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Experience, Depression and Decision-Making

Abstract:
The aim of the article is to discuss the specifics of human actions and decision-making processes from the psychopathological perspective. The concepts of action and decision making are reported in the context of human experience and the experiential structure of self-determination. The starting point is provided by considerations related to the notion of mental illness as described by Lennart Nordenfelt, as well as Antoni Kępiński's concept of informational metabolism. The consequences of and changes to decision-making processes in mental disorders will be presented on the example of depressive experience. Decision-making process can be understood in terms of three-dimensional pre-reflexive experience that undergoes changes in depressive patients: space of possibility, sense of agency and time experience. The analysis will allow us to better understand the structure of experience attributable to people suffering from depression.

Keywords:
psychopathology, experience, depression, decision-making, Antoni Kępiński, Lennart Nordenfelt

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possibility, sense of agency and time experience. The analysis will allow us to better understand the structure of experience attributable to people suffering from depression.

1. Decision-making in psychiatry

The decision-making process has been the subject of medical and psychiatric scrutiny due to its practical implications for the health and lives of patients. This pertains equally to correct clinical decisions reached by doctors and to responsible decisions made by patients or individuals experiencing a mental crisis. In the present article the focus will be primarily on depressive patients' ability to make decisions from their subjective and experiential perspectives.[1] This experiential perspective on decision making has struggled to achieve widespread recognition in the area of mental health. As Owen says, "Psychiatrists often comment on the difficulty of assessing decision-making capacity in people with depression; better understanding of the phenomenology of depression is imperative for refining clinical and legal techniques for such determinations."[2]

There has been considerable criticism with regard to the notion of automatically identifying mental illness with a patient's complete inability to make decisions in vital issues. This criticism focuses particularly on a patient's ability to decline the proposed treatment (usually pharmacological) and the therapists' capacity to institutionalize patients against their will.[3] Where mental capacity is discussed in the legal and clinical literature, emphasis is placed on a number of elements whose existence is a necessary condition for determining the presence of mental health. For persons to be deemed fit to make independent decisions they must have the ability to understand information and properly assess the reality of their situation. Factors limiting an individual's ability to make choices include: lack of understanding of information input (usually pertaining to the symptoms and treatment of their disease), the inability to remember information, and the incapability of relating the same to their particular life situation. In a clinical context, a particularly important ability seems to be related to accounting for the incoming information in the decision-making process, as well as the ability to effectively communicate one's decisions to others. In clinical practice non-acceptance of a proposed treatment (e.g. pharmacological) can be treated as indicative of the lack of decision-making competence. But usually the ability to make decisions is not entirely eliminated in cases of mental disorders, which is why therapeutic efforts are aimed at supporting the affected person in their decisions and thus facilitating their struggle with addiction, delusions, phobias, and so forth.[4] Therefore one can see that the issue of decision-making in mental

1) In the article we more focus on experiences of depression than its strict classification categories and subtypes. These kinds of experiences are consistent with a "major depressive episode" or "major depressive disorder" (DSM). How highly variable and diverse the concept of depression is can be read in the publication by Jeniffer Radden, *The Nature of Melancholy: From Aristotle to Kristeva* (Oxford: Oxford University Press, 2000).

2) Gareth S. Owen et al., "Temporal Inabilities and Decision-Making Capacity in Depression," *Phenomenology and the Cognitive Sciences* 14, no. 1 (March 2015): 164.

3) Hanna Pickard, "Psychopathology and the Ability to Do Otherwise," *Philosophy and Phenomenological Research* 90, no. 1 (2013): 135–163, https://doi:10.1111/phpr.12025, and Thomas Hindmarch, Matthew Hotopf, and Gareth S. Owen, "Depression and Decision-Making Capacity for Treatment or Research: a Systematic Review". *BMC Medical Ethics* 54, no. 15 (2013): 287–295, https://doi:10.1186/1472-6939-14-54.

4) Schlimme claims that even in cases of suicide accompanying depressive states, there is nonetheless a type of agency described as "minimal sense of self-determination". Situations wherein choice does not exist typically accompany extreme situations of a complete lack of insight or loss of awareness. In such a case the affected individuals altogether lose their mental capacity and blindly follow commands, indiscriminately surrendering themselves to their destructive urges, affective or external stimuli (Jann E. Schlimme, "Sense of self-determination and the suicidal experience. A phenomenological approach," *Medicine, Health Care and Philosophy* 16, no. 2 (2013): 211–223, https://doi:10.1007/s11019-011-9358-4.

health provides full scope of inspirational discussion, and seems to be relevant in clinical and theoretical sense. Experiential perspective reveals the bodily and emotional aspects of depression. It concentrates on foreground and background bodily feelings, including one's sense of reality and familiarity. Deviations from "normal" and "healthy" ways of finding oneself in the world may change the experience of agency, patterns of behavior and possible relations with other people.

2. Mental illness as a compulsion

Reasons for why it is so difficult to grasp a morbid aspects of human experience is revealed by the analysis of Lennart Nordenfelt's concept of mental illness. The author's analysis concentrates on beliefs, desires, and behaviors that constitute the machinery of mental illness as assimilated by philosophy of action. An incapacity for decision-making seems to be a significant criterion in our understanding of the concept of mental illness. Health is a bodily and mental condition which allows the realization of an individual's vital goals under normal circumstances. Mental illness is caused by internal factors that lead to compulsions which cannot be rationally explained.[5] The irrational and often incomprehensible behavior that stems from such compulsions narrows one's ability to make informed choices, or forces choices further exacerbating the patient's pain and suffering. As observed by Nordenfelt, "many mentally disordered persons have a life-situation that is very narrow in the sense that many of their actions are compelled. The subjects have to perform (or feel that they have to perform) a particular action that is, for many reasons, undesired."[6]

The compulsion referred to by the Swedish philosopher of medicine is most evident in the context of addiction, phobia, or kleptomania, but can also be related to severe clinical disorders such as schizophrenia or depression. The alternatives of action available before the onset of the disease become significantly narrowed, the emerging compulsion limits the possible choices. Attitudes, beliefs, or desires imposed by internal factors (not environmental, social, or educational) are beyond the subject's ability to freely and independently modify. For instance, a paranoiac will perceive his life as threatened, losing the capacity for objective inference and so will become unable to account for any arguments and facts to the contrary. Generally speaking, the compulsion to act/behave in a certain manner falls within the scope of attitudes and intentions which need not be pathological. This may take the form of a perfectly ordinary sense of danger, the presence of an external, unbearable pressure, possibly stemming from certain dogmatic beliefs or the inability to perceive alternative goals. Nordenfelt describes the limited capacity for altering one's own beliefs, intentions and desires in terms of "fixation" which may be maintained and nurtured by patients themselves or may be the effect of external forces/factors that are beyond their control. Delusions are examples of irrational fixed beliefs that are not amenable to change in light of conflicting evidence and not easily modified through psychotherapy. The above does not mean, however, that the content of delusion determines the patient's behavior, just as clinical addiction does not solely account for auto-destructive behavior. In the context of rational and responsible decision-making, actions (i.e. ones that do not stem from a compulsion) reflect the real beliefs and desires of the patient, and fit into one's personal system of values and goals.

The concept of fixation as proposed by Nordenfelt may have certain hallmarks of determinism in the sense of narrowing the patient's experiential perspective and yielding to the demands of a single belief or desire. It can also entail the emergence of a belief or desire which contradicts the patient's previous value system and finds no support in their previously held desires and beliefs. The compulsion and the related narrowing of

5) Lennart Nordenfelt, *On the Nature of Health. An Action-Theoretic Approach* (Dordrecht: D. Reidel Publishing Company, 1987).

6) Lennart Nordenfelt, *Rationality and Compulsion: Applying Action Theory to Psychiatry* (Oxford: Oxford University Press, 2007), 183.

choices results from the denial of the patient's access to a part of his or her previously maintained value system, or from an inconsistency or contradiction present in the network of beliefs. The rationality of action and belief is not derived solely from consistency and adequacy to facts but, rather, from the characteristic human ability to correct and revise one's own beliefs/desires based on reason and insight. Being a rational subject is not just a constant deliberation and conscious scanning of one's beliefs in terms of their coherence, compliance with facts and the quality of justifications. A large part of our beliefs and attitudes have a hidden implicit character. The troublesome lack of insight and rationality of beliefs and desires becomes generally visible in the situation of exceeding social expectations and acceptable standards of behavior. As a result, part of the experience becomes acutely expressive and hyper-conscious. This is accompanied by a change in the structure of the patient's experience, what is of particular interest to the phenomenological approach in psychiatry.[7] Nordenfelt's philosophy of action focuses on the explicit beliefs, desires and behaviors – "defective machinery of mental illness."[8] However, he is aware of the need to reach more basic elements of the psychopathological experience, which consist of specific dimensions of the changed experience. One cannot base one's understanding of mental illness solely on the concepts of mental ability and disability but has to also consider more primordial inclinations and the ability to enter certain intentional states.

Antoni Kępiński's analysis introduces us to the complexity of the disease experience and, together with the phenomenological descriptions of psychopathology, show the important dimensions of the depressive experience: changes in the sense of agency, the experience of narrowing the space of possibilities and changing the perception of time.

3. Antoni Kępiński, life dynamics and depression

The introduction of Antoni Kępiński's theoretical perspective allows us to show key elements of depressive experience in a broader perspective. We add that the figure of Antoni Kepiński (1918–1972), so crucial for the tradition of Polish psychiatry, seems to be worth spreading and popularizing in the global philosophy of psychiatry.[9]

Kępiński proposes a complex and multi-faceted depiction of a human being, one that is deeply rooted in biology but also takes into consideration our phenomenological and social dimensions. The notion of energetic-informational metabolism accounts for the sphere of unconscious biological determinisms and the world of emotions over which we have only very limited control, as well as the social and conscious dimension which allows for considerably greater control over one's behavior.[10] From this perspective, we seem to be caught between two distinct determinisms – biological and social. A person's behavior is perceived in terms of his general character and his attitude "away from" or "towards."[11] This reflects a very basic relationship with the environment, which we find in the animal world and which constitutes the basis for the dualisms of: extraversion/introversion, autism/syntony, schizo-/cyclo-. The attitude "towards" consists in opening oneself to the world, meeting it halfway,

7) Thomas Fuchs, „Depression, Intercorporeality and Interaffectivity," *Journal of Consciousness Studies* 20, no. 7–8 (2013): 219–238.

8) Nordenfelt, *Rationality and Compulsion*, 88.

9) Jakub Zawiła-Niedźwiecki, "Antoni Kępiński's Philosophy of Medicine – an Alternative Reading," *Folia Philosophica. Ethica – Aesthetica* – Practica 28, no. 2 (2016), 23–35. http://dx.doi.org/10.18778/0208-6107.28.04.

10) Andrzej Kapusta, "A Life Circle, Time and the Self in Antoni Kępiński's Concept of Information Metabolism," *Filosofija. Sociologija/ Philosophy. Sociology*, no. 1 (2007): 30–33 and Jan Ceklarz, "Rewizja koncepcji metabolizmu informacyjnego Antoniego Kępińskiego," Psychiatria Polska 52, no. 1 (2018): 165–173, https://doi.org/10.12740/PP/65751.

11) Antoni Kępiński, *Melancholia* (Warszawa: Państwowy Zakład Wydawnictw Lekarskich, 1977).

being ready to implement certain functional structures (intentions and plans). The attitude "away from" entails withdrawal from contacts with one's environment, closing oneself off to the world. The adoption of one of said attitudes over the other is conditioned biologically and genetically, as well as shaped in early childhood through primary experiences. It cannot be decisively concluded that the attitude "towards" is desirable and "away from" is not. Excessive malleability in one's contacts with the environment, over-adaptation, is likely to result in shallow relationships and conformism. On the other hand, the attitude "away from" encourages escape into the world of dreams and reflections, a rich internal universe. Another type of attitude, which Kępiński describes as "above", is the characteristic attempt of any subject to implement the existing functional structures and impose one's visions, plans, and values on reality. In order to be able to predict complex person's behavior, one must understand the value system to which the person adheres.[12] In humans, the conditions behind the decision making process are highly complex, governed to a considerable extent by automated and unconscious mechanisms. The simple rule according to which one should always act upon values placed the highest in the value hierarchy is not always enough; people do not always act the way they wish they would. Therefore, Kępiński differentiates between real and ideal value hierarchies. The former is closer to human biology and our drives, the latter is co-shaped by the world of culture. People are often unaware of the complexity of their own value systems and are therefore incapable of integrating their biological and social facets. The real hierarchy is manifested in real choices and behaviors in the past. The ideal hierarchy focuses on the future, for instance in the form of ideals and exaggerated self-perceptions. The biological and emotional layer activates functional structures by force of habit and familiarity, whereas the sociocultural layer acts in relation to the strength of belief in one's value system and personal commitment thereto, through acceptance of the existing norms and values.

The central concept accounting for the nature of human actions and the specifics of psychopathology is, in Kępiński's depiction, "a decision." The decision-making process involves the imposition and implementation of their own functional structures and values on external reality based on more primary biological and emotional attitudes and preferences. The integrational effort entailing transformation of the reality by establishing functional structures and exploiting the dynamics, changeability of the same, facilitates a positive response in the subject. Conversely, any difficulty in establishing such structures will lead to a sense of discomfort, anxiety and sickness. In Kępiński's opinion we have a rather limited ability to influence our own life dynamics and modify our feelings and moods. Emotions are related to the first phase of informational metabolism and constitute the autonomous basis for more complex and conscious activity. The color palette of our feelings and moods lies predominantly beyond our conscious awareness and proves notoriously difficult to describe in objective and precise terms. Notions such as necessity or destiny (*ananke*) are often evoked in this context.

In depressive states life dynamics is reduced, which is reflected in the processes of building and demolishing internal functional structures. Kępiński emphasizes the fact that the symptoms of mood deterioration are most strongly manifested in the form of decision-making difficulty: "A sad person sees everything as difficult, even impossible. Small issues are elevated to the level of serious problems."[13] In depression, decisions which would normally be made without a moment's thought, even unconsciously, such as decisions related to everyday activities that had long been automatized, become so difficult that they require full mobilization. The inability to create and implement functional structures is related to an emotional and affective change, described by the metaphor of color pattern. The color pattern influences our thinking and perception of reality, it stems from a deeply primordial area of our activity, processes that are, for the most part, beyond our control. A normal human experience entails the realization of one's plans and possibilities but also the incidence of failures. This

12) Antoni Kępiński, *Psychopatie* (Warszawa: Państwowy Zakład Wydawnictw Lekarskich, 1977).

13) Kępiński, *Melancholia*, 103.

facilitates developing a realistic perception of the world, sense of agency and self-determination inscribed in relationships with other people. An affective change leading to a unilateral perspective can result in generalization of one's attitude towards the world (fixation) and distortion of one's self-perception.

Kępiński lists the following characteristic features of a depressive experience: invariability, habituality, dread of infinity, as well as changes of the spatio-temporal structure. Invariability consists of the depletion of color, due to which the patient develops the conviction that his life situation and experience never changes, and indeed that it can never be changed. Space of possibilities and sense of agency are limited. Habituality is found in the inability to understand people who are joyful and smiling, the desire to commune only with the pessimistic vision of the world. It is difficult to take into account some possibilities in their potential actions. Dread of infinity is exacerbated in more severe forms of depression accompanied by a sense of guilt, fear of a disaster and death, as well as suicidal thoughts. The common time and space become irrelevant, instead the individual events, thoughts and fantasies come to the fore. In depression we have distorted perception of time and space. Time is stretched but space shrinks. Simultaneously, in the absence of hope for the future, time seems to be infinite. Decisions are difficult because there is no open space of possibilities, no perspective of a different, future time (the futility of current choices vis-à-vis the infinite). There is a sense of being frozen. Normally, people oscillate somewhere between solemnity and fun. The changeability of functional structures, continuous pursuit of new goals and tasks, and belittlement of superior life goals tint life with a sense of immaturity and pleasure-seeking. On the other hand, stubborn adherence to fundamental life priorities gives life an air of solemnity. Unchangeability of functional structures may lead to resignation or rebellion. Resignation is manifested in one's unwillingness to act and acceptance of one's own fate. Rebellion is the refusal to accept the terrifying world of darkness and dread. It can be manifested through psychomotor agitation or suicidal attempts.

4. Depressive life experience and decision-making

Clearly, in Kępiński's analysis mental capacity and decision-making changes are particularly apparent in the context of depressive disorders. Many of his comments and observations on the depressive experience find corroboration in contemporary phenomenological research. In the review of literature pertaining to the decision-making capacity of depressive patients, Hindmarch mentions "lack of appreciation" and "destruction of accountability."[14] The patients' lack of appreciation is connected with cognitive and emotional deficits, due to which patients fail to accept the relevance of their somatic nonpsychiatric (e.g. cancer) disorders to their future condition and are not able to relate medical facts to actual situations (even if they do understand some medical facts). Accountability consists of decisional authenticity and concern for one's own welfare as an expression of an autonomous, conscious choice, and accountability for one's own actions. On the other hand Schlimme[15], when discussing the phenomenology of depressed mental life, points to prospective expectation of disappointment and depressive habituality. Depressed patients adopt a specific position vis-à-vis themselves, the surrounding world and other people, one that is pre-reflective and manifests itself in the expectation of likely, indeed inevitable disappointment and the perception of tasks as 'unachievable', 'disinteresting' or 'unpromising'.

Phenomenological studies of depression allow a more systematic way of capturing the various dimensions of depressive experience. These are very primary aspects of experience, which can be described as a general

14) Thomas Hindmarch, Matthew Hotopf, and Gareth S. Owen, "Depression and Decision-Making Capacity for Treatment or Research: a Systematic Review". Medical Ethics 54, no. 15 (201313): 287–295, https://doi:10.111186/141472-6939-1414-54.

15) Jann E. Schlimme, "Depressive Habituality and Altered Valuings. The Phenomenology of Depressed Mental Life," *Journal of Phenomenological Psychology* 44, no. 1 (2013) 92–118, DOI: 10.1163/15691624-12341246.

sense of reality and familiarity, as well as more specific and sophisticated patterns of experience that in normal conditions bring a sense of security and autonomy. Depression is the result of affective orientation disorder towards the world. Affective or mood disorders evoke a kind of profound change and reveal normally integrated aspects of personality. To better illustrate and organize the relevant aspects of depressive experience, we point to its three dimensions: space of possibility, sense of agency and time experience. These dimensions could be seen in the analyses devoted to Kępiński and are consistent with the understanding of mental illness as leading to the experience of coercion and limitations in the behavior of the patient. Changes in depressive experience are to a large extent pre-reflective and influence the decision-making process.

1. Decisions can be perceived as a certain space of possibility; possible experiences, relationships, behaviors. The space of possibility is narrowed down or even entirely closed off in depressive patients. It is manifested through loss of energy needed to realize previously adopted plans and goals, even trivial work and family related tasks and duties. A patient may lack the will and motivation to take up certain actions and will perceive many of them as beyond his or her ability to perform. Indeed, at a certain point the patient will become unable to even conceive of other possible areas of activity. This aspect of the disorder is emphasized by Ratcliffe:

> Depression, I maintain, involves a change in the kinds of possibility that are experienced as integral to the world and, with it, a change in the structure of one's overall relationship with the world. To describe this in detail, I focus on more specific themes that are consistently emphasized in first-person accounts: altered bodily experience, loss of hope, feelings of guilt, a diminished sense of agency and self, altered experience of time, and isolation from other people.[16]

2. Decisions can also be described as manifestations of the sense of agency. Under normal circumstances, the subject feels in control of their own decisions and accepts their consequences. Agency also entails, at the bodily level, the possibility of physical performance of certain tasks and of experiencing them as one's own needs tied to a sense of self-satisfaction. A depressive patient loses, among other things, that very sense of agency, of being able to influence reality, and therefore does not feel responsible for the same in any way other than through guilt and frustration. Weakened agency is often expressed in the following way: "I lose faith in myself and my ability to cope with life. There seemed to be no future, no possibility that I could ever be happy again or that life was worth living.[17] From the phenomenological and philosophical perspective emotions are often recognized as the agentive and subjective element of our experience. They belong to the broader class of active world-orientation intimately connected with embodied sense of capability. which reminds Merleau-Ponty schema I can / I cannot. „Some of the central experiential changes reported by sufferers from depression likely result from an affliction of agency: from an awkward dysfunction or disability of active goal-pursuit that goes along with a profound sense of inability and even incapacity, virtually paralysing the depressed person."[18] The destruction of the experience of subjectivity in the case of depression seems less radical than in the case of schizophrenia. The sense of basic self is largely preserved in affective patients. In the case of schizophrenia basic self becomes fragmented and collapsed.

3. Decision-making processes in individuals suffering from mental disorders can also be described by reference to their altered experience of time. Depressive states are characterised by a prevalent focus on the past and the present. The

16) Matthew Ratcliffe, *Experiences of Depression: A Study in Phenomenology* (Oxford: Oxford University Press, 2015), 2.

17) Jan Slaby, Asena Paskaleva, and Achim Stephan, "Enactive Emotion and Impaired Agency in Depression," in *Depression, Emotion and the Self: Philosophical and Interdisciplinary Perspectives*, eds. Matthew Ratcliffe, Achim Stephan (Exeter: Imprint Academic, 2014), 55.

18) Slaby, Paskaleva, and Stephan, "Enactive Emotion and Impaired Agency in Depression," 34.

future perspective is lost. Patients find it difficult to not only think about the future but even to accept the possibility that the future may be in any way different from the present. They may be prone to derivatively rationalize their withdrawal and inactivity, treat it as justified; they consider certain activities as pointless, not worth the effort. Let's have a look a classic description of the depressive change of time perception by Erwin Straus: "The vital inhibition in endogenous depression also initially only influences the experiences of the future, by means of the alteration of the potential action and its effect. But as the accumulating time slows down, stalls and finally comes to stop, the structure of what is in the past also changes. As soon as the internal life story undergoes stasis, the sense and prevailing meaning of events along the stretch of life that has already been traversed is altered as well."[19]

The three aforementioned aspects of decision-making are closely interrelated, which we could see during the presentation of Kępiński's views on mental disorders. The narrowing down of the space of possibility is accompanied by a limited sense of agency, withdrawal from the focus on the future in favour of the past. The way in which we act and perceive ourselves in the world is reflected in our perception of the world itself. Our subjectivity is defined by the possibilities that the world offers. From the experiential perspective, decision-making difficulties are predominantly cognitive and often latent; patients typically lack the adequate insight into the changes affecting their own experience. Primary changes take place at a very primitive level of one's relationship with the world, other people, and one's self-perception. Pre-reflective change often triggers secondary reactions, usually in the form of misplaced justification.

Depressive life experience is much alike the aforementioned narrowing down of the patient's perspective and experience, which deprives the perceived world of its richness, narrows one's value system (often described as demoralization), limits the perceived availability of possible engagement scenarios, and hinders one's ability to make responsible decisions. As observed by Matthew Ratcliffe: "in depression, one not only believes that *p*; one becomes increasingly unable to appreciate how anyone could possibly believe otherwise, as nothing else feels salient."[20] Depressive pessimism and despair become the only viable options, incontestable ideas. Decision-making becomes an impossibility or is limited to a vision of the world so narrow that it can hardly be treated as a genuine reflection of the patient's true values. That is not to say, however, that the patient is incapable of reasoning. Instead, that reasoning is limited to only a single option; other options are not taken into account, treated as unimportant or unattractive because they seem incompatible with the individual's emotional attitude. The depressive certainty of the pointlessness of any action may in fact be reminiscent of a religious or ideological conviction when it comes to determining the viability of particular values and attitudes. That certainty does not stem from a solid analysis of various beliefs and opinions, but rather from one's surrender to the affective misery, depressive attitude.[21] The limited nature of beliefs and attitudes accompanying depression, the sense of pointlessness with regard to certain actions, becomes more evident to patients in remission. They begin to realize how narrow their thinking really was, how many possibilities they failed to acknowledge. The deterioration of the decision-making capacity, although progressing differently in every case, is nonetheless gradable. The logic of depression may vary but ultimately it stems from the initial loss of

19) Erwin Straus, "The Experience of Time in Endogenous Depression and in the Psychopathic Depressive State," in *The Maudsley Reader in Phenomenological Psychiatry*, eds. Matthew R. Broome et al. (Cambridge: Cambridge University Press 2013), 210. See also Marcin Moskalewicz, "Toward a Unified View of Time: Erwin W. Straus' Phenomenological Psychopathology of Temporal Experience," *Phenomenology and the Cognitive Sciences* 17, no. 1 (2018): 65–80, https://doi.org/10.1007/s11097-016-9494-7.

20) Ratcliffe, *Experiences of Depression*, 275.

21) The cognitive functions and affective-behavioral mechanisms accompanying the decisions made by depressive patients are studied by neurocognitive sciences. Such research is usually conducted from a narrow and detailed perspective. It could be ventured that the perspective of phenomenology and embodied cognition provides a more comprehensive framework for this type of detailed and narrow studies.

confidence in certain plans and projects, failure to perceive certain available choices, and eventually leads to the generalization of one's attitude towards the entirety of possible experience. This yields the intuitive belief that the world has lost its potential, the conviction of living in a world deprived of subjectivity – the difficulty of accepting even the possibility of different attitudes in others. The belief that one is deprived of any viable free choice is often accompanied by a sense of hopelessness, loss of self-esteem and crushing guilt. Habitual behaviours become the most persistent in the patient's attitude. The actions that are taken are often triggered by a sense of anxiety and threat.

Ratcliffe discusses the various aspects accompanying depression. He mentions the loss of drive, life energy, curiosity, but also a sense of endangerment and fear which stems from the overwhelming loss of meaningfulness and feelings of guilt. The depressive experience is usually a surprise to both the patients themselves and their environment. Influenced by this unfamiliar change, neither the patients nor their loved ones are able to rely on the previously developed behavioural patterns and resources. From the phenomenological and cognitivist perspective, decisions made by a patient are based on the continuous input of information and cues from their surroundings.[22] One cannot separate the world of the patient from their immediate environment. Meyen observes that environmental influence can indeed serve beneficial therapeutic functions:

"Pictures of children or, rather, the actual presence of loved ones can perhaps provide the sort of cues that patients need to better perceive possible consequences for themselves. Online perception of relevant cues is the basis for any adaptation. People who have to decide about their treatment while they stay in hospital may be deprived of many of their normal environmental cues. Accommodating patients' ongoing perception of (new) cues might help them engage the world and confront the actual treatment decisions that have to be made."[23]

Decisions made by patients constitute a new, unfamiliar situation for them, thus becoming unpredictable and not always consistent with their previous, pre-disorder preferences. Meyen suggests that our actions are always triggered online, resulting from engagement in our current circumstance. Therefore, the inconsistency of patients' choices when compared to those made prior to the onset of the disease (in line) ought not to be automatically treated as a symptom of a mental capacity disorder. One should also take into account the particular area of competence. The ability to make decisions in one area does not necessarily entail the same in another.

Conclusions

Compulsion and mental incapacity are essential dimensions of mental illness. Research into the nature of depressive disorders has demonstrated the importance of emotions and the role of pre-reflective attitudes in the processes of decision-making. Their role cannot be boiled down exclusively to a distortion of rationality, indeed they prove to be the necessary condition for any decision-making capacity as such. They constitute the pre-cognitive structure determining one's engagement in the world and facilitating the sense of openness towards it and meaningfulness of the same.[24] Given this significance of emotions in the context of our ability to define our place in the world, we should strive to further phenomenological and cognitive analyses of the states accompanying depression and other mental disorders. In the above text we pointed out the three dimen-

22) Phenomenological research coincides with the enactive approach popular in the cognitive sciences: Slaby, Paskaleva, and Stephan, "Enactive emotion and impaired agency in depression".

23) Garben Meynen, „Depression, Possibilities, and Competence: A Phenomenological Perspective," *Theoretical Medicine and Bioethics* 32, no. 3 (2011): 184, https://doi:10.1007/s11017-010-9171-8.

24) Andrzej Kapusta, "Understanding in Psychopathology and Engaged Epistemology," Kultura i Wartości 8, no. 4, 2013: 149–160.

sions of experience depression: space of possibility, sense of agency and time experience that exacerbate clinical and legal considerations on the issue of decision-making in psychiatry. Research in these areas will allow a better understanding of the decision-making processes and clinical assessment. Phenomenological studies of decision-making processes in psychopathology are not enough to build a decision-making procedure for patients, but rather to contribute to a better understanding of the determinants of decision-making processes. The study of depressive experience is intended to improve understanding, but also provide a better assessment of the patient's decision-making.

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