that is, "states of the form p & you desire p." According to the subjective formulation, however – as first sketched by Heathwood -- it is subjective desire satisfactions, "events of the form you believe p and you desire p" which are the basic goods (Lin 104; cf. Heathwood 2006: 548). I believe that the problem I raise in this paper is a problem for either formulation, so I leave it aside in what follows.

being. A person's desire must be temporally concurrent with its satisfaction (or its frustration) for that satisfaction (or frustration) to be good (or bad) for her. Third, and finally, the Simple View is restricted to *present-directed* desires. That is, only the satisfaction or frustration of desires a person has *concerning the present* count with respect to her well-being. For example, if I have a desire that I now be listening to Mozart and that desire is frustrated, then my life goes worse.

Put briefly, according to the Simple View the only desires that are relevant to my welfare are the actual, present-directed desires I am currently experiencing. If I am currently desiring a chocolate donut and get it, that is an instance of desire-fulfillment which improves my well-being. And if I would strongly like, at this very moment, for my headache to stop, but it doesn't, this makes my life go worse for me. Later I will entertain versions of the desire theory which allow the satisfaction or frustration of past, idealized, or even masked desires to affect well-being. For now, however, I merely want to raise a problem for the Simple View.

Before moving on to that problem, however, I should address a potential concern one might have with my project. A chief part of my complaint against the desire theory is that it cannot explain the *badness* of certain instances of severe depression. But someone might think that the desire theorist can simply reject this explanatory burden. He might hold, instead, that the desire theory is simply a theory of *well-being*, and that it has nothing to say about what makes life go badly.[12]

Now, from Heathwood's characterization of the desire theory above, it seems evident that the theory *is* typically thought to have something to say about both well-being and ill-being. With that said, it is still possible for a defender of the desire theory to hold that the typical view is wrong: the desire theory, she might insist, *ought* to be seen as a theory of well-being alone. Suppose we go along. There are two ways that theories of well-being could relate to theories of ill-being: either the

[12] Thanks to an anonymous referee for pressing me to consider this possibility more thoroughly.

theories are *symmetrical* or they are *asymmetrical*. If the former, then what makes our lives go badly is the converse of what makes our lives go well: for instance, desire-frustration, the (apparent) converse of desire-satisfaction, makes our lives go badly. If the theories are asymmetrical, however, then the two theories are independent of one another – that is, the explanation of what makes our lives go badly is independent of the explanation of what makes our lives go well. We could imagine, for instance, that desire satisfaction makes one's life go well, but pain (where this is not understood in motivational/conative terms) makes one's life go poorly.

Our interlocutor is therefore claiming that we should treat the desire theory asymmetrically. Desire satisfaction makes our lives go well, but something else makes them go poorly.[13] Now, if the only way to resist the argument of this paper is for the desire theorist to 'go asymmetrical,' that would be an interesting result in its own right. However, I don't think this gambit will work, for two reasons.

First, an asymmetrical theory is a very strange outcome. One reason to think so is that well-being and ill-being are opposites: if one is (all-things-considered) well off, one cannot simultaneously be (all-things-considered) badly off. Since these states are opposites, it is reasonable to expect their determinants to be opposites, too. That would explain why one excludes the other: a state of net desire-satisfaction cannot be a state of net desire-frustration, too. But if the determinants of well-being and ill-being are not opposites, then it would seem possible to be both high in all-things-considered well-being and in all-things-considered ill-being. We should seek to avoid this result.

Second, and more importantly, even granting the intuitive plausibility of an asymmetrical theory of welfare, the argument of this paper still has bite. That's because, as I will go on to show,

[13] One could also hold that nothing (properly speaking) makes our lives go poorly, for ill-being is merely the absence of well-being (cf. Augustine 1996). I ignore this possibility in what follows.

the desire theorist is still forced to claim that nothing can benefit certain of those who are severely depressed. This is still a highly implausible result; thus, my argument still cuts against the desire theory even conceived merely as a theory of well-being.

2.3 Depressive Anhedonia and Absent Desires

As noted in the introduction, I take it as uncontroversial that suffering from depression makes a person's life go worse for her, and that *severe* depression is a worse state to be in than mild depression.[14] A case of depression like that described so vividly by Solomon is not a peripheral or complicated case about which intuitions might reasonably differ. If the desire view cannot accommodate this fact, it is in trouble.

Clinical depression comes in a variety of different forms and involves many different symptoms. Here I am chiefly concerned with one aspect of depression in particular: *anhedonia.* For the purposes of diagnosis, the DSM defines anhedonia as a "markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day" (APA 2013). This aspect of depression is made vivid in the quote from Andrew Solomon with which I began the paper. Completing his novel (a longstanding goal) and receiving positive reviews of it gave him no joy; he felt no motivation to return friends' phone calls or even to make himself lunch. All he felt was "nullity."

Implicit in the DSM definition are two dissociable forms of anhedonia – *motivational* and *consummatory (*Treadway and Zald 2011). A person is experiencing the former when she feels little or no motivation to do things she formerly enjoyed; she is experiencing the latter when formerly

[14] This does not mean that I deny that depression ever has instrumental benefits. Sometimes it does. For example, it can serve as an indication that something has gone deeply wrong in one's life (Andrews and Thompson 2009). Moreover, depression can plausibly be a merited response to circumstances (Graham 1990). But none of this is incompatible with claiming that depression – particularly when it is severe-- is a paradigmatic state of ill-being.

pleasant activities or experiences produce little or no pleasure. In more colloquial terms, one might experience a deficit in *wanting* (motivational anhedonia) or a deficit in *liking* (consummatory anhedonia).

Some depressed individuals suffer from motivational anhedonia without experiencing a corresponding deficit in consummatory pleasure: they anticipate little or no enjoyment from various activities or experiences, but still enjoy them when they get them (Sherdell, Waugh, and Gotlib 2012). In these cases it is somewhat unclear whether to say that the individuals have lost their desires; though they lack motivation for certain goals, they still enjoy those goals upon obtaining them. In some instances of major depression, however, both forms of anhedonia are present (Nakonezny et al 2010; Li et al 2015). These cases suggest a clearer picture of desire loss: when a person suffers from deficits in experienced pleasure, then experiences or activities she was formerly motivated to pursue will lose some of their luster – she will anticipate less enjoyment from them going forward. This diminished anticipatory pleasure in turn feeds a motivational deficit. As this process iterates, a person will naturally become less and less motivated to pursue that which formerly gave her pleasure.

In short, as decreases in positive reinforcement inform anticipation of future positive outcomes, decreased motivation may result. Over time, a person can lose his motivation for the goal entirely. Thinking about the goal engenders no anticipated enjoyment; it presents itself as pointless, barren. Thus, he ceases to desire it. I take it that this is more clearly a picture of desire loss because in these cases the individual has no motivation to pursue or bring about the goal, and the individual

does not enjoy the goal upon obtaining it.[15] Thus, both those who take pleasure and those who take motivation as central to desire should be happy (cf. Schroeder 2006).[16]

If this process is relatively localized, the scope of a person's desire loss is small, and so minimally disrupting to a person's life. In some cases, however, this process is not localized. It is cases like those to which I now turn.

2.3.1 The Problem of Absent Desires

Sometimes anhedonia can be quite general, encompassing, as Solomon makes clear, even such basic desires as the desire to eat something for lunch. When depression gets this bad, simple tasks like getting out of bed or taking a shower become challenging. A kind of total motivational paralysis sets in.

Given that anhedonia can be this general, it seems possible that a person might become so mired in apathy that she ceases to have any desires at all. In fact, such cases are more than merely possible – there are, I contend, actual cases of what we can call *complete conative collapse*. Viktor Frankl's description of certain victims of the Nazi concentration camps provide illustration of the sort of depression I have in mind. About these individuals Frankl writes

> The day would come when [they] would simply lie on their bunks in the barracks, would refuse to rise for roll call or for assignment to a work squad, would not bother about mess

[15] Here some may be tempted to object that depression does not cause one to *lose* one's desires; rather, it *masks* them. The depressed are, say, still disposed to get pleasure from obtaining various goals, but because of their depression this disposition is unable to manifest. I postpone discussion of this worry until section 4.

[16] On the other hand, Timothy Schroeder (Schroeder 2004) has defended a more neuroscientifically-sophisticated account of desire on which the kind of depression I have sketched here need not be seen as resulting in the loss of desire. As he puts it, a theory of the kind he develops "is committed to holding that a desire can exist in a creature that cannot, by its nature, move or feel" (Schroeder 2015: §1.5). This is, as I understand it, because of the way in which Schroeder understands the concept of 'reward,' which he does not treat as synonymous with 'pleasure' (Schroeder 2004, Schroeder 2006: 635-637). I think a full discussion of these issues would take me a bit too far afield; here I will simply note that if Schroeder's view of desire is correct, then it may well furnish a reply on behalf of the desire theorist, but also that his view is controversial, for it is quite revisionary, and thus very far removed from the commonsense picture of desire -- as he himself notes (Schroder 2015: §1.5; see also Brook 2006). In addition, one might wonder how the satisfaction of a desire which bears no necessary connection to motivation or pleasure could really be good for an agent. So even if Schroeder is right about what desires are, his view might not be a friendly one for desire theorists.

> call, and ceased going to the washroom. Once they had reached this state, neither reproaches nor threats could rouse them out of their apathy. Nothing frightened them any longer; punishments they accepted dully and indifferently, without seeming to feel them. (Frankl 1986: 117, quoted in Ghaemi 2013: 94).

Frankl refers to such a state as "*melancholia anesthetica*" and regards it with the greatest horror (Frankl 128). It therefore seems that a state of complete apathy – of total desirelessness – is not only conceivable, but actual.

Individuals suffering from a condition like that described by Frankl seem plainly to be very badly off. It seems appropriate to pity them; if given the choice, no healthy person would choose to trade places with them.[17] Though a state of utterly desirelessness is sometimes taken to be a goal worth aspiring to (at least, on some probably mistaken interpretations of Buddhist doctrine) reflecting on Frankl's concentration camp victims indicates that to be in such a state is actually to be doing very poorly.[18]

Yet about this state the desire theory is silent. According to the simple version of the theory we are currently considering, these individuals no longer possess desires which can be frustrated, as is evidenced by their indifference not only to the demands placed upon them, but even to their bodily functions, to threats, and to physical pain. If no desires are being frustrated, then the desire theory has no grounds for ascribing ill-being. But it is simply not plausible to suppose that those individuals Frankl observed in the Nazi camps were not in a terrible state. Indeed, the desire theory would seem to have no grounds for treating Frankl's concentration camp victims as subjects of welfare ascription at all. As a result, the desire theorist seems forced to hold that the victims Frankl describes cannot be benefited, and therefore that freedom from their hellish circumstances would

[17] Here I am setting aside the question of whether other victims of the camps might rationally prefer to take their places, given that they – the totally desireless – seem at least to no longer be feeling any pain.
[18] Some readers may be put in mind here of Nietzsche's criticisms of the Buddhist goal of *nirvana*, understood as the complete absence of desire (Panaioti 2013). Whether this an accurate interpretation of Buddhist doctrine or not, the horror which those like Nietzsche feel when contemplating a state of utter desirelessness suggests precedent for regarding states of absent desire as states of ill-being.

not be good for them, given that they have long since ceased to desire it. Further, the desire theorist must maintain that nothing further can go badly for them. If they are physically assaulted by guards, for instance, then they are not made worse off. But these conclusions are absurd.

Call this 'the problem of absent desires.' Note that this problem is different from other cases of 'absent desires'. Accounting for posthumous harms, for example, poses a similar sort of challenge for desire-based theories of welfare (Portmore 2007). Yet it is not so implausible to bite the bullet and concede that the dead cannot be harmed (or benefited): if the dead have ceased to exist, one might argue that there is no subject who could be harmed by the frustration of the deceased's ante-mortem aims.[19] For the severely depressed, however, such a response is not plausible. These are still living, breathing human beings; there is still clearly a subject of harm here.

Someone might also be tempted to draw an analogy between the severely depressed prisoners and individuals in a 'persistent vegetative state' (PAS). They might argue that it is not so implausible to suppose that PAS patients cannot be benefited or harmed; thus, we shouldn't be troubled by an argument that reaches the same conclusion with respect to certain of the severely depressed. But here, too, the analogy does not hold. Such conclusions are controversial even with respect to PVS patients, who lack all conscious experience whatsoever (PVS Task Force 1994). But consider how striking it would be to make a similar claim with respect to the severely depressed prisoners. These individuals retain conscious experience: they are aware of themselves and their surroundings, and we have no reason to suppose that their depression has rendered them incapable of interpersonal interaction. Though they lack desire, they retain many of the elements of mental life which PVS patients lack; thus, the analogy fails. It is therefore a far greater stretch to conclude that the prisoners are beyond welfare ascriptions than to say the same of PVS patients.

[19] Not that this is the end of the story. See Bradley (2009) for a thorough discussion of the issue of posthumous harm.

I contend that this problem makes what I have called 'the Simple View' unacceptable. The concentration camp victims are in a very bad state, but they are not suffering any actual, concurrent, present-directed desire frustration. In what follows, I show that the problem extends to desire-based theories generally, that is, to those which modify the Simple View. Either the modifications fail to deal with the problem I have identified, or else they come at too great a cost, incurring additional problems which make them unacceptable.

2.4 Objections

Second-order desires. The first objection to my argument turns on the distinction between first-order and second-order desires. A second-order desire is a desire that one have some first-order desire – say, a desire that one desire another's well-being (Frankfurt 1971). Perhaps depression suppresses first-order desires while leaving second-order desires untouched. If this is right, then the defender of the desire theory could argue that the severely depressed remain welfare subjects. Things go poorly for them insofar as their second-order desires are frustrated.

It is certainly true that milder cases of depression may often involve a great deal of second-order desire frustration: as a person loses his desires to go to work or take care of his appearance, for instance, he may accordingly develop second-order desires that those first order desires be restored.[20] Without treatment, however, his first-order desires are likely to continue to be frustrated. This is plainly a bad state for a person to be in.

However, I resist the conclusion that the desire theorist can escape the problem of absent desires by appealing to second-order desire for the following reason. Many animals (and small children) can experience depression (Rottenberg 2014: 39-56), but it is plausible that they lack

[20] But of course he doesn't have to *develop* them: he made have simply had certain second-order desires all along.

higher-order thought. Now, imagine that as a result of mistreatment a nonhuman animal is brought to the same state of profound depression that the concentration camp victims experienced. Appealing to frustration of second-order desires will not explain why it is bad for the animal to experience this sort of depression. (Nor can second-order desires explain why such a creature remains a welfare subject.) But as with the victims Frankl describes, I assume such a state *is* bad for a creature to experience, human or not. So frustration of second-order desires cannot account for its badness.

Idealized desires. As noted above, according to the Simple View, what is good for a person is what that person *actually* wants. Yet actual-desire versions of desire-satisfaction theory are faced with certain problems. For example, a person may actually desire to eat a slice of pie, not knowing that the pie will actually cause him to have a severe allergic reaction (Heathwood 2015: 139). It seems that if he gets what he actually wants, he will be made worse off. Because of problems like this, some philosophers opt for *idealized* versions of the desire theory (Rawls 1971; Railton 1986). One way of idealizing desires is to appeal to an *ideal advisor,* a fully-informed and rational version of oneself. According to Peter Railton's version of this view, "an individual's good consists in what he would want himself to want, or to pursue, were he to contemplate his present situation from a standpoint fully and vividly informed about himself and his circumstances, and entirely free of cognitive error or lapses of instrumental rationality" (Railton 1986: 16). Since my ideal advisor is fully informed, he would not want me to eat the slice of allergenic pie, and thus satisfying my desire to eat the pie is not good for me.

Perhaps appealing to an ideal advisor can save the desire theory from the argument in this paper. We can grant that the current selves of Frankl's concentration camp victims have no desires and yet appeal to the desires of idealized version of these individuals to explain what is nevertheless

good and bad for them. Their non-idealized selves may want nothing, but their idealized selves may want for them to be liberated. Thus, liberation would be good for them.

One thing to note here is that making this pushes desire theorists toward giving up (or at least weakening) the so-called "resonance constraint," (Rosati 1995). Suppose, for example, that my ideal advisor wants for me to change careers. Yet from my actual, benighted state, I cannot be made to desire the career path that my ideal advisor desires for me. Were I fully informed and rational, then I would desire it, but since I am rather far from either state, I do not and, indeed, cannot desire it (cf. Rosati 1995: 299-314).[21] Therefore, I am, as Railton puts it, "alienated" from my own well-being (Railton 9). If only views which abandon (or weaken) this constraint can accommodate the problem of this paper, that's an interesting result given its fairly widespread endorsement.

With that said, such a view might still seem to return the conclusion that nothing is good or bad for Frankl's concentration camp victims. This is because an ideal advisor needs some raw material with which to work. That is, one's idealized self merely shapes, organizes, and makes coherent one's set of actual desires. If one has no actual desires to begin with, then adding full information and rationality is not going to generate new ones. To see this, suppose I am someone in the concentration camp. My fully-informed advisor knows, let's say, that I will soon be liberated. He knows that the war will be over soon and that there are many opportunities for me in the post-war world. His powers of reasoning are unimpaired. But how does he get from these beliefs (plus his intact powers of reasoning) to desires for his un-idealized self? *I* don't care that I will soon be liberated; why, then, would he? The (Humean) thought here is simply that beliefs and reason alone are insufficient to produce intrinsic desires. There is thus no desire set to be made ideal; given that a

[21] As Connie Rosati puts the worry, "the 'fully-informed person,' though purportedly you, may not be someone whose judgments you would recognize as authoritative" (Rosati 1995: 299).

person wants nothing whatsoever, her fully-informed and rational self will also want nothing. The problem appears to simply re-emerge at a new level.

Past desires. But perhaps this is too quick. Maybe my ideal advisor's raw material is not as impoverished as I have been claiming. I *used* to desire things, after all, so maybe we can include past desires in the mix. One thing I used to like to do, for example, is spend time with my family. My ideal advisor knows I will soon be liberated, and that my family is still alive, etc. This knowledge, along with my past desire to spend time with my family, might allow my ideal advisor to form the desire that I be liberated (since liberation will allow me to spend time with them, and I used to like doing that). Thus, liberation would be good for me.

Now, making this move requires abandoning the temporal concurrence requirement discussed above. Abandoning this requirement produces problems, however (cf. Parfit 1984; Portmore 2007).[22] When I was a child I had all sorts of desires the satisfaction of which now would not be good for me. For instance, I formerly desired to listen to bad mid-'90s pop music, but no longer do. Why is listening to that music no longer good for me? The most plausible answer (from a desire-based theorist of well-being) seems to be because I no longer have a desire to listen to it. I've grown up. Now, if satisfying a past desire is no longer good for me when the desire is absent, then the proposal above would seem imperiled. After all, the concentration camp victims have no desires, and so satisfying past desires wouldn't be good for them any more than satisfying my discarded childhood desires would be good for me. Alternatively, one might put the point by saying that given that my childhood desires for various things gives me no *reason* to pursue those goals in the present, the concentration camp victims' past desires to see their families gives them no reason to pursue,

[22] Parfit (1984: 157) provides the example of his past – but since extinguished -- desire to become a poet. He argues that it would be strange to claim that he has any reason to write poetry now, given that he "no longer [has] even the slightest desire to do so."

e.g., liberation in their current state. Because of this, the satisfaction of the concentration camp victims' past desires will fail to benefit them. But then it will remain the case that the desire theorist is forced to conclude that liberation is no longer a benefit for these individuals. The problem persists.

Moreover, the desire theorist remains unable to vindicate the intuition that the concentration camp victims are badly off. According to the view we are now considering, what justifies the belief that these individuals are very badly off is that they have numerous past desires, all of which are currently being frustrated. But suppose I once had a desire to be an astronaut. In my current state, achieving this dream is a matter of complete indifference to me. Am I harmed by the frustration of a desire I long ago discarded? It seems to me that the answer is plainly 'no'. The cessation of a past desire cancels the possibility that its frustration might harm me. To suppose otherwise is to suppose that I am beset by a whole panoply of harms arising from the frustration of discarded past desires. Indeed, it seems that the piece of common advice -- expressed, for example, in Epicurus's *Letter to Menoeceus* – that one ought to minimize one's desire set (that is, abandon desires the satisfaction of which will be difficult or subject to chance), would be in vain were it the case that abandoned desires could still harm us.

Masked desires. Some may object that it is not plausible to see depression as causing a loss of desire; rather, depression merely prevents one's desires from manifesting. In other words, depression *masks* desire. The depressed individuals in the concentration camps are still disposed to, say, feel pleasure when they think about being freed. They may even retain the disposition to be motivated to do what they can to bring about that goal. Yet their depression is such that these dispositions cannot manifest.

To make this objection clearer, we need to introduce a distinction between *standing* and *occurrent* desires. Call a desire 'occurrent' if it is such as to be "playing some role in one's psyche at the moment," and 'standing' if it is not (Schroeder 2015). A desire is 'playing some role in one's psyche' if it is a desire one is consciously aware of, and if it is actively determining (at least in part) one's behavior. The hunger one feels as lunchtime approaches is an example of an occurrent desire. Alternatively, desires which "lie at the back of one's mind" (e.g., a desire for "a new pair of skates") are standing desires (Schroeder 2015).

The objection, then, is that the concentration camp victims retain standing desires, but that depression masks these desires, preventing them from manifesting (and in turn guiding behavior, etc.) And as evidence for this, note that when individuals suffering from depression recover, the vast majority of their desires come back exactly as they were before. It would be something close to a miracle if these desires were simply re-built from scratch. The desires must have remained – dormant – all along.[23]

Now, some of this may be oversold: it is true that many desires come back, but many others do not; experiencing depression changes a person. Indeed, many etiological theories of depression hypothesize that its primary function lies in compelling an organism to relinquish desires that are not in the organism's best interest (Price et al 1994; Nesse 2000; Rottenberg 2014). Not only that, but recovery takes a long time and often proceeds in fits and starts. It may well be that on that long, slow road a person really is rebuilding many of his desires from scratch. So I don't think the 'miracle' argument is dispositive.

[23] Thanks to an anonymous referee for providing this additional evidence for the masking objection (and for helping me see the force of the objection more clearly).

But suppose that the desires really are masked. Is it good for a person to have her masked desires satisfied? Imagine a more mundane case of depression: for instance, let's suppose that I am mildly depressed and as a result have lost my taste for lasagna, my favorite food. By 'lost my taste' I mean that my desire for lasagna is now masked: I no longer acknowledge the desire's presence, and it is unable to play a role in determining my behavior.[24] You don't realize this, however, and hoping to cheer me up, make lasagna for dinner. Now, if it is true that satisfying masked desires is good for us, then we ought to predict – all else equal – that when considering a description of a depressed person whose masked desire is satisfied, we will have the intuition that the person described is getting some benefit (though perhaps a small one). In addition, we ought to have the intuition when considering descriptions of depressed individuals having their masked desires frustrated that those people are receiving some (perhaps small) harm.

But I think this prediction is not borne out. When I reflect on the scenario just described – my depressed self sitting down to a meal I no longer profess even to want – it is hard for me to conclude that getting the lasagna is still good for me. (Or that it is any better for me than getting some other equally nutritious pasta dish for which I've never expressed a preference.) Intuitively, then, it seems that getting the lasagna is no longer a benefit, and thus that satisfying masked desires does not benefit a person. Now let's suppose that you fail to make lasagna at the last minute because you have to stay late at work. Is having my masked desire frustrated bad for me? Again, it seems not. So even if depression merely masks desire, it does not seem that this fact saves the desire theory. Of course, intuitions may differ here; perhaps there is a debunking story to be told that would explain why my intuitions about these cases are no mark against the desire theory. Maybe the benefit (or the

[24] Additionally, we can add the further stipulation that the satisfaction of my masked desire fails to produce pleasure in me. The pleasure, too, is masked: when I taste the lasagna I taste the cheesy richness of it, the acidity of the tomato sauce, and so forth, but these sensory experiences fail to be pleasurable. This stipulation allows us to include Heathwood's version of desire satisfactionism – according to which "pleasure is the subjective satisfaction of desire" (Heathwood 2006: 539) – among the targets of my example.

harm) is simply too small, or maybe the cases are under-described. But absent such a debunking explanation I am forced to conclude that one cannot appeal to masked desires to explain what is good or bad for the severely depressed.[25]

Bite the bullet. But maybe we shouldn't judge that this is such a terrible state to be in. Suppose the desire theorist simply bites the bullet and concedes that on her theory, the individuals in the Nazi camps are in fact neither well-off nor badly-off, for if they really are utterly without desire, then they are beyond the reach of welfare ascriptions. Now, it is important to see that the desire theorist would not be denying that a monstrous injustice has been done to these people. It certainly has. They have been gravely harmed. But once they reach the state Frankl describes, then they have ceased to be subjects of welfare. Nothing can go badly for them any longer.

But, as noted above, this seems too much to stomach; for my part I cannot come to believe that it would not benefit them to be freed or harm them to be beaten. In fact, when combined with the claim – not infrequently held -- that facts about welfare are the sole determinants of right action, biting the bullet implies that it is no longer *wrong* to beat the prisoners Frankl describes. But this is surely wrong; thus, desire theorists will be forced to abandon the otherwise tempting thesis of welfarism. The costs of holding on to a desire-based theory of welfare begin to multiply.

I think these consequences are highly implausible – so implausible, in fact, that we should reject the desire theory. Ultimately, I do not have a knockdown argument against the 'bite the bullet'

[25] With that said, a question remains: how do we decide when a disposition has been lost as opposed to merely masked? We might point to changes in the properties which ground those dispositions. Suppose we drop a vase on a hard surface and it does not shatter. Upon examination, we find that the vase's newfound resilience coincides with some change in its microstructural properties. I take it that we might then have good reason to think that it has lost its disposition to shatter. Some cases of conative collapse are like the shatterproof vase: if one's total desirelessness is a result of neurological damage, for example, I think we should hold that the dispositional bases (of the individual's desires) have been radically changed, or even destroyed. If so, then no disposition remains. The desires are lost. My claim could then be restricted to only certain cases of absent desires – that is, those in which the dispositional bases have been radically altered or destroyed. If we still hold – as I think we should – that individuals in those circumstances are very badly off, then the desire view is still in trouble.

strategy. But insofar as you share – as I do – the intuition that these implications are unacceptable, then you will want to look for an alternative account of what makes our lives go well and badly. The desire theory can only say that absent desire is a neutral state, but it is not the only theory out there. Perhaps an objective list account, for instance, could do better (cf. Fletcher 2013; Rice 2013.) It might say that the concentration camp victims Frankl describes lack most – perhaps all – of the objective goods of life, and have many of the bads. So their state is very bad for them. And of course there are many other options we might explore.

2.5 Conclusion

I conclude that the problem I have identified in this paper shows that we should reject desire-based accounts of welfare. These theories holds that what determines our welfare are facts about our desires – and only that. The cases of conative collapse discussed above show that these theories have very implausible implications. They fail to accommodate the intuition that the individuals described in this paper are very badly off; indeed, they fail to accommodate the intuition that they are even welfare subjects at all. Since these implications are unacceptable, we should reject desire-based theories. Desire isn't all there is to welfare.[26]

[26] Many thanks to John Doris, Julia Driver, Charlie Kurth, Jason Gardner, Mark Piper, Dylan Doherty, and the two anonymous referees for their extremely helpful feedback on previous drafts of this paper.

Chapter 3: Depression and Ill-Being: Hopelessness, Meaninglessness, and Loss of Self

In this chapter I build on the conclusions of the previous one. I provide a more fully-developed characterization of the badness of depression in hopes that this will illuminate the nature of ill-being. Taking as my central example the victims of Nazi oppression discussed in chapter 2, I discuss three harms which depression gives rise to: hopelessness, meaningless, and what John Doris (2015: 184) refers to as "evaluative collapse," which I'll understand as involving a 'loss of self.' From this I'll draw the moral that hedonist theories of ill-being are false, and that conclusion, coupled with the negative verdict for desire-based views from chapter 2, strongly suggests that ill-being is partially a mind-independent matter, or in other words, that all purely subjective accounts of ill-being are false.

3.1 Introduction

In the previous chapter I argued that depression makes trouble for desire-based theories of welfare. We saw that desire-frustration was an incomplete answer to the question 'What makes depression bad for me?' As a result, instances of desire-frustration cannot be the sole determinants of ill-being. There is more to life going badly for you than simply not getting what you want.

In this chapter I want to more fully characterize the harm of depression in order to shed some light on the nature of ill-being. In doing so, I'll take as my guiding insight Andrew Solomon's observation that the opposite of depression is not happiness, but *vitality* (Solomon 2001: 443). First, I ask: what makes those prisoners of the concentration camps I discussed in the previous chapter so badly off? I'll then suggest a (partial) answer: the harm of severe depression – the kind the prisoners experienced -- lies in part in what John Doris (2015: 184) calls "evaluative collapse," which I'll argue

is tantamount to a *loss of self*.[27] This claim will of course require quite a lot of unpacking, but roughly my view is that depression diminishes the self by undermining one's *values* or *cares*. When a person is depressed, she begins to care less about the things she once cared about, but the things we care about make us who we are; thus, without them we lose parts of ourselves.

Loss of self is a serious harm in its own right. However, this loss also gives rise to another, namely, a loss of *meaning*. Depression makes our lives (subjectively) meaningless. But since meaningfulness is – as I'll argue – a crucial aspect of well-being, for one's life to lose its meaning is for one to lose the possibility of a flourishing life. One's life may be replete with other goods, yet without meaning those goods will never add up to a good life.

I'll then draw the moral that hedonist theories of ill-being are inadequate, for they cannot explain the badness of meaninglessness. This, coupled with the results from chapter 2 strongly tell against any fully mind-dependent theories of ill-being. In short, reflection on depression demonstrates that subjective accounts of ill-being are false.

3.2 Valuing, Caring, and the Self

In order to characterize the kind of 'loss of self' I regard as a central harm of depression, let us first return to Frankl's discussion of the concentration camp prisoners. Frankl understands the badness of the state of apathy he finds in some of the prisoners as the loss of a *future* (Frankl 1986: 119ff). How he understands this concept is best illustrated by examples of prisoners who *didn't* succumb to total apathy. Of two prisoners who were able to keep going even under the most extreme duress, Frankl writes

> …each of them had a life with quite concrete tasks awaiting him in the outside world. One of them had published a series of books on geography, but the series was still incomplete.

[27] "Partial," because of course part of what makes the predicament of the depressed bad for them is pain, among other things.

> The other had a daughter abroad who loved him devotedly. That is, a task was waiting for the one, a human being for the other. Accordingly, both were reassured as to that singularity and irreplaceability which impart meaning to life in spite of suffering (Frankl 119).

Those who were able to go on, then, kept hold of something that those who succumbed to total apathy lost. Frankl calls this a 'future', but there are two different (though causally related – as I'll show) ways that we might unpack that concept. On the one hand, those prisoners who kept going held on to *hope*; on the other hand, they continued to *care*. I'll explicate each of these in turn.

3.2.1 Losing Hope

I'll understand hope as "a positive attitude that goes beyond what the facts tell us," (Tiberius 2008: 150). A person who hopes that *p* desires that *p* but need not *believe* that *p*; nevertheless, she remains open to the possibility, thinks it is possible, or perhaps even likely (Tiberius 150). In other words, to retain hope that some object of one's desires will be fulfilled, one need retain some sense that such fulfillment is possible, or at least that the evidence against it is not "overwhelming" (Tiberius 150).

Thus, one way of understanding the loss of a future in Frankl's terms is as a loss of hope. Those prisoners who succumbed to despair were those who lost all hope; for every desire they had, hope in its fulfillment became impossible. They may have hoped for liberation, for reunion with their near and dear, or for an end to Nazi rule, but in each case these hopes may have been crushed by the sense that the evidence against their fulfillment was overwhelming. It is easy to see how, from inside the camps, the possibility of liberation, reunion, or the end of the Nazi regime would look so slight as to be absurd. Eventually, in the face of overwhelming evidence to the contrary, most of us give up hope that a desired outcome will come to fruition.

So they became hopeless. To lose hope with respect to some desired outcome *p,* one need not cease to desire that *p*; one need only lose the expectation that the outcome will obtain (or, indeed, form the contrary expectation that it will not). Therefore, it may well have been the case that

the prisoners continued to *desire* their freedom, even after its prospect became so (subjectively) improbable that their hopes were dashed. They simply didn't think their desires would ever be fulfilled.

3.2.2 Ceasing to Care

However, we might understand Frankl's remarks in a slightly different way. Here, what is lost is not (merely) hope, but rather the *cares, commitments, or values* that make a person who she is. This understanding is compatible with the first – indeed, I think it follows as a consequence of hopelessness. It is easy to see the connection between losing hope and ceasing to care when one reflects on the *function* of depressed mood. As noted in previous chapters, the most plausible etiological theories of depression hypothesize that its primary function lies in compelling an organism to relinquish desires that are not in the organism's best interest (Price et al 1994; Nesse 2000; Rottenberg 2014). Desires that an individual has lost hope in being fulfilled would seem to qualify as such desires: pursuing desires one does not reasonably expect to be fulfilled is a poor use of energy and resources. Depression functions as a mechanism for compelling the abandonment of these hopeless desires, causing the individual to slowly lose his emotional investment in them, which as I'll argument in a moment, is tantamount to, ceasing to care about them. Thus, hopelessness begets apathy. The prisoners who fell into the deepest despair, then, ceased not only to hope that some desired end come to fruition; they ceased to *care* whether it did.[28] In so doing, they lost two further things: *meaning* in their own lives and (part of) their very *selves*.

[28] As Rottenberg and others argue, generally speaking losing investment in a hopeless goal is a step on the way to recovery. It might seem misleading, then, to describe those who have lost their cares as being in the *deepest* despair or in a more advanced state of depression. But that's wrong, for three reasons. First, as Rottenberg himself notes, depressed *mood* helps a person unwind her investment in unpromising goals; *depression*, however, is depressed mood gone haywire, leading to an overly general motivational shutdown. Second, one's hopelessness need be rational, and in depression it generally isn't: if one ceases to care about important goals for irrational reasons, then one is worse off than the person merely in hock to an irrational hopelessness. Finally, a narrow disengagement from unpromising goals is healthy; however, the prisoners Frankl describes are (tragically, rationally) disengaged from even the goal of continued existence.

3.2.3 Caring and the Self

Not all of a person's desires are plausibly construed as values or things she cares about. (I'll use these two terms – values and cares – interchangeably in what follows.) The most vivid example, of course, is addiction. The unwilling alcoholic desires to drink, but even though that desire is motivationally efficacious, it is wrong to say that he values drinking. What he does care about are his health and well-being, for example, and that his overwhelming desire to drink jeopardizes these cares is part of what makes addiction so traumatic: the unwilling addict is compelled to sacrifice the things he cares about. Thus, desires and values can come apart: even when a desire is the strongest one in a person's desire set, it need not be what that person values or cares about.

How, then, should we understanding valuing or caring? Here there are numerous proposals, most of which start from the assumption that those desires one cares about are those one *identifies* with in some way. However, explicating this notion of identification has proven difficult. A variety of different attempts have been defended over the years (Frankfurt 1971; Watson 1975; Ekstrom 1999, 2005; Shoemaker 2003, to name a few). To assess the various merits of these different proposals would take me too far afield, so in what follows I'll make use of Shoemaker's approach.[29]

According to David Shoemaker, "caring requires…emotional vulnerability": when I care about some object X, "I am rendered vulnerable to gains and losses – to emotional ups and downs – corresponding to the up-and-down fortunes of X" (Shoemaker 2003: 91). This view accords well with intuition: consider, for example, someone who upon being dumped by their partner, evinces no

[29] One reason I prefer Shoemaker's approach is that it avoids certain problems that have plagued other views, especially Frankfurt's. According to Frankfurt identification is a matter of higher-order desires, that is, desires that take other desires as their objects. However, his view is open to an objection from 'inverse akrasia' (Arpaly and Schroeder 1999: 167). Consider Huck Finn, who desires to help Jim and also desires *not* to desire to help Jim. Huck, of course, *does* help Jim, and in so doing does the right thing and (intuitively) seems to deserve moral credit. His helping Jim, in other words, seem to reveal something praiseworthy about who he is as a person. But Frankfurt's view gets this wrong: since on this view his desire to not desire to help Jim is what is associated with his true self, his helping Jim is unreflective of any praiseworthy character on his part.

distress or other negative emotions. It would ring false for such a person to insist that nevertheless she really did *care* about the relationship. Surely if she did care, she would exhibit some emotional discomfort upon its ending. This emotional vulnerability then gives rise to other features we typically associate with caring: for instance, "as a direct result of such vulnerability," one will be disposed to develop certain desires, such as a desire to promote the continued well-being of X (Shoemaker 92). In addition, "in many cases" caring about X will involve a judgment of X's value (Shoemaker 92): one's "set of cares… [gives] rise to one's set of evaluational judgments," but one's set of cares is "more inclusive and wide-ranging" than one's set of judgments (Shoemaker 114). As a result, it seems that (on Shoemaker's view) a person can care about X without judging it to be valuable, but one cannot value X without caring about it. And, to repeat, one cannot care about X without being emotionally vulnerable: "without the ability to feel, one would (by definition) be without the capacity to care, leaving one's decision-making landscape flat and without salience" (Shoemaker 114).

With this understanding of caring in hand, we can make sense of the claim that some severe cases of depression involve a loss of cares. For certain of the profoundly depressed, the emotional vulnerability constitutive of caring is lost. (Or at least masked – a point I will return to later.) Many depressed individuals report a thoroughgoing emotional numbness. On the website 'Healthtalk.org,' which is a database of self-reported experiences of various mental illnesses, one woman describes herself as having "no emotions on anything. I don't feel happy, I don't feel sad. I've just got the same face on all the time." Another – Ruby – describes her numbness a bit more evocatively: "you could light a firecracker up my arse and I wouldn't flinch" (Healthtalk.org). And these reports of emotional flattening are not atypical. Jonathan Rottenberg and colleagues have explored the ways in which depression affects "emotional reactivity," finding that depressed individuals exhibit "emotion context insensitivity," that is, a reduced positive emotional response to positive stimuli and a

reduced negative emotional response to negative stimuli (Rottenberg, Gross, and Gotlib 2005: 627). Depression, then, can suppress a person's capacity for emotional vulnerability.

This, I argue, explains why so many depressed individuals report having difficulty or even being unable to care. If emotional reactivity – to both positive and negative events – is blunted, then the capacities which underlie a person's ability to care have been diminished. In other words, suppressing a person's capacity for emotional vulnerability suppresses her ability to care. Now, except in rare cases it is probably wrong to say that the *capacity* to care has been *lost*. Instead, depression would seem to suppress the manifestation of that capacity; the emotional vulnerability, being a disposition, is still present in the individual, but is blocked or masked and so unable to become occurrent. The depressed individual thus will report being unable to care about things she formerly cared about; nevertheless, it may be wrong to say that she *really* or *truly* doesn't care about those things. It is enough for my purposes here that her ability to care is merely masked.

There are, then, at least two ways what Frankl calls the loss of a future – a feature I have argued in central to the experience of depression for many individuals – can be understood. It may begin as the loss of hope, and for many that is as far as it goes. Now, the harm of hopelessness is clear enough. The person who ceases to hope need not cease to desire; she may still *want* very much to finish her doctoral program, let's say, but nevertheless she believes that this desire will never come to fruition. A person in such a state is plainly badly off, and the explanation is not hard to find: she suffers from the (subjective) frustration of her desires. She wants X, but believes (mistakenly or not) that X will not obtain. Where the desire was stronger, the frustration of that desire will be felt the more keenly. For some desires -- an all-consuming love, for instance – loss of hope in their fulfillment may be utterly devastating.

That depression fosters hopelessness – through negative self-talk that makes a person think she isn't capable or deserving, for example, or through negativity biases that lead her to magnify her setbacks and play down her achievements – is an important reason why it is such a terrible illness. (That such hopelessness is very often *irrational* compounds the evil.) But as I've noted, sometimes depression progresses beyond hopelessness into profound apathy: one ceases not only to hope, but to care. And what makes apathy bad for us – especially the all-encompassing apathy of the concentration camp prisoners discussed in chapter 2 – is less obvious. In the remainder of the paper I attempt to address that question.

3.3 Apathy, Evaluative Collapse, and Meaninglessness

In chapter 2 I argued that the badness of apathy couldn't be fully captured by a desire-frustration account of ill-being. Now, that isn't to say that desire-frustration may not be part of the answer, at least part of the time. As noted in the previous chapter, ceasing to care about things one formerly did can be quite alarming; often, we may desire to care about various things, or form desires that our cares be reestablished. One case where this is especially clear is postpartum depression, where the loss of cares is deeply threatening. As one woman, describing her experience with the illness, admitted, "I felt nothing toward my baby…One day I woke up and I didn't care about her" (Silbener 2011). New mothers who find themselves feeling this way are understandably deeply troubled by it, beset by feelings of guilt and shame. They find it more difficult to parent effectively and fulfill daily tasks; they worry that they are bad mothers. The attenuation of their cares thus becomes something they strongly desire to reverse.

But there is more to the harm of apathy than desire-frustration. As the example of postpartum depression shows, our cares are central to *who we are*; in other words, what a person cares

about is a crucial aspect of (or is perhaps identical with) her *self*. This is the upshot of Shoemaker's work on caring. He writes

> …our identity as functioning, well-developed agents—as something more than just wantons—is constituted by our nexus of cares. Who we are—from the way that we construe the world and our experiences to our desires, values, goals, and ideals—is shaped by, colored by, or filtered through our emotional lenses (Shoemaker 113).

As a result, when our cares change our identity changes. As John Doris puts the point

> "…personal continuity varies with evaluative continuity. When a person's values change, they become less like the person they were before; at the extreme, if a person's values are completely changed, they are no longer the same person" (Doris 2015: 183).

Thus, changing one's cares means changing oneself.[30] And *losing* one's cares means *losing* one's self: a far more unsettling prospect.[31] Doris, for example, asks us to imagine a kind of "values bleach" that would turn a person into "someone who didn't care much at all about much of anything," a figure he calls "Milksop" (Doris 183). Such a substance would thus produce what he calls "*evaluative collapse*," an outcome we'd have good reason to fear (Doris 184).

Now, I contend that severe depression is a real-world example of a values-bleach: it turns thriving people full of cares and commitments into Milksops; it engenders evaluative collapse. Women who have suffered from postpartum depression often describe their experiences in these terms. Commenting on her illness, for example, one woman writes: "The hardest thing about [postpartum depression], for me, has been the loss of my self—wondering 'Who am I now?' 'Where

[30] This is, of course, a very big claim, and one which involves no small amount of controversy. Think how much different a middle aged person is from his teenage self, or for that matter how different an elderly man is from the person he was in middle age. If these changes are sufficient to make them *different people* (qualitatively, if not numerically) then what (self-interested) reason does the middle aged man have to, say, preserve his health? Whoever it is that benefits, it won't be *him*. Now, I suspect that the changes that take place over a normal lifetime are not generally so great as to have these implications, but I can only flag the issue here. These issues will have to be left for another day.

[31] Philosophers who endorse the view that there is more to a person than just her psychological states – e.g., those who endorse what Doris (185) calls "something further views" -- will balk at this claim, of course. Though I incline towards a "nothing further" view about the self, I don't intend to fight that battle here, either. Those who endorse something further views are welcome to reject my claim that depression ever leads to an attenuation or loss of self; my claims about self-alienation or incoherence will nevertheless stand.

have I gone?' and even harder, 'Will I ever return?'" (Hibbert 2014). Her depression made her unrecognizable to herself – *who am I now* – through the loss (or attenuation) of the cares that were central to her identity as an agent. And, of course, this is not something unique to postpartum depression: as I've noted, losing one's ability to care is a central feature of many cases of depressive illness.[32]

It isn't hard to see why the prospect of total evaluative collapse is a thing worth fearing. As Doris observes (Doris 185), such a state is close sibling of death: a person who loses all of his cares ceases, in a very real sense, to be. Now, I want to hedge this somewhat, as there is more to a person, I think, than just her cares; though these form the core of one's identity, other things like temperament and character traits matter, too (cf. Haybron 2008: 183-4). But with that said, evaluative collapse implies very serious damage to one's identity. The concentration camp prisoners were not dead, of course, but they were far from living, thriving human beings, too.

Nor do things seem less bleak if we suppose that depression is not capable of *destroying* a person's cares, but rather suppressing or smothering them, preventing the emotional dispositions constitutive of one's cares from manifesting. In such a state, we might say that a person is *alienated* from herself. It may therefore be true to say that she still cares about various things – her work, her friends and family, her hobbies and artistic concerns – because the capacity to care about these things is still present. Nevertheless, from her own perspective, these cares have been lost: from her vantage point, she is someone she no longer recognizes, or scarcely anyone at all.

[32] Dan Haybron echoes this point as well. He notes that "changes in emotional state, particularly mood propensity, are tantamount to temporary changes in personality…" before adding: "Consider how a normally happy person might react to a bout of depression: 'This just isn't me; I feel like I'm not myself anymore, like a different person has taken over my body'" (2008: 183).

At this point someone might object that we can't really make sense of the notion that losses of self are harms to a person. Vanessa Carbonell, in her illuminating paper discussing *sacrifices* of self (wherein one gives up a part of who one is for some greater good) writes that such losses "are not best characterized as losses of the constituents of a person's wellbeing, because it does not make sense to think of the person herself as being part of her own wellbeing" (Carbonell 2015: 68).[33] Setting aside cases of total evaluative collapse, then – which, as noted above, might be understood as a kind of cessation of personhood – it is hard to understand why 'loss of self' is bad for a person.

However, I think Carbonell's skepticism is unwarranted. There are a number of ways to explain the harm of loss of self. The answer I favor understands these losses as undermining agency: losing one's cares renders one a less effective or functional agent.[34] As Shoemaker notes, losing her cares renders a person's "decision-making landscape flat and without salience" (Shoemaker 114). When noting much matters to a person, choice becomes impossible (or perhaps too easy) – no option has anything to recommend it, so decision-making might as well be a coin flip. This is, unsurprisingly, not a recipe for the prudent exercise of practical reason. Further, as one becomes increasingly alienated from the cares which constitute one's identity, it becomes harder to carry out long-term plans or engage in any kind of meaningful projects. After all, what's the point? In causing a person to lose touch with himself, then, depression makes it harder for him to have many of the goods which contribute to a fulfilling life. In fact, this fate is very possibly *worse* than death, or at least it is often judged to be. In 2016 the *Economist* magazine reported the results of a study which interviewed numerous individuals who had been admitted to the hospital for a variety of serious illnesses (Economist 2016). The individuals were asked whether they judged any of a number of

[33] As an example of a sacrifice of self, Carbonell provides the case of William Queen, who worked as an undercover agent for many years. This work required Queen to undertake an entirely different persona, suppressing his own. Moreover, his job required him to say and do many things that were inconsistent with his values. Carbonell argues that such work amounted to a sacrifice of his self.

[34] And, as I'll discuss below, losses of self threaten the meaningfulness of one's life.

different symptoms to be "worse than death." At least half – and often quite a bit more – thought numerous agency-destroying symptoms like "being unable to get out of bed" or "relying on a breathing machine" were fates worse than death. It seems that we often value our capacity for effective agency more than we value life itself. Without the former, the latter is simply not worth having.

Before moving on, however, I want to address another worry about my argument. I've argued that depression undermines the self, but what of those people for whom depression appears to *constitute* some aspect of their selves? Some people, we might think, just wouldn't be the same person if they were no longer depressed: imagine Lincoln without his melancholy, or Plath, or Poe. Their depression seems a part of who they are. Such thoughts underlie the not-uncommon feeling of "uplift anxiety," the unease some depressed individuals have when their depression is alleviated by antidepressant treatment (Haybron 2008: 183). This unease "reflects a feeling that one is naturally an unhappy person," and that as a result of antidepressant treatment "one is no longer oneself" (Haybron 183).

If it is true that for some people depression is a part of who they are, might it be as bad for them to be treated for depression as I've argued it is for a healthy person to become depressed? In both cases we might think there is some loss (or at least masking) of the self: perhaps antidepressants mask a depressed person's true identity in the same way that depression masks a healthy person's true identity. The upshot would seem to be that we shouldn't treat certain people for depression: such treatment would be something akin to killing the patient in order to save her.

If my argument had that implication then it would be in trouble; fortunately, it does not. I have argued that depression alienates a person from herself through an emotional flattening: the severely depressed exhibit reduced positive and negative emotional reactivity, and since emotional

reactivity is necessary for a person to care about anything, depression makes it harder for those who suffer from it to care. Antidepressant treatment, when successful, restores a person's emotional reactivity. It doesn't *change* a person's cares; rather, it makes her *able* to care again. Moreover, I've argued that the harm of losing oneself lies in large part on the damage it does to effective agency. But antidepressant treatment doesn't involve any comparable diminishment of agency -- in fact, just the opposite.

It is indeed hard to imagine Lincoln without his somber bearing, but this is not because the values which constitute the core of his identity are somehow bound up with his depression. As I mentioned previously, there is more to a person than just his values: Lincoln just wouldn't be Lincoln without his self-deprecating humor or his tendency towards introspection, for example. Of course, many of these traits are causally implicated in depression, and I suspect that uplift anxiety stems from the not-wholly-mistaken worry that antidepressant treatment will warp these other aspects of one's personality. Nevertheless, it is no part of my argument that antidepressant treatment should ever be resisted on pain of making a person other than who they are.[35]

3.4 Meaninglessness

I want to take stock of what's been established thus far. Taking my cue from Frankl's insight that what distinguished the crushingly depressed from their still-struggling brethren was that the former had suffered a *loss of future*, I've argued that depression deprives a person of her future in two ways: either by undermining her hopes, or by precipitating evaluative collapse. Furthermore, I've argued

[35] But suppose all this is wrong; that is, suppose depression really is a part of who certain people are. It still need not follow that antidepressant treatment ought to be resisted by those individuals. The cost of losing a valued aspect of oneself will simply need to be weighed against the multiple benefits of no longer be depressed – the alleviation of psychological distress, the increased ability to carry out valued projects, and so forth. While it is certainly conceivable that for some individuals these benefits will not outweigh the cost of losing a part of who they are, for the vast majority it seems reasonable to suspect that they will – and ought to -- take the bargain.

that the harm of evaluative collapse lies in its undermining of coherent and effective agency. Depression, in its most insidious form, threatens our very selves, which in turn threatens our access to a whole range of goods. But though I think the chief harm of evaluative collapse lies in the damage it does to effective agency, there is one further aspect that merits discussion. The weakening of a person's cares threatens his life's *meaningfulness*. Meaningfulness is a crucial aspect of a flourishing life: without it, our lives do not go well for us, regardless of the other goods we might enjoy.

There are four views one could have about what makes a person's life meaningful: that it is determined purely subjectively, purely objectively, by both subjective and objective factors, or else that there are two things – subjective meaningfulness and objective meaningfulness – each determined separately. Purely subjective views are popular in psychology and with some philosophers (e.g., Frankfurt 1982). According to them, a person's life is meaningful just in case she has the right sorts of *attitudes*: for instance, just in case she finds she finds her projects and relationships fulfilling or engaging, or is passionate about them. If a person is excited to get out of bed in the morning and seize the day, then his life is meaningful for him, meaningful in the only way it could be. Purely objective views, on the other hand, hold that a person's attitudes are irrelevant: what makes someone's life meaningful is wholly a mind-independent matter – say, whether or not he has produced more good than evil in the world, saved lives, created lasting works of art, pleased God, or something similar (Metz 2013). Hybrid views – most famously, Susan Wolf's – hold that both subjective and objective features are necessary. On Wolf's view, meaningful lives are "lives of active engagement in projects of worth;" or, as she puts in in a later work, "meaning arises when subjective attraction meets objective attractiveness," (Wolf 1997: 209, 2009: 9). Therefore, one's life is meaningful only when one has both the right attitudes and has them towards the right objects. Finally, one might hold that there is just subjective meaningfulness – i.e., having certain feelings or

attitudes – and objective meaningfulness – i.e., making a difference in the world – and that it is wrong to try to shove both into the same box or focus on one to the exclusion of the other.

What's important for my purposes is that meaningfulness not be a purely objective matter, for depression, I'll argue, only undermines subjective meaningfulness.[36] Fortunately, Wolf (2009: 14) has a compelling argument against objectivist theories. She asks readers to consider a variation of the famous 'Myth of Sisyphus'. According to the myth, the gods have condemned Sisyphus to roll a heavy stone to the top of a steep mountainside, at which point the stone will roll to the bottom again, forcing him to repeat the process for all eternity. In the original version, Sisyphus's task is the paradigm of a pointless activity: his rolling the heavy stone up the mountain again and again accomplishes nothing whatsoever. In Wolf's variant version, however, Sisyphus's task *does* accomplish something, namely, scaring off some vultures who would otherwise terrorize a small village. As a result, Sisyphus makes a difference in the world; without him, the village would be wiped out. Should we then say that Sisyphus has a meaningful life?

Wolf holds that we should not. That one's apparently pointless task might produce some unappreciated good is not sufficient to give one's life meaning. Some sense of fulfillment from or engagement with the task is required: if my life is spent monotonously typing away under the flickering fluorescent lights in some grey office cube every day, and if this task gives me no joy, provides me no sense of purpose, or fails to be fulfilling in any way, then we should not say that my life is meaningful (full stop) even if, through some fantastic causal pathway, it produces some great

[36] At least, it only *directly* undermines subjective meaningfulness. It might indirectly undermine the objective meaningfulness of a person's life by, for instance, causing them to fail to complete some worthwhile project.

good.[37] When people seek 'a meaningful life' this cannot be what they are after. Thus, a purely objective account of meaningfulness is inadequate.

As a result, we must countenance a subjective aspect of meaningfulness. Whether that is *all* there is to meaningfulness need not concern us here; what matters is only that meaningfulness have a subjective dimension. Part of what makes a person's life meaningful, in other words, is the attitudes she takes to that life. Having established that claim, it is easy to see how depression threatens meaningfulness. Consider what Wolf has to say regarding the attitudes that contribute to making a life meaningful, which she groups under the label '*active engagement*':

> "A person is actively engaged by something if she is gripped, excited, involved by it. Most obviously, we are actively engaged by the things and people about which and whom we are passionate. Opposites of active engagement are boredom and alienation" (Wolf 1997: 209).

In other words, people are 'actively engaged' in the projects or relationships which make them feel especially alive. Quite evidently, they *care* about these projects or relationships; as Wolf puts it, they feel *passionately* about them.

But depression robs a person of her cares; as a result, it undermines the attitudes that are necessary for her life to be meaningful. This is no minor matter, as meaningfulness is a crucial aspect of well-being. Literature provides numerous examples of figures bereft of (subjective) meaning: take, for instance, Frank Bascombe in Richard Ford's *The Sportswriter*. Bascombe is the epitome of emotional detachment, seemingly indifferent to the death of his son, his divorce from his wife, and the needs (even the existence) of his surviving daughter. Bascome drifts through life, driven, seemingly, only by the goal of staying at arm's length from all emotional involvement. He pursues an

[37] Intuitions may be muddy about the Sisyphus case, I suspect, and if so the culprit is the fact that 'meaningful' is equivocal. Sisyphus-the-oblivious-village-savior's life is meaningful in an objective sense – he *makes an important difference in the world*. But it is not meaningful *for him*. The moral I think we should draw from this is just that there are two different senses of meaningfulness; however, I leave this argument aside since Wolf's case is adequate to show that any purely objectivist theory is unacceptably counterintuitive, and this is all that is required for my argument.

un-taxing career (switching from fiction writing to the comparatively bloodless art of sports-writing) and a quiet, routine life in the suburbs; he approaches every aspect of his life with a cold, clinical eye. Now, in many ways Bascombe's life is not a good one – he has lost a child and a marriage, after all. But bracketing, if one can, those great harms, it still seems clear that his life suffers for its lack of meaning. Nothing much matters to him, and that's – in part – why his life is not a good one.

Of course, fiction furnishes plenty more examples like this: Camus's Meursault, for example, or Mr. Duffy in Joyce's *A Painful Case*. In each case, part of what ails these characters – part of what makes their lives bad for them – is their lives lack of (subjective) meaningfulness. To be a Milksop for whom nothing much matters is to be badly off, and badly off in virtue of that fact. Indeed, imagine a person who has numerous other goods: friends and family, health and financial security, career success and respect, but for whom none of these things *matter*. She's just 'going through the motions,' so to speak. People like this are not inconceivable: it's possible to stumble into many of the goods of life without really trying, after all, and it also isn't unheard of for a person to acquire those goods, genuinely value them, and then suddenly come to see her life as meaningless. Antti Kauppinen (2015: 1), for instance, provides the example of Konstantin Levin in *Anna Karenina*, a healthy and respected man with a happy family life whose crisis of meaning nevertheless leads him to declare "Without knowing what I am and why I'm here, it is impossible for me to live." Of such people it is wrong to say that their lives are going well for them: without meaning the other goods just don't add up to a good life. That's part of the horror of depression: it makes it impossible for one to benefit from the goods in one's life.[38]

3.5 Conclusion: A Moral about Ill-Being

[38] It's also part of what makes someone's depression so difficult for *others* to deal with. In many cases, the person suffering from depression has by all accounts a very good life, which can breed confusion and resentment on the part of others. Depression can look like ingratitude.

To wrap things up, I want to draw a moral from the foregoing. Thinking about the ways in which depression is bad for us helps to better illuminate the nature of ill-being: as I argued in chapter 2, depression rules out a desire-based theory of ill-being. Here I want to argue that meaninglessness makes trouble for another subjectivist theory, namely, hedonism.[39] I'll understand hedonism about ill-being to be the view that the only things that are bad for us are unpleasant experiences (e.g., pain). Now, since meaninglessness is not bad in virtue of its felt character, it cannot itself be bad according to hedonism. Of course, the attitudes which constitute active engagement (as Wolf puts it) are pleasant: it feels good to be fully wrapped up in some project about which one is passionate. But their absence need not be painful. Consider again the figure of Bascombe. Though he drifts pointlessly through life, this fact does not appear to cause him any psychic torment. He is relatively happy – if happy is the right word – leading a meaningless existence, taking little interest in much of anything. In short, it is not difficult to conceive of a figure for whom meaninglessness is no (experiential) burden; the truly apathetic need not experience any pain from the lack of meaning in their lives. In spite of this, we still judge meaninglessness to be a bad thing.

How, then, can a hedonist account for the judgment that a meaningless life is a bad one? It seems their only option it to suppose that a meaningless life is one without a (distinctive sort of) pleasure, viz., the pleasure of active engagement. But this view is an odd one. My life lacks all sorts of pleasures – I've never tasted a durian fruit, for example. But this only means that my life is not as good as it might be; things would be better for me if I could count the taste of durian fruit among the pleasures of my life. However, it isn't as though a meaningless life is just less good than it could

[39] I'm not the first person to note that meaningfulness make trouble for subjective theories of well-being: Wolf, too, argues that hedonists are unable to account for its prudential value, and that this is a serious mark against their view (Wolf 1997). However, my argument differs from hers in important respects. My focus is on ill-being: hedonism, I argue, can't explain why meaninglessness is *bad* for us. This shift in focus allows me to avoid the objection that Wolf has to rely on her own distinctive account of meaningfulness – one which crucially involves objective elements hedonists will surely want to reject – if her argument is to go through. By contrast, my argument works even if one assumes that meaningfulness is purely subjective.

be, as would seem to be the case if meaningfulness were just one pleasure among others. Rather, we judge it to be positively *bad* – perhaps not even worth living. And that is strange on a hedonist account of meaninglessness's disvalue. Are some pleasures worth more than others? Are some pleasures *essential*? Perhaps that is what the hedonist will have to say. But if so, then *why*? This would seem to be a version of Mill's qualitative hedonism, a view long thought to be smuggling surreptitious values under its ostensibly hedonist cloak. Better, then, to accept that meaningfulness is an independent good, and its absence an independent bad; better, in short, to reject hedonism.

Chapter 4: Depression and Physician-Assisted Suicide

In this chapter I address the question of whether it is ever permissible to grant a request for physician-assisted suicide for an individual suffering from depression. I take for granted that physician-assisted suicide is sometimes permissible; thus, the question is only whether there is some feature of depression which makes it impermissible to grant requests for PAS to individuals suffering from the disorder. There are three requirements for PAS: *suffering*, *prognosis*, and *competence*. First, an individual must be suffering from an illness or injury which is sufficient to cause serious, ongoing hardship. Second, one must have exhausted effective treatment options, and one's prospects for recovery must be poor. Third, the individual must be judged competent to request PAS; that is, her decision-making capacity must not be impaired. I argue that many cases of treatment-resistant depression meet the first two requirements. Thus, the key question concerns the third. There are four features of depression which might compromise a person's decision-making capacity: (1) cognitive rigidity; (2) delusional beliefs; (3) negative or pessimistic biases (in attention, information processing, and reasoning); (4) inauthentic preferences. I investigate whether, when, and how these features of depression might compromise the autonomy of depressed patients. Ultimately, I conclude that PAS requests from depressed patients can be permissibly granted in some circumstances.

4.1 Introduction

Consider the following case. A woman has suffered from severe, treatment-resistant depression since her early teenage years, and is now in her early 30s. To combat her illness she has tried

everything from antidepressant medications, to various forms of therapy, to electroshock treatment. She has even enrolled in clinical trials for experimental antidepressant treatments, all to no avail. Her depression is debilitating. It has made it impossible for her to succeed professionally and has stymied her attempts at building deep, long-lasting interpersonal relationships. On many days she finds it impossible even to get out of bed. Now, seeing no further options, she has decided to request physician-assisted suicide. She has no dependents, and though she recognizes that ending her life will cause sorrow to her close family members, she no longer sees any alternative. No treatment has been effective; her life is a constant torment.

Such cases are not the stuff of philosophers' imaginations. In 2015, in Belgium, doctors granted a request for physician-assisted suicide (PAS) from a 24 year old woman named Laura (Buchanan 2015). Though physically healthy, Laura had been suffering from treatment-resistant depression for years, going all the way back to childhood. With nothing seeming to work, Laura chose to end her own life. The treatment-resistant depression Laura was suffering from is unfortunately not an uncommon affliction. Depression affects between 10% and 15% of the U.S. population (NIMH 2016), and "as many as 20%" of cases fail to respond wholly or partially to treatment (Atiq 2006, p. 2). Thus, treatment-resistant depression affects millions of individuals, some of whom will be suffering from depression that, like Laura's, is completely debilitating. It is no small matter, then, whether these individuals are barred from choosing PAS.

Yet in most cases they are. In most places where PAS is legal – in Canada, for example, and in all the U.S. states that have legalized the practice – PAS is restricted to terminal illnesses (those which will result in the patient's death is six months or fewer) only (Kennedy 2016; CNN Library 2014). This effectively prohibits individuals suffering from mental illness from choosing PAS. Moreover, such restrictions enjoy fairly widespread support: for instance, a recent poll of the

Canadian public found that a large majority -- 78% --"said 'psychological suffering' on its own should not meet criteria for a doctor-hastened death," (Kirkey 2016).

In this paper I address the question of whether it is morally permissible to grant requests for PAS from individuals like Laura – i.e., those suffering from treatment-resistant depression. I will not argue for the moral permissibility of PAS as such; rather, I argue for a conditional claim: *if* granting a request for PAS in the case of bodily illness (like metastatic cancer) is sometimes permissible, then, I argue, granting requests for PAS in the case of severe, treatment-resistant depression is also sometimes permissible.

To make my case, I first argue that no blanket prohibition on PAS for mental illnesses is tenable. Then, having made the case that mental illnesses are in no morally relevant respects different from somatic illnesses when it comes to PAS, I turn to the specific case of depression. I argue that for a person's condition to make them an appropriate candidate for PAS it must meet certain requirements concerning the degree of *suffering* it causes, its *prognosis,* and its effects (or lack thereof) on the *competence* of the individual making the request. Ultimately, I argue that the majority of the Canadian public is wrong to think that granting requests for PAS in the case of mental illness – and specifically, PAS for depression – is never permissible. Some cases of severe depression meet all three requirements for PAS – they cause tremendous suffering, have a poor prognosis, and preserve a patient's decision-making competence. In such cases, there should be no barrier to patients' choosing to end their lives with the assistance of medical professionals.

4.2 Three Conditions for PAS

First, I argue that PAS is only morally permissible in cases where suicide is rational, that is, when the individual making the request is suffering to a degree that makes ending her life plausibly a benefit to her. This condition is meant to be in accordance with the widespread belief that the role of doctors

is to attend to the well-being of their patients. A doctor's role is never to intentionally make a patient worse off; thus, a doctor ought to prescribe medication meant to end a patient's life only when ending her life is not judged to make her worse off. This condition can be met, for instance, in cases of end-stage cancer where the patient's remaining life will be filled with considerable pain and little benefit. It will not be met in cases where a patient is merely "tired of living" or has some other complaint judged to be insufficient to make life on balance not worth living (Lane 2013). Extant laws governing PAS like the new law in Canada appeal only to "enduring physical and psychological suffering that is intolerable" (Kennedy 2016), and I think judging what merits this designation can be left to competent doctors, in dialogue with their patients. My aim in this paper is simply to show that it is a mistake to think that only terminal somatic illnesses can meet this criterion; some cases of depression, as I will argue below, meet it as well.

Secondly, PAS is only permissible in cases where the individual's prognosis is sufficiently poor. A person diagnosed with a highly treatable cancer who wished to choose PAS so as to avoid undergoing chemotherapy, for example, would not be an appropriate candidate. However, this condition should not be interpreted as restricting PAS only to terminal cases. As I will go on to argue in the following section, such a restriction is unjustified. Nevertheless, granting requests for PAS in cases where an individual has an illness or injury which is sufficient to cause serious suffering but from which they have a very good chance of recovery would not be permissible on my view.

Finally, the individual making the request for PAS must be deemed competent. What this amounts to requires a bit of spelling out. In this paper I will be making use of the highly influential framework for understanding patient competence outlined by Grisso and Appelbaum (Grisso and Appelbaum 1998). Their model has been put to use primarily in cases involving refusal of treatment

– especially life-saving treatment – but its applicability to the case we are currently considering is clear. They understand patient competence as involving four key components:

1. The ability to express a choice
2. The ability to understand information relevant to treatment decision-making
3. The ability to appreciate the significance of that information for one's own situation, especially concerning one's illness and the probable consequences of treatment options, and
4. The ability to reason with the relevant information so as to engage in a logical process of weighing treatment options (Grisso and Appelbaum 1998).

Following Thomas Hindmarch and colleagues, we can summarize these four abilities as *expression, understanding, appreciation, and reasoning* (Hindmarch et al 2013). However, this list is incomplete. As Rudnick (2002) suggests, it needs to be supplemented with a fifth criterion, that of *authenticity*. For a patient to be considered fully autonomous, he must be able to express authentic preferences. By this I mean that he must be able to accurately reflect upon and identify his core commitments, values, and plans, and be able to express preferences in accordance with these core values (Miller 1981, p. 24). Where a patient's expressed preferences are plausibly not in accordance with his long-standing commitments and values, this is evidence that he is less than fully competent. Honoring preferences which are not truly the individual's own is inconsistent with the dictate to do no harm.

Of the four abilities Grisso and Appelbaum highlight, *appreciation* is by far the slipperiest one. It is also the one most often claimed to be compromised by depression (Hindmarch et al 2013). I will have more to say about the details of appreciation and the other abilities later on in the paper; for now, it suffices to say that any patient failing to demonstrate a sufficient degree of any of these abilities cannot be judged competent to make a request for PAS. Thus, a patient whose illness compromises his capacity to reason effectively (as, for instance, might be the case in someone with

severe dementia) cannot be deemed competent to request PAS. Whether, when, and how depression compromises patient competence is a complex set of issues that I will take up in section 6.

4.3 PAS and Mental Illness

It might be thought that PAS should be restricted to certain forms of terminal somatic illness, for instance, metastatic cancer. This is, for instance, the position of current Canadian law and the laws of several American states. What I will argue in this section is that there is nothing about mental illnesses *qua mental illnesses* which makes individuals suffering from them unsuitable candidates for PAS. That is, there is nothing *in principle* wrong with granting PAS for mental illnesses. If there is a reason not to grant a request for PAS from someone suffering from a mental illness, it is only because in that particular case one of the three conditions enumerated above – of suffering, prognosis, or competence – is not met.

First, consider the case of Bill. Bill, who is the same age as Laura, is suffering from metastatic cancer. His prognosis is not good – he has six months or fewer left to live. Those months will be filled with much pain and gradual deterioration of his capacities, both mental and physical. To avoid this, Bill requests for assistance in ending his life.

Suppose someone wants to grant that PAS is permissible in the case of Bill but not in the case of Laura, above. What could she point to in order to explain the difference between the two cases? Well, the most salient difference between the two cases is that Bill's illness, but not Laura's, is bodily. But why should that make a moral difference? One putative explanation can be quickly dismissed – namely, that mental illnesses are not really illnesses. Some thinkers (e.g., Szasz 2001) have defended this view, but it will not be seriously considered here. Nor is it plausible to suppose that mental illnesses (unlike late-stage cancer, for example) are incapable of causing sufficient

suffering. As will be developed more fully later in the paper, many mental illnesses cause profound and debilitating suffering.

There are two other reasons to suppose that PAS is only ever appropriate for physical illnesses, never mental illnesses. The first is that one might think that mental illnesses are not typically *terminal* illnesses. Perhaps PAS is only ever legitimate when one is already facing death. It might be claimed that depression, all on its own, will not kill a person, and that therefore sufferers of depression are never fit for PAS. Now, one might wonder about the claim that depression is never a terminal illness, given the significant risk of suicide. In fact, "the lifetime probability of suicide in depressed patients appears to be approximately 15%" (Clark, Beck, and Alford 199, p. 29). For some patients the likelihood that they will commit suicide may be so great (given, say, past attempts and the severity of their condition) that their cases might plausibly be considered 'terminal'. But more importantly, the principle that PAS is only legitimate for terminal illnesses is false. If one's condition causes suffering sufficient to make suicide rational, then PAS is permissible whether or not the condition will kill the patient. Imagine that we could keep Bill alive indefinitely despite his cancer. He would remain in severe pain, confined to his hospital bed, but he would not be in danger of dying. Would this fact render his request for PAS inappropriate? No, it would not. For consider: why is it morally permissible to allow Bill to choose PAS in the case of terminal illness? I submit that it is because the goods of Bill's remaining life will be vastly outweighed by the badness of his suffering and loss of agency (cf. Lachs 2013). Given this, we judge his request to end his life and avoid such suffering reasonable. But this justification applies equally well to the case in which Bill's illness is – though equally severe – not terminal. In such a case Bill will have more life remaining, but if six additional months would not have been a benefit to him, why would, say, 20 additional years? After all, the fact that a period of intense suffering will be longer rather than shorter is not a reason

to prefer it. Given this, I conclude that PAS can sometimes be appropriate in cases where one's illness is not terminal.

The second reason to prohibit PAS for mental illness is that our knowledge of mental illness is rudimentary in comparison to our knowledge of physical illnesses. We know considerably more about the origins and characteristic trajectory of (most) physical illnesses than we do about (most) mental illnesses. We also know a great deal more about how to manage and treat physical illnesses than we do about mental illnesses. Psychopharmacological treatment for depression, for instance, is only about 50 years old. Our medical knowledge of mental illness and the tools we have available to treat it are thus in very early stages.

Thus, medical progress being what it is, we might suppose that in 10, 20, or 50 years' time we will have dramatically improved our understanding of mental illness and how to treat it. Perhaps a breakthrough in antidepressant research is imminent. It might be thought, then, that allowing a patient to choose PAS is acting too hastily. If he could just hang on a little longer, we could provide him with a much more effective treatment for his condition.

Maybe so, but this is a thin reed on which to place the weight of a prohibition on PAS for mental illnesses. It is certainly possible that an effective cure for treatment-resistant depression is just around the corner. It is also possible that it will be many decades before such a treatment becomes available; indeed, it is possible that it will be quite a bit longer than that. Should this fact force those suffering now from choosing PAS? If so, then it ought to disqualify those suffering from somatic illnesses as well. It is *possible* that Bill will be cured if he just enrolls in another clinical trial for an experimental cancer treatment. Perhaps, then, we should withhold from him the option of choosing PAS.

I think that is a bullet not worth biting. In cases of severe mental illness that have endured for years without remitting or responding to treatment, it is reasonable to think that the probability of effective treatment is sufficiently remote to justify allowing the individual suffering to choose PAS. We know, for instance, that with each successive (failed) treatment, the probability that a person will recover from depression decreases (NIMH 2006). And while it is true that depression can often spontaneously remit, long-term studies like the Collaborative Depression Study (CDS) indicate that some depressed individuals remain depressed for 10 years or more: in the CDS, about 6% of patients had not recovered 15 years after their first diagnosis (Boland et al 2002).

I conclude that there is no reason to think that granting a request for PAS from someone suffering from a mental illness is never permissible. This is not too surprising, as the line between mental and physical illness is far blurrier than we often imagine. Robert Woolfolk and John Doris write

> When we examine many somatic illnesses (e.g., hypertension) from the various standpoints of etiology, symptomatology, and treatment, they emerge as complex entities with multifaceted interacting components, *with both mental and physical causes.* (Woolfolk and Doris 2002, p. 478 – my emphasis).

Given that somatic illnesses quite frequently involve psychological causes and components -- and as Woolfolk and Doris go on to note (478), are often treated, at least in part, via psychiatric medication – and given that psychological illnesses not infrequently involve characteristically physical causes and symptoms, we should be somewhat reticent to draw sharp metaphysical or normative lines between physical and mental illnesses.

4.4 Suffering

As noted above, PAS is only permissible in cases where the individual is experiencing suffering sufficient to outweigh the value of whatever goods the person has in her life. Do any cases of depression meet this condition?

It is true that the pain of depression is, at least typically, different in character from the pain experienced by someone suffering from end-stage cancer. We do not give severely depressed people fentanyl.[40] And it is true, too, that some aspects of depression are not best characterized by describing them as 'painful.' Apathy, for instance, seems bad for us without its badness being well-characterized in terms of pain.

But neither of these considerations should persuade us that depression cannot produce profound suffering, for it plainly can. Indeed, a significant part of the stigma still attached to mental illness is the minimizing of psychological suffering. In *Shoot the Damn Dog: A Memoir of Depression*, Sally Brampton writes,

> 'Sometimes,' says a fellow depressive, 'I wish I was in a full body cast, with every bone in my body broken. That's how I feel anyway. Then, maybe, people would stop minimising my illness because they can actually see what's wrong with me. They seem to need physical evidence' (Brampton 2008, p. 98).

We should therefore be on guard against any suggestion that psychological suffering is not or cannot be severely debilitating. Indeed, few disorders are as profoundly disrupting as severe depression. Take for instance the case of Deanna Cole-Benjamin (Dobbs 2006). Despite a life filled with goods – a happy family life, a rewarding job – in the early 2000s Deanna's mood began to darken for no reason she could identify. "It began with a feeling of not really feeling as connected to things as usual," she told a *New York Times* reporter documenting her story. "Then it was like this wall fell around me. I felt sadder and sadder and then just numb." She slowly began to find that even "the

[40] As ever, there are reasons for caution here. Kross, et al (2011) found, for example, that intense social rejection can activate areas of the brain "that support the sensory components of physical pain." Perhaps physical and emotional pain are not so dissimilar after all.

simplest acts – deciding what to wear, making breakfast" were an immense difficulty. This slow loss of motivation or will is a classic symptom of depression, and in the most severe cases it can be extraordinarily extensive. Even getting out of bed or taking a shower can appear impossible to the sufferer, leaving them effectively immobilized (cf. Solomon 2001). And this loss of will can lead to the loss of careers, friendships, pastime pursuits – in short, many of the things that make life enjoyable. In addition to this, Deanna began experiencing a persistent, intense desire to die. She "thought obsessively" of drowning herself in Lake Ontario. But "the worst part," according to Deanna, "was not being able to feel anything for my children. To hug them, to have them hug me, and feel nothing. That was devastating."

But along with this feeling of emptiness there is a kind of pain. As Dr. Helen Mayberg, an expert on deep-brain stimulation treatments for depression, notes

> [T]alk to a depressed person, and you have this bizarre combination of numbness and what William James called 'an active anguish.' 'A sort of psychical neuralgia,' he said, 'wholly unknown to healthy life.' You're numb but you hurt. You can't think, but you are in pain. Now, how does your psyche hurt? What a weird choice of words. But it's not an arbitrary choice. It's there. These people are feeling a particular, indescribable kind of pain (Dobbs 1996).

So, for some with severe depression, the goods of life – the joys of friendship, fulfilling work, or parenthood – are in some deep sense rendered inaccessible, and in their place there is an "indescribable kind of pain." If this isn't bad then I do not know what is. What bads could there be in severe physical illness that are not contained here? In physical illness there is pain, and we have seen that there is pain in depression, too. Is the pain of the former worse than the pain of the latter? I can see no reason to think so. In physical illness there is also a loss of agency – often quite extensive– and this, too, is true of depression. In both cases there can be the loss of other goods – one's job, one's relationships – and in both there can be hopelessness and a persistent desire to end

one's life. Because the things that make serious physical illness terrible are present in cases of severe depression, I contend that our first condition is met.

4.5 Prognosis

That a condition causes serious suffering is not sufficient to legitimate a claim for PAS, however. As was established above, some conditions cause serious pain and suffering but have good prognoses – certain types of cancer, for instance. For it to be permissible to grant a request for PAS, a patient's suffering must be such as cannot be expected to remit or respond adequately to treatment.

Several generalizations about the overall course of Major Depressive Disorder (MDD) can be made. Beck and Alford (2009, p. 44) note that for cases of MDD "there is typically a well-defined onset, a progression in the severity of the symptoms until the condition bottoms out, and then a steady regression (improvement) of the symptoms until the episode is over." However, MDD is highly prone to recurrence: a person who has experienced a "single episode" of MDD, for example, has "at least a 60% chance of having a second episode," and the likelihood of recurrence increases with each subsequent episode (p. 62). Moreover, there is a small tendency for MDD to become chronic (that is, for a patient to experience no complete cessation of illness or interval of remission between episodes), with between 5% and 30% of individuals – depending on the stringency with which one defines 'complete remission' -- failing to achieve complete remission of symptoms (p. 62).

Many treatments for depression are available, but evidence for their efficacy is mixed (Kirsch et al 2008). Indeed, "more than one third of patients treated for depression will become treatment-resistant" (Souery et al. 2006, p. 16). There is reason for caution, however, when assessing this claim. Typically, a patient is deemed treatment-resistant "when at least two trials of antidepressants from different pharmacologic classes…fail to produce a significant clinical improvement" (Little 2009, p.

167). However, to have a legitimate claim to PAS, a patient must be treatment-resistant in a very broad sense. To make this precise, we might adopt the staging model for treatment-resistant depression developed by Thase and Rush (Thase and Rush 1997). This model has six levels or 'stages' of treatment-resistance:

Stage	Description
0	No single adequate trial of medication
1	Failure of at least 1 adequate trial of medication
2	Failure of at least 2 adequate trials of at least 2 distinctly different classes of antidepressants
3	Stage 2 resistance plus failure of an adequate trial of a tricyclic antidepressant
4	Stage 3 resistance plus failure of an adequate trial of an MAOI
5	Stage 4 resistance plus failure of a course of bilateral electroconvulsive therapy

It is worth emphasizing that all trials must have been deemed 'adequate,' that is, "pseudo-resistance" – or apparent resistance as a result of treatment non-compliance -- must be ruled out (Souery et al. 2006). Thus, a candidate for PAS must meet the criteria for Stage 5 resistance. In addition, a patient should be deemed resistant to various therapy protocols – e.g., cognitive-behavioral therapy. Finally, "organic" causes of depression need to be ruled out. That is, the individual's treatment-resistant depression must not be caused by some other, treatable, disorder – for example, hypothyroidism, other neurological diseases like Multiple Sclerosis, or alcoholism.

As is evident from the Thase and Rush model, to meet the highest degree of treatment-resistance, a patient must fail to respond to electroconvulsive therapy. There is a fair amount of evidence that ECT is effective, at least in the short term, though it comes with a risk of certain (typically short-term) cognitive impairments **(**Barbui et al. 2007). Because of its apparent efficacy and

its tolerable risk-profile, no request for PAS ought to be granted to an individual who has not sought treatment via electroconvulsive therapy as well. Lest this be thought to be asking too much, it is important to note that while electroconvulsive therapy is not in the least a pleasant experience, neither is chemotherapy. As ever, I argue for parity: if it is judged that a request for PAS from an individual with cancer who has refused to undergo chemotherapy treatment is inappropriate, it should similarly be judged that a request for PAS from an individual who has refused electroconvulsive therapy is equally so.

An individual must meet the criteria for treatment-resistance outlined above – he must fail to respond to (or tolerate) multiple classes of antidepressant medication, multiple kinds of therapy, and even fail to respond to electroconvulsive treatment – to meet the prognosis criterion. Moreover, an individual's depression must be chronic – persisting without significant remission over a period of years -- and thus be judged highly unlikely to remit on its own. How should one decide if depression is suitably chronic? The DSM regards an episode of major depression as chronic if it persists without remission for at least two years. This is not an atypical outcome: about 20% of those diagnosed with MDD will fail to have recovered in two years (Spijker et al. 2002). For some sufferers, their condition persists well beyond the two year mark: in addition to the data from the CDS outlined above, another longitudinal study found that 7% of those diagnosed with MDD were still depressed ten years later (Mueller et al. 1996). Here it seems impossible to give precise guidelines. The judgment that a patient's depression is unlikely to remit of its own accord will need to take into account her entire medical history, and will need to be made by a competent mental health professional.

As noted above, it is of course *possible* that some new class of drug or novel therapy protocol will become available which can treat this individual's depression, but this possibility is not sufficient

to render his request for PAS illegitimate. If he has suffered for years with no effective treatment then it does not seem that anything good is achieved by forcing him to continue to live merely in the hope that some possible treatment will become available at some point in his lifetime.

4.6 Competence

The key question, then, is whether a severely depressed person can ever be judged competent to make a fully-informed and autonomous request for PAS. This question may initially strike some readers as puzzling – perhaps even offensive. After all, we do not – and generally should not – treat those suffering from depression as in any way less autonomous than anyone else. Consider the implications of treating depression as routinely compromising autonomy. Would we then judge that Abraham Lincoln, to take just one example, was not fit for the presidency?[41] Mental illness is already stigmatizing. Is the line of inquiry I am about to pursue simply going to add to that stigma?

This worry about adding to the stigma of mental illness is a real one, and I do not want to diminish it. However, I think it can be avoided by keeping a few things in mind. First, the question we are investigating concerns a person's competence to request the end of her own life – no small matter. To make such a momentous request, it is appropriate to ask that a person meet a very high standard of competence. To say that the severely depressed may not meet this standard does not imply that they do not meet the standard of competence necessary to govern their own affairs in all sorts of daily tasks. Thus, our conclusions here should not be taken to imply any sort of sweeping paternalism concerning those suffering from depression. Furthermore, as I will go on to discuss, the ways in which depression can compromise competence primarily concern a person's reasoning regarding self-directed, prudential matters. In other words, depression may make it more difficult for a person to reason effectively about *her own good*. This implies nothing about whether a depressed

[41] I owe the example to Christiane Merritt.

person can reason effectively about other matters; the impairment, such as it is, is domain-specific. Again, a sweeping paternalism concerning those with depression is unjustified. Finally, it is worth bearing in mind that we are here concerned with the most severe cases of depression, those sufficient to make a request for PAS rational in the first place. If it turns out that severe depression can compromise competence in certain ways, this need imply nothing about the milder forms of depression with which we are all more familiar.

With these caveats in place, I note that there is a fair amount of evidence that depression compromises patient competence in some cases. In a meta-analysis of 17 studies concerning depression and patient competence, Thomas Hindmarch, Matthew Hotopf, and Gareth Owen found that depressed patients were judged to be lacking in competence (using the model outlined above) in anywhere from ~3% of cases to as high as 31% (Hindmarch, Hotopf, and Owen 2013, pp. 3-7). Impaired appreciation was cited as the most common deficit in depressed patients, though some also showed signs of impaired reasoning abilities. We thus have reason to believe that depression at least sometimes impairs patient competence to the point where a request for PAS should not be granted. However, when and how depression compromises competence is complicated. In what follows I examine several commonly cited features of depression which have been judged to negatively affect patient competence. I conclude that none of these features is sufficient to justify a blanket prohibition on PAS for depressed individuals.

4.6.1 Cognitive Rigidity

In a review of the literature concerning depression's effects on decision-making capacities, Tsou (2013, pp. 14ff) highlights the specific phenomenon of *cognitive rigidity*. Certain depressed individuals – in particular, those who have been or are currently suicidal – show "a tendency toward dichotomous (all or nothing) thinking and cognitive inflexibility that makes it difficult for [them] to

formulate alternative solutions to problems" (2013, p. 14). It is easy to see how this characteristic of certain cases of depression could compromise a person's practical reasoning capabilities. If she is unable to contemplate alternative solutions to her current problems, for example, then she may well request PAS simply out of an inability to see the other options available to her.

Three points are worth noting here. First, there is no reason to suppose that *every* individual suffering from depression – or even that every depressed individual contemplating suicide – will show signs of cognitive rigidity (cf. Tsou 2013, p. 15). Whether a patient requesting PAS shows cognitively rigid thinking can and should be assessed by a competent psychiatrist. Second, it is important to distinguish irrational rigidity from an accurate perception of a person's alternatives. Someone may well be unable to contemplate solutions to his relentless emotional pain and misery because no such alternatives exist. Thus, clinicians need to be careful not to see irrationality where there is none. Tragically, sometimes a person is right to see no good alternatives to his predicament short of ending his life.

Third, and most importantly, patient blindspots brought about by cognitively rigid thinking can be corrected for via therapy. For instance, a therapist might help a patient to see alternative solutions to his problems that he has not considered or too quickly dismissed and might help him assess the various merits of these solutions. If his desire to end his life persists through this process (and, as will be discussed later, is consistent with his considered values), then his request ought to be honored. Therefore, while depression may incline an individual to black-and-white thinking and thus may lead her to think that her options are more constrained than they truly are, this need not rule out the possibility that a request for PAS from a depressed individual is made competently and should be honored.

4.6.2 Delusional Beliefs

Some cases of depression involve delusional beliefs or hallucinations. Beck and Alford, for example, relate the tragic story of a 21 year old solider serving in the Korean War, who accidentally killed his comrade and best friend "Buck". The solider subsequently fell into a very deep depression, eventually suffering intense hallucinations and delusional beliefs. At times he believed that Buck – whom he claimed to still be able to hold long conversations with – wanted him to kill himself (Beck and Alford 2009, p. 86).

Now, clearly a person in this soldier's condition would not be an appropriate candidate for PAS, were he to request it. His 'choice' to end his life, which is driven by his psychosis, does not meet the minimal standards for an autonomous decision. His desire to die is premised on a delusional belief – viz., that his dead friend wants him to end his life – and this belief, because it is delusional, is highly resistant to rational correction. Because of this he cannot be judged to meet the standard for competence in *reasoning* outlined above. Moreover, it would be unacceptable to allow a delusional patient to elect for PAS without attempted treatment. In this soldier's case, electroconvulsive therapy proved highly effective, ridding him of his psychosis and other features of his depression (2009, p. 86). The prognosis criterion is therefore not met in this case either.

Full-blown hallucinations are relatively rare, but delusional beliefs are not uncommon in cases of major depression. "I am a monster," "Everyone secretly hates me," "I will never amount to anything," and other intensely negative beliefs about oneself or one's position in the world are not infrequent features of the disease. Where such features are present, PAS cannot be considered an option. Psychosis is incompatible with the reasoning criterion for patient competence; moreover, it is inconsistent with the criterion of authenticity. A desire premised on a delusional belief (e.g., a desire to die because one is 'the worst person in the world') cannot be considered a desire which is

fully and authentically one's own. If one really knew the truth about oneself then it is highly plausible that the desire to end one's life would cease.

All of this, however, leaves open the possibility of granting a request for PAS in cases where psychotic features are not present or have been effectively treated (without their treatment alleviating the patient's other symptoms). Any depressed individual requesting PAS thus needs to be deemed free of psychotic symptoms by a competent professional. If psychosis has been ruled out and the patient continues to desire an end to her life, then -- provided the suffering and prognosis criteria have been met -- there is no impediment to her request being granted.

4.6.3 Negative Biases and Inauthentic Preferences

Much of the literature concerning the ways in which depression compromises an agent's decision-making capacity focuses on its effects on *appreciation*. For example, Rosenblatt and Block write the following in reference to refusal of treatment requests from depressed patients:

> [A patient's] depression and hopelessness may be coloring her worldview and causing her to forgo treatment because she is unable to appreciate its benefits. Thus, she may be making a decision based on an unrealistically pessimistic cost-benefit assessment… (Rosenblatt and Block 2001, p. 324).

And Rudnick makes a similar point (again, with respect to refusal of treatment):

> …major depression may sometimes disrupt appreciation of the benefits of treatment due to undervaluing positive outcomes while focusing on negative outcomes of treatment and thus skewing the weights given to treatment outcomes in favour of treatment risks (Rudnick 2002, p. 152).

As has been well-established (Clark, Beck, and Alford 1999; Beck and Alford 2009), depression is characterized by the development of negative or pessimistic biases concerning one's self worth, one's future, and the world around oneself. Someone suffering from depression, then, may request PAS because he cannot imagine a future life worth living, yet his failure of imagination may be

directly attributable to biased thinking brought on by his depression. A depressed person may well expect the future to be bleak even when there is every possibility that it will not be.

In addition to biased thinking – which compromises appreciation and reasoning -- a depressed person may express preferences which they would disavow were they not deeply depressed. In his recent book *Responsibility from the Margins*, David Shoemaker makes much of the thought that the severely depression person is "just not herself" (Shoemaker 2015). The aim of Shoemaker's book is to highlight the deep complexity lying beneath the surface of our practices of holding agents responsible. More precisely, Shoemaker sees the literature concerning moral responsibility as conflating three different kinds of responsibility attribution, and he uses what he calls 'marginal cases' – cases where our judgments regarding moral responsibility are conflicted – to bring out this deep structure. One such example of marginal agency, according to Shoemaker, is clinical depression. Agents suffering from the disorder are not wholly unresponsible for their actions, as, say, infants are. Nevertheless, Shoemaker contends that their actions often fail to reflect their true character. To illustrate, he asks whether we should judge a depressed person who refuses to get out of bed, bathe, or even eat as 'lazy' (p. 128). The answer, of course, is that we should not, and the reason is that these actions (or lack thereof) are not reflective of the depressed individual's true cares and commitments – indeed, they betray them (p. 128). Such actions are not, in Shoemaker's terms, "attributable," that is, they are not reflective of the agent's character, and so not evidence for character traits like laziness.

The worry, then, is that depressed individuals may express preferences which are not truly their own. Someone may wish to die not because of a clear-eyed perception that his life has nothing worth valuing left in it, but simply because he is incapable of caring about himself or seeing himself as worthy of life. These beliefs and attitudes would be disavowed, however, were he no longer

depressed. In such cases we ought to judge the individual as lacking in decision-making competence – in particular, as not meeting the authenticity criterion -- and thus as not able to make a legitimate request for PAS.

Pessimistic biases and reduced self-regarding concern are near-enough constitutive of deep depression (the kind that would merit a claim to PAS in the first place) that these issues may seem to render any request for PAS in cases of severe depression illegitimate. Such a judgment would be too quick, however. Return to the case of Laura with which I began the paper. Laura has been depressed for *years*. No treatment has been effective. Her life is filled with pain and nothing gives her any joy. It has been this way for as long as she can remember, and absent some medical breakthrough, it will remain this way long into the future. When Laura contemplates her future, she judges it to be bleak. *And she is right to.* Her future *is* bleak. Her depression robs her of the good things in life and gives her nothing in return but suffering. Whatever pessimistic biases Laura is laboring under, her perception of her future prospects is tragically accurate.

Nor should we judge her preference for death as inauthentic. Her preference may well be the following: *should my life cease to have any value, I would prefer to die.* If that is what she desires, then she might well continue to hold that preference were she no longer depressed. Of course, were she cured of her depression she would cease to desire her death, but that does not show that her desire to die given that her depression has robbed her life of value is inauthentic. Indeed, Laura's preference seems eminently rational. If one's life is truly filled with suffering and lacks any compensating good, then it seems reasonable to desire its termination.

For these reasons, I think a blanket prohibition on physician-assisted suicide for severe depression would be a mistake. Though depression can have a negative impact on one's decision-making abilities, this is not an insurmountable obstacle, as I have tried to show. Working with a

trained therapist can help ameliorate biased thinking – be it cognitive rigidity, undue pessimism about one's future, or inaccurate perceptions of self-worth – and help patients come to a clearer perception of the reasons, if any, for continuing their lives. In a few tragic instances – as in Laura's – the patient and his doctor may come to the conclusion that her life is truly no longer worth living. In these instances a request for PAS ought to be granted.

4.7 Conclusion

In closing, a word of caution. To say that depression may in some rare instances make a person's life no longer worth living is emphatically *not* to say that this is the usual case. As many disability advocates note, we need to treat these sorts of judgments with extreme caution, for it may well be true in many cases that

> [An individual's disabilities] do not render life untenable; rather, it is society's treatment of people with disabilities that demoralizes them and spoils their quality of life. Through discriminatory practices, neglect, social segregation, and impoverishment, society exhausts the spirits of people with disabilities and then, labeling their depression "rational," lobbies for a legal mechanism to discard them (Gill 2004, p. 179).

In making the case for an expansion of the circumstances under which PAS can be judged permissible, it is important to note that this is not meant in any way to undermine the provision of support and accommodation for those with mental illness. Indeed, an expansion of support for those with mental illness and a reduction in stigma surrounding mental illness are essential. To argue, as I have, that some few lives could be rendered so miserable by mental illness that it is a cruelty to withhold the means to a safe, relatively painless, and dignified death is not to argue that we should prefer PAS for the mentally ill to doing whatever we can to make their lives better. Much of what makes mental illness difficult is assuredly of social origin – ostracism and stigmatization, for instance – and can be ameliorated by making society more accommodating of the mentally ill. Were

this to happen, the cases wherein depression renders a person sufficiently miserable to make PAS attractive might hopefully drop, or even vanish altogether.

Chapter 5: Why Good People Should Be Unhappy

In this final chapter I argue that – contrary to a long tradition in moral philosophy – the cultivation of virtue is inversely related to psychological happiness, and thus to well-being. That is, the more a person cultivates virtue, the more she will – and ought to be – unhappy. Following a number of contemporary virtue theorists (e.g., Rossi and Tappolet 2016; Arpaly and Schroeder 2014; Adams 2006; Hurka 1993), I argue that to be virtuous is to care about the right and the good de re. And truly caring about, e.g., the welfare of conscious creatures, necessarily involves feeling negative emotions when those creatures are harmed or threatened, have their rights violated, and so on. This fact, coupled with a claim about how virtuous persons ought to direct their attention (in brief: towards instances of suffering, injustice, and the like) results in the conclusion that virtuous people ought to feel a preponderance of negative emotion – or, in other words, that they ought to be unhappy.

5.1 Introduction

Many philosophers argue that virtue and well-being are closely linked. Some argue that well-being just is a life of virtue (Russell 2012). Others contend that possessing virtue is a necessary condition for well-being, though not a sufficient one (Foot 2001; Badhwar 2014). Yet as is well known, both of these views face deep problems, for as Bernard Williams memorably noted, it seems readily apparent that there can (and do) exist at least some vicious individuals who are "by any ethological standard of the bright eye and the gleaming coat, dangerously flourishing" (Williams 1985: 46).

Few, however, have advanced the claim that virtue is in fact *contrary* to happiness. But I'll argue that this is precisely what we should believe; given the commitments of a prominent

contemporary strain of theorizing about virtue, it follows that virtuous people should be unhappy. I won't maintain that every conception of virtue has this upshot – Stoic accounts, for example, plausibly escape it – but many do. In particular, I'll contend that what we might call *conative* approaches to virtue entail that the virtuous should be sad. The account of virtue defended recently by Nomy Arpaly and Tim Schroeder is a paradigm of the views I have in mind.[42] On their view, virtue is an "intrinsic desire for the right or good [de re]" (Arpaly and Schroeder 2014: 492). In other words, the virtuous desire that conscious creatures experience (perhaps deserved) happiness, that justice is done, that rights are respected, and so forth. Moreover, they have an aversion to the bad, correctly conceived – so they are pained when creatures suffer, when injustice is done, and when rights are violated. To be virtuous, in short, is to *care about the right things* – to want to see them proliferate, to take measures to promote and sustain them, to protect them and feel distress when they are threatened or harmed.

This is an attractive picture of virtue and I won't challenge it in what follows. Instead, I'll argue that it leads to the view that good people should feel a preponderance of negative emotion. In order to do so I focus on a crucial but somewhat overlooked aspect of the moral psychology of the virtuous: *moral attentiveness*. The degree to which individuals pay attention to moral matters has become a focus of some recent work in moral psychology (Reynolds 2008), and I draw on some of that research in what follows. In brief, I argue that for a *properly attentive* agent, circumstances will tend to furnish an abundance of reasons for those who care about (and desire) the right and the

[42] Numerous 'conative' approaches to virtue have been developed in the past twenty years or so. Hurka's (1993) higher-order account of virtue as loving the good and hating the bad is one example, as are the more recent approaches defended by Adams (2007), Rossi and Tappolet (2016) and Bommarito (unpublished). (Though it is worth noting that in Adams's case, virtue involves cognitive elements as well as conative ones.) Any view on which virtue centrally involves 'loving' 'caring about' or 'desiring' the right and the good de re would seem to fall within the scope of my argument.

good to be distressed.[43] Given that negative emotions are constituents of unhappiness, it follows that a crucial aspect of moral virtue -- moral attentiveness – tends towards ill-being.[44]

In what follows, I first show that moral attentiveness is an important part of moral virtue. Then, I argue that the virtuous ought to attend *preferentially* to instances of suffering, vice, and injustice, that is, to what is bad in the world. Of course taking account of what is good is important, too – too much attention to the world's ills breeds misanthropy and despair. But the virtuous person should allocate more of his attention to the bad, since, to paraphrase Marx, the important thing isn't simply to take account of the world, but to *change it*. Next, I argue that negative emotions – especially compassion, sadness, and indignation – are the fitting emotional response to suffering, injustice, and the like. Finally, I respond to a number of objections to my view.

5.2 Moral Attentiveness

A while back a certain meme was making the rounds on Facebook with the following message:

> My intention is to fill up Facebook with baby animals to break the saturation of negative images and videos. If you like this post, I will choose a baby animal for you.

This message was then followed by some pictures of cute baby animals. Just anecdotally, the meme seemed fairly popular: I recall half a dozen friends on Facebook who posted some version of it. But why the felt need to "break the saturation of negative images and videos?" Of course, the answer is

[43] How much distress is sufficient for unhappiness? Here we need to refer to the psychological literature addressing the *threshold* for happiness/unhappiness. In reviewing some of this work, Dan Haybron (2008: 139-142) draws the conclusion that what he calls the "received view" – namely, the view that one is happy just in case one's emotional life is "more than 50 percent positive" is false; in fact, one needs considerably more than half of one's experiences to be positive in order to be happy (Haybron 140). This implies that circumstances will need to be quite positive for the virtuous to be happy, and this, I argue, is very unlikely assuming that to be virtuous a person must be properly attentive to the world around herself.

[44] That virtue tends towards unhappiness by way of attentiveness is, I think, implicit in the long tradition of linking melancholy with traits like wisdom and sensitivity. For a discussion of some of this literature see Woolfolk (2002).

obvious: because such images and videos are upsetting. Having your social media feed filled with stories of injustice, suffering, and cruelty can really get you down.

On the other hand, such complaints can seem selfish, even childish. It's important that people – particular relatively comfortable, affluent Western people – be made of aware of the suffering and injustice around them. Reading stories or seeing videos of, for instance, racial injustice, can certainly make people uncomfortable, but that bit of discomfort is heavily outweighed by the greater need to highlight the continuing prevalence of such injustice. There are, in short, strong moral reasons why we ought to make ourselves aware of instances of suffering, injustice, and of our own moral shortcomings, since only then can we do anything to change them. In other words, there are important moral reasons to cultivate *moral attentiveness*.

The psychologist Scott Reynolds defines 'moral attentiveness' as "the extent to which one chronically perceives and considers morality and moral elements in his or her experience" (Reynolds 2008: 1028). I contend that the morally virtuous person will seek to cultivate this trait. Thus, he will aim to allocate his attention toward the morally relevant features of the world around him. By 'morally relevant features' I have in mind things like the following: the suffering of others and instances of injustice, opportunities for generosity or courage, one's past actions and character, and so forth. To illustrate the importance of moral attentiveness, imagine someone rushing past a person in distress, in a manner similar to the famous Princeton Theological Seminary study (Darley and Batson 1973). The person in a rush might be late for work, and in her hurry she might fail to pay adequate moral attention. That is, she might fail to attend adequately to what is morally salient in her situation – in this case the distress of others. It isn't that this person doesn't *care* about others' well-being; if she had perceived the distressed individual, she would have helped, let's say. Rather, she simply failed to attend to appropriately, and this failure precluded her doing anything to help. Thus,

moral virtue requires that insofar as one aspires to be virtuous, one will aim to avoid becoming morally distracted, that is, having one's attention diverted by comparatively unimportant things. The virtuous keep their focus on what is morally important.

One might worry that the kind of moral attentiveness just sketched makes the virtuous agent sound a bit too much like a busybody, always trying to involve himself in others' business, or else like a kind of egoist always on the lookout for an opportunity to burnish his moral credentials. However, exercising virtuous habits of moral attention does not require that we always react to those moral features of our situation to which we attend. Sometimes the best option for the virtuous agent is noninterference. Part of being properly virtuous is knowing when one's assistance is required and when it would be an imposition. Nor is the moral attentiveness I've outlined here necessarily egoistic. Virtuous people are alert for opportunities to exercise virtue not because they desire credit in the eyes of others, but because, for instance, they desire the well-being of others for its own sake. Our attention is drawn to things for all sorts of reasons, but nothing said above concerning virtuous habits of attention implies that the virtuous agent's attention is drawn to moral features for selfish reasons.

Further questions concern the scope of this moral obligation. Granted the person rushing in to work should have attended to the distress of the individual she passed by on her way, but must the virtuous also attend to the suffering of those living far away? Must a virtuous person attend to instances of injustice she can do nothing about? Such demands might seem pointless at best, counterproductive (because, for instance, distracting) at worst. However, in our increasingly interconnected world I think the scope of one's moral attention ought to be quite broad. The interconnectedness of the modern world undercuts to a large extent the worry that attending to distant suffering or injustice is pointless because there is nothing one can do about it.

Furthermore, there is something to be said simply for being a *witness*. I concede that it is hard to make precise the value witnessing another's suffering or ill-treatment has; nevertheless, I think that value is real. Imagine that I turn on the news and hear of some great injustice taking place in a far off country ruled by a despot. This dictator's regime has impoverished his people; many of them have been killed, their rights have been systematically denied, and now he is planning some further great purge. Suppose further that there is nothing I or anyone else can do about this. No military intervention will stop him (his country is a nuclear power), and no aid agencies can enter the country. Shame has no effect on his behavior. Faced with these facts, should I simply change the channel? Should I forget about what I've just heard? Should I devote no further attention to this issue? I think the answer to these questions is a firm 'no.' It is important to bear witness.

One explanation of the value of witnessing is that one's sympathetic attention to the suffering of another is a way of communicating one's solidarity with that person. Another explanation is that such attention communicates that the individual's suffering *matters*. Moreover, the disposition to attend to such suffering (and feel negative emotions concerning it) is indicative of a disposition to care about such suffering generally; in other words, it is indicative of being the kind of person who cares about harms befalling others – i.e., a virtuous person. Given this, I think that even when we are not in a position to help others, nevertheless we are obliged to give them our attention, to not look away. This means that the demands virtue makes on our moral attention are very broad indeed.

I should note, however, that the virtuous do not necessarily need to always be going out *looking* for instances of suffering and injustice. Simply by being fairly responsible consumers of news media – by staying informed of what is going on in their region and around the world –plenty of opportunities for fitting negative emotion will make themselves known. My picture of moral

attentiveness, then, is not that of someone obsessively trying to find things to feel bad about. Instead, it is someone who does not flinch away when confronted with the manifold evils in the world around her.[45]

So, to sum up: the virtuous agent attends to the morally relevant features of his situation; he is always on the alert for opportunities to help, for instances of injustice, and so on. Such attention ranges broadly; thus, the virtuous agent attends not just to what is happening in her own backyard, but to events quite distant from her as well. This is necessary not only because it puts one in a position to help, but also because it is important to be a witness. Now, attending to what is morally relevant does not necessarily mean attending to what is morally bad, and thus the virtuous agent's attention need not necessarily be focused solely on the negative – a point I will return to below. The point I want to stress in what follows is that *the greater part of it will be*.

5.3 Accentuating the Negative

No one would deny that there is a great deal of suffering and injustice in the world. But is there more to feel sad about than happy about in the world we live in? I confess I find it hard to see how a reflective person could fail to answer in the affirmative.[46] Yet rather than try to adduce evidence for

[45] One final worry is worth addressing: the concern that the picture of moral attentiveness I have sketched is really a picture of objectionable moralizing. The moralizer is the person who, as Kant puts it, "allows nothing to be morally indifferent" (Kant 1996: 536). Such a person over-classifies events and situations as morally relevant, and one might worry that the virtuous agent as I have described her –always on the look-out for instances of wrongdoing and the like -- risks falling into just this trap. However, it is no part of morally virtuous attention that the non-moral be classified as moral. Deciding what is or is not a moral matter is a separate issue from deciding what merits one's attention. In addition, the virtuous agent recognizes degrees of moral seriousness. Thus, extremely minor moral issues deserve little (if any) attention. An obsessive focus on minor moral infractions is no part of moral virtue.

[46] Here it seems worth reiterating the point that the scope of moral concern is quite broad: our moral obligations don't stop at our doorsteps, or even at the water's edge. So, even if a person's local circumstances provide many opportunities for joy, satisfaction, hope, optimism, and other positive emotions, he need only broaden his horizon a bit in order to see the manifold opportunities for fitting negative emotions all around him. Further, we can add to the reasons for pessimism here by noting that the welfare of nonhuman animals ought also to be incorporated into the sphere of our moral concern. So even if the balance of good to bad comes out positive for *humans* – which, again, I find dubious – the same will need to be said concerning nonhuman animal life as well.

that claim -- something I am not even sure is possible -- I will argue instead that the bad should occupy more of our attention than the good.

Why should the virtuous person have an attentional bias towards the negative? The reason is that the primary (though not sole) importance of moral attentiveness is the connection it has to moral change: you can't fix what you can't see (or don't know about), after all. Given this, and given that it is in cases of injustice and suffering that change is needed, it follows that the morally virtuous agent will have a pronounced bias in attention towards the negative. One way to think about this is in terms of *salience.* A feature is salient for an agent "in so far as that feature exerts an involuntary draw on the agent's attention," (Chappell and Yetter-Chappell 2016: 449). Moreover, "what we find salient reveals what we care about" (Chappell and Yetter-Chappell 449). Now, since a virtuous person ought to care *more* about alleviating suffering and correcting injustice than about celebrating the good, it follows that suffering and injustice should be more salient for him. These evils will draw his attention first, and more quickly; they will tend to occupy more of his psychological life.

Moreover, it isn't just the suffering of others and injustice in the world around us that we should attend to; our own moral failings should occupy our attention, too. All of us could be better than we are; all of us do the wrong thing sometimes. Awareness of these facts furnishes important opportunities for moral improvement, and thus it is crucial; however, it also provides further opportunities for feelings of guilt, regret, and disappointment, or in other words, for the experience of unhappiness-constituting emotions. Thus we have more reason to think that the virtuous will feel more negative than positive emotions on the whole, and so more reason to expect them to be sad.

Of course, as I have noted, it is also highly important to attend to instances of positive improvement in the world, and in ourselves. But that is consistent with claiming that the virtuous person should spend more of his time attending to and seeking out instances of injustice and

suffering so as to do what he can to improve them. Therefore, even if the balance of positive to negative (and thus, of positive-emotion-evoking to negative-emotion-evoking) is tilted in favor of the positive, the virtuous person's attention won't be.

5.4 Fitting Responses

Someone might grant that moral attentiveness is important, and grant that we should preferentially attend to the bad, yet still claim that the fitting response to instances of suffering, injustice, and other evils isn't *sadness* or other unhappiness-constituting emotional states. In fact, especially when considering distant evils, perhaps an emotional response is not called for at all. If this is right, then my argument from attention to unhappiness is blocked.

Now, which response is appropriate will of course depend on what type of stimulus one is considering. So to clarify matters a bit, let's narrow our focus to just suffering (whether human or nonhuman). Further, since the proper response to the suffering of others will depend on how it came about -- was it the result of someone's (malicious) actions? Was it self-caused? – let's keep things simple and focus just on suffering without (apparent) agential cause. Suffering due to illness, for example.[47] There is quite a lot of this kind of suffering in the world. What is the right response to it?

The obvious answer is *compassion.* Following Nancy Snow, we can characterize compassion as "a relatively intense emotional response to the serious misfortune of another," one which involves "a 'suffering with' the other and includes a concern for the other's good" (Snow 1991: 197). When we feel compassion, we recognize that the other's suffering is significant (this distinguishes it from sympathy, which on Snow's view one might feel in response to another's indigestion). Moreover, we

[47] I say 'apparent' because a person's illness might of course be traceable to the actions of others – for instance, as a result of exposure to pollution. I elide these complications in what follows.

suffer with them: we feel sadness and distress ourselves.[48] As Snow puts it, when one feels compassion (as opposed to pity), the "emotional distance" between oneself and another "is crossed" (Snow 197). Compassion makes us vulnerable to the plight of another.

I take it that all parties to this debate will grant that compassion is called for when confronted with the suffering of one's near and dear, or of a friend. Imagine someone who discovers that a close friend has been diagnosed with a serious illness, yet remained unperturbed by this news. Not that she is cold or cruel, necessarily – when she sees her friend, she may be quick with comforting words and offers of assistance, for example -- but nevertheless, suppose she fails to *suffer* with her in any meaningful way. Whatever else we might say about S, I think we would be right to conclude that she failed to respond appropriately. For her response to be adequate to the circumstances, some genuine suffering on her own part is necessary.

But what about those distant from us? Should the suffering we read about in the news evoke the same response? Well, imagine a person who, while watching a news broadcast about a natural disaster destroying the lives and livelihoods of thousands in another country, reacts as our character above did. He may wish the disaster hadn't happened; he may express his hope that the survivors get the help they need as soon as possible. He may even consider donating the Red Cross – in fact, he may do so. But in response to the broadcast – which, let us suppose, vividly depicts the suffering and loss caused by the disaster – he fails to suffer, even in a mild way, with the victims. The news doesn't *bother* him.

[48] Snow's view is not atypical. On Martha Nussbaum's analysis compassion is a paradigmatically painful emotion (Nussbaum 2001: 302), and of course Nietzsche infamously held that feeling compassion "increases the amount of suffering in the world" -- which for him was reason to reject it (Nietzsche 1881/1997: 134). Compassion, then, is not an emotional response conducive to psychological happiness.

If we think that receiving news of a friend's distress merits distress on our parts, we should think that news of distant suffering does, too. After all, it isn't as though lives that are further away from us are any less valuable. It isn't as though the loss described in that broadcast was less serious. Perhaps it is *somewhat* less vivid, less immediate; still, our man isn't reading in a textbook about some event that happened long in the past. He can *see* the survivors on his TV screen. Nor, I contend, does it matter that he has no personal relationship with these individuals. Perhaps we have stronger obligations to our near and dear, but that does not mean we have none whatsoever to those with whom we do not share a close bond. Surely then he should suffer *at least a little* in response to the plight of those described in the broadcast. To fail to respond appropriately to their suffering is to fail to respond appropriately to their shared humanity.

At this point someone might wonder: but *why* does it matter how a person feels in response to these events? After all, in neither case are the objects of these emotional responses aware of how the agents feel about their situations. It'd be one thing to show no distress upon *visiting* a sick friend -- as, for example, in the case of Michael Stocker's cold Kantian hospital visitor (Stocker 1976). That risks hurting feelings, at the very least. But why should it matter how one responds simply to *news* of a friend in distress?

To describe a sorrowing response merely as 'fitting' is unsatisfying. I'd like to then sketch a deeper explanation for why feelings matter, one which relies heavily on the conative conceptions of virtue I am targeting in this paper. Recall that on such conceptions virtue is, at its heart, a matter of caring about the right and the good. If the virtuous are those who care about the welfare of others – who desire it for its own sake—then they ought to experience feelings of sorrow and distress in

response to the plight of others, for this is constitutive of caring about their welfare.[49] As I noted in chapter 3, David Shoemaker argues that caring about something or someone requires a certain "emotional vulnerability": if a person cares about X, then she must be disposed to feel distress, sadness, and other negative emotions when X is threatened or harmed (Shoemaker 2003: 92). Thus, a person who fails – in the right circumstances – to feel these emotions when the object of her purported cares is threatened or harmed fails to care.[50] Now consider our stony friend and our stoic news-watcher. Neither of them feels distress or sorrow upon witnessing or learning about harms to others. As a result, we should conclude that both fail to care about the subjects of those harms. But a virtuous person *should care*. She should care about her friends and relatives, of course, but she should care about distant strangers, too.

Thus, negative emotions are called for when one is confronted by suffering or misfortune, whether distant or close to home. And of course there are many other types of evil to which the virtuous will attend, but space precludes a full consideration of all of them.[51] I hope, however, to have shown that the virtuous will spend a lot of time attending to what it is fitting to feel negative emotions towards. These emotions are not conducive to psychological happiness; indeed, they are *constitutive* of unhappiness. I conclude that cultivating moral attentiveness – a moral duty – is inversely related to happiness.

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[49] This, in turn, explains (and justifies) the feelings of betrayal someone in the hospital might feel when visited by the cold Kantian who is merely doing his duty. To feel no distress at the plight of another evinces a lack of concern for that person's well-being; in other words, it reveals a lack of care.

[50] As with all dispositions, of course, the conditions of manifestation are important. If a person fails to feel sadness (when some putative object of concern is harmed or lost) because she is *manic*, for example, that need not indicate a lack of caring. Thus, my claim is only that in *normal circumstances* a person who cares about X will feel sadness when X is harmed or lost. I do not have space to fully spell out what constitutes 'normal circumstances,' but at the very least they involve a person's being fully informed and psychologically healthy.

[51] It seems clear that negative emotions will be called for with respect to (at least the) large majority of moral evils. With respect to injustice, for example, the proper response is either moral indignation (Wallace 1994) or else "moral sadness" (Goldman 2014; Menges 2014). Neither of these is a happiness-constituting emotion. Similar remarks go for one's own vice (guilt, shame) and other evils to which the virtuous ought to attend.

5.5 Objections

An initial worry with my argument is that the portrait of moral attentiveness I've drawn is far too demanding on our emotional lives.[52] Someone might wonder whether the virtuous person can ever attend to and enjoy the simple pleasures of life: for instance, watching her daughter perform in a school play. If I am right, it seems that the virtuous person ought to be in a state of turmoil during the performance -- even allowing that she can attend at all – as she reflects upon the suffering and injustice in the world. A school play pales in importance compared with such evils, after all. At the very least, it seems that she should be checking Twitter on her phone in order to give her attention to whatever atrocities are taking place while she sits in the audience. The objection, in other words, is an emotional analogue to the demandingness objection leveled against Singer-style maximizing consequentialism. Even if – a big if! – good people are justified in spending time and money attending baseball games and school plays, it seems that if I am right their emotional lives will nevertheless have to be given up in service of their moral ideals. This is an implausibly demanding picture of moral virtue. Surely good people are allowed to relax sometimes.[53]

I don't want to be too concessive here: I think morality *is* highly demanding on both our wallets and our attention. With that said, I do think good people can be perfectly justified in putting Twitter aside in order to take in a baseball game, a school play, or some other non-moral past-time. That's for two reasons. First, a monomaniacal focus on the world's ills is incompatible with being a productive agent. The emotional investment it would require would simply be crippling. One's attention to the evils of the world needs to be limited by the damage negative emotions can do to our motivation and capacity to act. (Compare: one's giving to famine relief needs to be tempered by

[52] I owe this objection to Kit Wellman.

[53] In other words, one might worry that the picture of moral virtue I've described is really a picture of what Susan Wolf calls "moral sainthood" (Wolf 1982). As Wolf convincingly argues, moral sainthood is not a condition one should aspire to, and one might worry that all I've done is provided further reasons in favor of that conclusion.

the realization that financial ruin will cripple one's ability to do any further good.) What is most important in the life of virtue is *doing* what one ought, not merely *feeling* what one ought, and when one's feelings are getting in the way of productive action they need to be dialed back. In short, compassion fatigue is a real phenomenon, and the virtuous person must guard against it. In order to do so, sometimes she'll need to take a break from attending to the sorrows of the world and binge-watch something on Netflix. Such non-moral uses of one's time can, in other words, be justified on moral grounds. Without them we'd be incapacitated.

Second, moral goods are not the only goods in the world. Moral virtue requires attention to what is morally important, but to be a well-rounded person one must take account of things like beauty and athletic skill, too. These are important goods in their own right, and without them our lives are impoverished. Sometimes, then, it is fully justified to turn one's attention away from the morally important and attend, instead, to great works of art, athletic contests, and other sources of non-moral good. Not only do these things renew the spirit, but appreciating them makes us better people, too.

I think, then, that there are ways to temper the demandingness of my proposal. However, other worries remain. Even if negative emotions don't incapacitate the virtuous, someone might insist that *any amount* of negative emotions – especially the sort of sadness that is constitutive of compassion – makes it *harder* for the virtuous to act. But as I've just conceded, action is what ultimately matters; feelings are secondary. In fact, one might think that individuals whose job it is to do emotionally difficult work – doctors, therapists, social workers – ought to cultivate a state of detachment. So, too, the virtuous: negative emotions just get in the way. They do no good and only

serve as a hindrance, making it harder for good people to do what virtue demands. Because of this, the virtuous should seek to minimize such feelings.[54]

Again, I certainly have no quarrel with the view that right action is the soul of virtue, but I resist the view that the virtuous should cultivate detachment. It is certainly true that repeated exposure to trauma can lead a person to develop an emotional distance: as one doctor notes, reflecting on his career thus far

> When a patient under my care dies, I ponder the fact, reflecting on nature's caprice and the patterns of mortality, but the sadness I feel is usually fleeting. Where once an emotional reaction of some depth occurred, now there is only an abstract equivalent (Berry 2007: 266).

But he goes on to write that "such frigidity worries me," labelling it a kind of "dehumanization," (Berry 266). And, crucially, he notes that emotional distance impedes his ability to provide comfort and support to those who desperately need it. In other words, it makes him *a worse doctor*. There is more to being a good doctor than just prescribing medication or running tests, and emotional distance erodes one's ability to do these other parts of the job. This observation helps us see that cultivating apathy is the wrong approach; emotional detachment makes it harder for us to do what virtue requires.[55]

Now perhaps there is some other aspect of virtue which militates against the unhappiness caused by attending to so much sorrowful stimuli. If so, then defenders of the connection between virtue and happiness could argue that virtue tends towards happiness because the effects of experiencing so many negative emotions is blocked by some other feature of a virtuous moral psychology. I can't rule this possibility out entirely, but prospects for it seem dim. I can think of

[54] Thanks to Eric Brown for both providing the worry and illustrating it with the example of doctors and therapists.
[55] Moreover, though I don't dispute that negative emotions can have a deleterious effect on one's motivation to act, they do not always or necessarily do so: compassion for another's plight can be an effective motivator, for example.

three features to which they might appeal. First, perhaps the virtuous stave off unhappiness by focusing on their own contributions. They may derive a lot of strength and satisfaction from the knowledge of their own virtue. But this strays close to immodesty, at least if – as is plausible – modesty is virtue which is constituted by a certain lack of attention towards one's positive qualities (Bommarito 2013). More promising is the suggestion that the virtuous may retain their equanimity by cultivating traits of optimism, hope, or faith. Things are bad now, but the virtuous may resist unhappiness by placing confidence in the belief that they will get better. I do not want to argue that optimism is irrational or that faith is misguided. On the contrary, I think these traits are very important to the moral life. But staying hopeful is a strategy for staving off *despair*, not unhappiness. Upon visiting my sick friend in the hospital, I should – assuming it is within reason – remain optimistic that she will eventually return to good health. But this doesn't mean that I shouldn't be unhappy about her current predicament.

Third, and most compelling, is the suggestion that the virtuous draw great strength from their friendships and other objective goods that are the wages of virtue. The truly virtuous cultivate the traits and habits of character required in a good friend: they are honest, kind, and loyal, for example. As a result it might be expected that they will form deep and lasting friendships, and that these friendships in turn provide reasons for profound happiness. These and other goods that are plausibly the result of a life of virtue might outweigh the unhappiness caused by their attentiveness to the suffering of others.

Yet I suspect this still isn't enough to stave off my pessimistic conclusions. My worry is that possessing goods like true, lasting friendship is in many ways a matter of *luck*, as Aristotle famously notes. Virtue makes their possession more likely, but it certainly doesn't secure it. By contrast, it is not a matter of luck that the virtuous will find much to feel bad about: my argument from attention

is meant to establish that. So where a person is fortunate enough to find herself in possession of these goods (to a sufficient degree), then perhaps my argument is blocked. But the more likely scenario, I think, is that a person is less fortunate than this, and that the positive emotions generated by the objective goods of her life are insufficient to outweigh the negative emotions generated by her wide-ranging and sensitive attentiveness to the world around her.

5.6 Conclusion

I conclude that virtue – in at least one crucial respect – tends to make the life of the person possessing it *less* happy. The virtuous are attentive to the ills of the world around them, and they are emotionally responsive to these ills. While they work to change the evils they see, they are nevertheless moved by them. Objectors note that negative emotion can be demotivating, but I reply that it isn't always, and that it is necessary for discharging one's duties effectively. (Again, dispassionate doctors fail to fully realize their craft.) Nor do I think there are other aspects of virtue that blunt this negative emotion sufficiently for the virtuous to count as happy. I do, however, happily concede that *when* negative emotion begins to erode a person's ability to do what virtue requires, *then* it is time for self-care. Virtue can coexist with unhappiness, but not with clinically depression, for that is sadness that is disordered, inappropriate. Depression crushes a person's capacity to act, and so it must be guarded against. In the end, I recognize that this is a dispiriting message; however, I do not think the upshot is that we shouldn't be moral. I am siding with Kant against the eudaimonists: moral virtue has a cost. But that doesn't mean we shouldn't choose it. Sadness and a fulfilling, meaningful life can coexist.

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