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Phenomenology of emotions with special reference to dysphoria

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Dysphoria is a complex phenomenon which must be defined in the framework of different forms of affections. It belongs to the broader field of emotions, which are characterized by some essential features: i.e. movement, passiveness, transitoriness, and reference to the others. All these four essential features of emotion are specifically altered in depression, whose phenomenology is presented in a clinical case. In discussing dysphoria, a first distinction is made between particular and global affections. The first type encompasses emotions and feelings, while the second one includes humor, mood and temper. Dysphoria belongs to one of these global affective states: the humor, which has to do with the spatial dimension of existence. In dysphoria the patient experiences the world as oppressive and invasive of his/her intimacy; the others are lived as persons demanding answers or actions he/she is not able to fulfill. Finally, the phenomenology of dysphoria is analyzed through the four essential features described above and examples are given.

Keywords: dysphoria, mood, emotions, humor, phenomenology, psychopathology, hermeneutics.

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INTRODUCTION

Dysphoria is a symptom which is difficult to define. It has been used to refer to a sensation of displeasure prevailing in some affective disorders and which encompasses different emotions and feelings like irritability, anxiety, bad mood, impatience, pessimism, etc. All these affections have in common the negative form they are perceived by the patient, which implies a diffuse and marked sense of uneasiness. These patients are very sensible to several kinds of stimuli. They promptly react to minimal changes in the affective disposition of the others and can easily become aggressive. In this article we will try to find a place for this complex phenomenon in the framework of the different forms of affections characterizing human being. Since dysphoria belongs to the broader field of emotions, we think that an etymological research can help us in advancing in the knowledge of emotions in general and of dysphoria in particular, with special reference to its importance in affective disorders.

ETYMOLOGY OF EMOTION

The word “emotion” is derived from the French word *émotion*, appeared in the 16th cen-

tury, and that in turn derives from *émouvoir*, whose meaning is to move. The French word comes from Latin, *movere*, which has several meanings. At least two of these meanings correspond to reflexive verbs (to move and to tremble) and the others refer to transitive verbs, such as to transform, to stimulate, to disquiet, to frighten and to enthusiasm. From this brief etymologic digression we can infer some essential features of the so ubiquitous phenomenon of emotion. They are the following:

1st The *movement*: all the mentioned verbs refer to a change, a movement of the psychic life. That something makes me tremble, or stimulates me, means that a certain degree of transformation is produced in me; this can be either positive or negative, but it is always a movement. In the ambit of what romance languages call emotion, Karl Jaspers (1959) distinguishes between feelings, affections and moods and in the definition of each one of them he also uses the word “movement” or “course” (*Verlauf*), as for example: “The feelings are peculiar movements of the soul”, “The affections are complex temporary units (courses) of feelings”, etc. (p. 91).

2nd The *passiveness* of the subject who suffers the change. With the exception of the verb “to move”, that could refer to a voluntary movement (“I move”), all the other meanings point to the fact that the subject of *movere*, of the emotion, is a passive subject; that is to say, he cannot determine that which moves him. I cannot decide that something enthusiasms me, scares me or transforms me. We said that “to move” is in exception, although *movere* can also be used in passive form, referring to “being moved”. In his “Theory of emotions” (1965), Sartre says with respect to this: “What forms intrinsic part of emotion is that it apprehends in the object something that is infinitely besides it” (p. 111). And later he affirms: “We live emotively a quality that penetrates in us, that we suffer and that exceeds us everywhere” (p. 113).

3rd The *transitoriness*: the third element that seems of the greatest importance to us, in particular because it is very strikingly altered in the affective diseases, is its peculiar temporality. The emotions arise, completely invade the subject and then, after some time, which is variable according to the case, they disappear. Nobody can remain for a too long time joyful or sad or wrathful. It is extreme the case of those emotions which are very close to the body experience, such as the ones associated with the sense of taste and with the sense of smell, where the emotion is difficult to distinguish from sensation. The poet Rainer Maria Rilke described in only one verse this feature characteristic of oral emotions: “Wait... the flavor... and it has already escaped” (1977, Sonnet 15 of the 1st Part of the Sonnets to Orpheus). Both the aroma and the flavor (or the emotion awakened by them) invade the subject, prolong in a certain way the present, and then disappear. This phenomenon is ephemeral in the case of the aroma and a little more lasting in the flavor. That moment which stretches in the flavor is represented in the verse by the suspension points before and after the expression “*das schmeckt*”, that we have translated by “the flavor”, given the ambiguity that would have to say “that flavor”, which would be the literal translation. This peculiar temporality of the emotions, which can be specially appreciated in those which are associated to the senses of taste and of flavor,

was also described by Kant in his Anthropology, when he says that the pleasure produced by the sense of taste can only be fleeting and transitory to be able to please (Kant, 1838).

4th The *reference* to the other: the fourth element inferred from the etymology of the word emotion also appears in all the meanings of the original Latin word, but particularly from the first French derivation: *émouvoir*, to move. And this is the necessary presence of the other, of the world, in every emotion, something also expressed by Sartre (1965, p.76), when he says: “The emotional conscience is first of all conscience of the world”. And then he adds: “One does not need many reflections to realize that the emotion comes at every instant back to the object and is nourished by it [...] And how to speak of rage, in which blows are given, insults and threats are proffered, without mentioning the person who represents the objective unity of those insults, of those threats and of those blows”. And he ends categorically by affirming: “In a word, the moved subject and the moving object are united in an indissoluble synthesis” (Sartre, 1965, p. 77).

THE EMOTIONAL WORLD IN DEPRESSION

It is quite evident that the fundamental perturbation of this disease concerns the emotional life. It is not by chance that depression belongs to the group of the so called “affective diseases” or “mood diseases”. In German language the word “emotion” does not exist, but its concept is contained in three phenomena which in a certain way are different, but very close to one another: feelings, affections and moods (*Gefühle, Affekte und Stimmungen*). Let us see now how the described four essential features of emotion are specifically altered in this disease:

1. *The emotion as movement*: one of the fundamental phenomena of the nuclear depressive syndrome is the alteration of the body-world relation, that is, the classic psychomotor inhibition (Doerr-Zegers et al., 1971; Doerr-Zegers, 1993). It is the same phenomenon that Binswanger (1960) rightly characterized as “not being able to”. This progressive incapacity for paying attention, concentrating, deciding, acting, ends in that extreme state that is depressive stupor,

where there is no movement of the body and consequently every emotion disappears.

2. *The emotion as passivity*: the other central phenomenon of this nuclear depressive syndrome (Doerr-Zegers, 1997, pp.146-149), more or less corresponding to Tellenbach's "melancholy" (1961/1983), is the change in the experience of the own body, manifested as discouragement, anxiety, lack of energy, sensation of cold, multiples pains, etc. It is, in summary, a sort of "inflation" of the corporality, up to the point of not leaving space to the spirit and impeding the relation with the world and with the others. This feeling of being invaded by corporeality, without being able to defend oneself from it, would be as a caricature of the passivity proper of every emotion. It is the predominance of the "body as object" (*Körper*) over the "body as subject" (*Leib*).

3. *The emotion as rhythm*: emotion, as well as moods, is fundamentally rhythmic and periodic. Its temporality is impersonal, unlike the temporality of feelings. Strictly, one of the essential elements of emotion is its transitoriness, the fact that it cannot last indefinitely. We mentioned as extreme example the one of the emotions associated to the sense of taste and to the sense of smell. Now, the fact that emotions lose their natural rhythmicity is characteristic of depression. Instead of disappearing after having invaded consciousness, the depressive emotions remain: anxiety, discouragement, uneasiness last hours, days and weeks, perhaps constituting the most important cause of suffering of these patients, something dramatically represented in the so called "agitated depression".

4. *The emotion as com-motion*: but perhaps the most striking perturbation of emotional life in depressive disease is the one referring to the relation with the world and with oneself. The more a discouragement increases, the more the feelings (towards the other) disappear, annulling the subject. This perturbation, already present in the tendency of these patients to isolation and to silence and expressively in what Schulte (1961) called "*das Gefühl der Gefühlslosigkeit*" (the feeling of lack of feelings), acquire its most extreme degree in the so called nihilistic delusion of the Cotard syndrome.

Given the fact that in this syndrome all the above-mentioned characteristics of emotional life are presented very strikingly, we will illustrate our analysis with the description of a typical case of depression we have been treating for some time. We also think that in this way we can deeply understand the essence of depressive emotions in particular and of the disease "depression" in general.

A CLINICAL CASE

Verónica is a 40 years old woman, married and mother of three children. She has no morbid background and is described both by her husband and by her brothers as "totally normal" up to the beginning of the disease, two months before her admission to the Psychiatric Hospital. The relatives outline as characteristics of her personality her great dedication to the family and to the household. She never had conflicts neither with her husband, nor with her brothers, who remained living in a farm in the south when she moved to Santiago. The disease began few days after Verónica arrived at the house of her relatives to spend the summer holidays with her children. There she felt herself, for the first time, betrayed by her brothers, when they manifested the intention of not giving her the part of heritage she deserved, i.e. a plot of land on which she counted for building there a house where moving to live. Due to this difficulty, Verónica became very distressed and began to not sleep, to not eat and to lose weight. She also complained of multiple bodily pains. At moments she manifested the idea of not wanting to go on living. One day she was found by her sister trying to hang herself. After some therapeutic interventions in the zone, without fruitful results, Verónica was moved to Santiago and was admitted to the Psychiatric Hospital. It is interesting to outline that her disease begins when her personal life project is interrupted. This could be in a relation of meaning with her "not being able to do anything", characterizing the fully developed syndrome.

At the examination we found a lucid, thin woman, looking older than she was and attracting our attention for her great intelligence. Here we will textually reproduce her words:

“What happens with me is that I have everything dead; let us say that I am dead, that I am in vegetable state from my head to my feet. I have no sense of touch, neither sense of smell, neither sense of taste for food [...] My body is so light as it does not exist. I do not get tired, I can walk kilometers and nothing happens to me [...] I would like to feel the weight of my eyes to be able to sleep. How am I going to be able to rest if I do not feel my body? [...] And yet, I dream at nights. Why? Do the dead dream? [...] Nothing scares me anymore; I can't feel the anger. The body is heavy when it is alive, while I do not feel the weight of my body [...] I live a science-fiction life, the life of a dead person [...] When I take my children in my arms, I do not feel them [...] If my children knew that they love an artificial mother [...] My husband does not sleep with me, how is he going to be able to sleep with a dead! [...] I do not feel the direct contact with the things, neither with the others”.

We are in front of a classic melancholic depression with a Cotard syndrome. In North American DSM terminology this picture would correspond to a “depression of melancholic type with psychosis”. We will renounce to what could be an interesting psychodynamic digression, to concentrate ourselves in the analysis of her emotions and in the way they constitute - paradigmatically in this case - a bridge between the self and the own body, on one side, and the world, on the other.

Verónica represents an extreme case of emotional life perturbation in the sense of the classic “feeling of lack of feelings”, since she feels herself dead. This “feeling herself dead”, that other less severe patients describe as “freezing of the emotions”, is a judgment (for us certainly delusional) based on two primary experiences: not feeling the own body and not feeling the others. The first corresponds to what Husserl (1964) called the “primary level of the experience”. He defined the natural and pre-predicative experience as a direct and immediate relation with oneself and with the world, established *through the body and its senses*. And in Ideas I, he emphatically affirmed that only by its empiric relation with the body, the conscience becomes human and only by this means it occupies a place in nature's space and time (Husserl, 1950). In other words, it is the body, the flesh, its materiality itself, what prevents the conscience from floating in the air, empty of all content. And materiality

is weight and that is precisely what Verónica misses. The Lithuanian-French philosopher Emmanuel Lévinas (1989, p. 31) says with respect to this: “The liberty of the self is inseparable from its materiality [...] The definitive character of the existent, constituting in turn the tragic of solitude, is materiality”. It could also be said that without emotion - necessarily emanating from the body - there is no life. And for that reason Verónica affirms that she is dead.

But this extinguishing emotional capacity, in its disappearance impedes the relation with the world and with the others. Our patient tells us that when she takes her children in her arms, she does not feel them and that she doesn't feel the direct contact with the things. She thinks that her children would be scandalized if they knew that they love an artificial mother, and she understands that her husband does not sleep with her because “how is he going to sleep with a dead!” She also says that the television images and the words expressed by the others do not enter in her head.

In Ideas I (1950) Husserl affirms that we must remember that only through the experience of a bond between the conscience and the lived body it is possible something like the reciprocal understanding between the animal beings belonging to a same world. The openness towards intersubjectivity is produced from the body. Starting from the body and from the perception I have of it, I am going to be able to constitute the world surrounding me and through which the other bodies can be spatialized; and thus, from this center that is my body, I am going to constitute the global world and within it, the others. When perceiving a thing in the space, the subject “becomes aware of the pre-spatiality of his percipient flesh; what constitutes the occasion of the pre-appearing of the flesh as a ‘perception organ’ is the appearing of the perceived thing” (Bernet, 1993). The depressive patient with a Cotard syndrome returns to that primordial space called by Lévinas “the space of horror and of insomnia”, where nothingness and emptiness reign. When not perceiving, when not feeling neither her own senses (“I have no sense of touch, neither sense of smell, neither sense of taste”), nor the others (“when I take my children

in the arms, I do not feel them”), the patient cannot become aware of that “pre-spatiality of her percipient flesh” and consequently, there is no other possibility than to feel her body as dead.

It is interesting that Lévinas, when he describes the process of subjectivation, accepting that in every moment it is associated to the corporality and to the presence of the other, he affirms that the most elevated form of being subject and of relating with the world is joy. The otherness is deeply respected in joy. The other is not a mere manipulable object anymore, as in the way of appropriating that leads to the technique, but an enjoyable element. The self makes himself secure while enjoying the elements, neutralizing the otherness of these, up to incorporate them to the immanence of his subjectivity, which has been born from enjoyment. And in a moment he says that “life is love to life [...] life is satisfied sensibility” (Lévinas, 1987, p. 131). The regressive movement of the subjectivation process goes from the loving body to the sovereign body, from the sovereign body to the hungry body and from this, to the dead body, the nihilistic delusion about the body. It is noteworthy that in the last years, for the diagnosis of depression increasing importance has been given to anhedonia - not being able to enjoy things. And joy is based on the capacity to be attracted, moved, stimulated and transformed by the other, that is to say, on the ability to experience emotions or, more precisely, transitive feelings.

Now then, the most perfect form of relation with the world and otherness is reached through the fellow man. Two primordial elements outstand in this relation with the other: the face and the caress. The face of the other is the personalized transcendence and through it, through the face of the beloved, “the whole humanity is showed to me in its defenselessness” (Lévinas, 1987, p. 211). And that is the reason why the relation with the other is fundamentally ethic, because when the self discovers the fragility of all the others in the face of the beloved, he feels inclined to say: “Here I am; I make myself responsible for you”. Now, the most singular and proper vehicle for approaching the other is the caress:

“The caress, as the contact, is sensibility; but the caress transcends what is sensible [...] the caress

consists in not arresting anything [...] She searches, registers. It is not intentionality of unveiling, but of search: march toward the invisible. In a certain sense it expresses love, but suffers for incapacity to say it” (Lévinas, 1987, p. 267).

Here we cannot develop in detail the phenomenology of the caress, but it does seem important to us to indicate that if we accept that these two sensible elements, the face of the other and the caress through which I approach him, are fundamental in the constitution of intersubjectivity, we will have to recognize that in the deepest degrees of depression both are practically absent. For our patient the others more than faces are masks, and she herself feels as such when she is surprised by the fact that her children can love an “artificial” mother, that is to say, as unreal as a rag doll. The others are not a face for her, neither is she for the others. All the mystery of the face has disappeared and both her children and herself have been transformed in inanimate beings, in “artifacts”. And if she cannot recognize their faces, with greater reason she will not be able to caress them. She expressively refers to this subject when she insists in asserting her incapacity to feel them as alive persons when she takes them in her arms. It is difficult to find an example of failure of emotion intended as commotion which is more impressive than this one.

There is a final clinical fact that would be important to underline with respect to the emotional life of the depressive patient: unlike what occurs in organic apathy or in the peculiar alteration of affectivity observed in schizophrenia, the depressive patient suffers for the extinguishing of his emotions. Both anhedonia and not feeling the love they usually felt for their beloved ones is for them a source of suffering almost as important as anxiety.

DYSPHORIA AS A PATHOLOGICAL EMOTION

As we said in the introduction, it is noteworthy the scarce use of the term “dysphoria” in psychopathology and psychiatry. We did not succeed in finding the first description of it in old psychiatric literature. In Kraepelin’s Handbook as well as in Bleuler’s one, the word does not appear, even though both accurately describe abnormal affective states, which are close to what

we now understand as dysphoria. In the chapter “Abnormal Mood Emotions” Kraepelin (1927) states that under the effect of alcohol, but also in manic conditions, a special form of mood can arise, characterized by permanent irritability and restlessness and which in given circumstances can lead to agitation. He adds that in both cases, in the state conditioned by alcohol or by manic depressive illness, the awareness of the abnormality is lacking. Referring to possible similar symptoms in depression, Kraepelin makes very interesting observations. We will try to make a translation of the respective paragraph from a relative old German into English:

“Usually the sensation of displeasure proper of depression is accompanied by a sad mood. Sometimes, however, a sort of angry irritability is added to this mood [...] This way, a state of interior tension (‘innere Spannung’) arises, which can lead to intense emotional discharges” (Kraepelin, 1927, p. 191).

And later he says:

“We observe this peculiar state in the transition between depressive dysthymia and manic agitation in the manic depressive illness [...] It deals perhaps with an association between the depressive mood and the beginning of excitement.” (Kraepelin, 1927, p. 192).

These observations totally agree with the 50 years’ experience of one of us in the General Psychiatric Hospital of Santiago, Chile, only interrupted by three periods at the Psychiatric Clinic of the University of Heidelberg.

Eugen Bleuler speaks in this context about a “pathological irritability”. However, he does not describe it in details, only underlining that this particular perturbation of mood can be also seen in very different pathologies, such as organic psychosis, epilepsy, endogenous and reactive depressions, manic episodes, neurasthenia, etc. (Bleuler, 1975, p. 69). Another classical author, Karl Jaspers, mentions dysphoria only once and in the framework of epileptic disorders. In relation to the modern literature, it can be stated that dysphoria seldom appears. One example: in the worldwide known New Oxford Textbook of Psychiatry (Gelder et al., 2000; 2010) the word “dysphoria” is simply not mentioned. One could consequently pose the question whether dysphoria does exist or not. We think that there exist some psychopathological phenomena and/or

states, which with no other better word could be characterized as with “dysphoria”.

An interesting contribution to this subject - which could help us to approach the phenomenon dysphoria - has been recently made by Pelegrina (2006, 2016). He attempts to do a phenomenology of the human forms of being affected (what corresponds to the wide field of affectivity). The aim is to unveil their essence and in this way to differentiate the pathological forms from normal affective manifestations like sadness, rage, bad mood, etc. He proposes as something imperative to make first a fundamental distinction between *particular* and *global* affections. The first type encompasses *emotions* and *feelings*, while the second one includes *humor*, *mood* and *temper*. The latter are usually called “affective states”. We think, however, that the previously described characteristics of emotions correspond in every detail to what Pelegrina calls “affections”. Nevertheless, we will accept his conceptualization and also the fact that he considers “emotion” as only one kind of “affection”, because his phenomenological approach contributes to better grasp the essence of the phenomenon we are dealing with, i.e. dysphoria.

Emotions and *feelings* have in common the fact that they only appear in relation with a stimulus or as reaction to a given situation. Emotion is always a “com-motion”, as we saw in our previous etymological research; that means that the otherness is always present. It is not a feeling I experience towards something or somebody, but the invasion by the stimulus annulling me as an active subject. I am always passive in front of an emotion. I suffer from an emotion. The emotions, their stimuli and their reactions are not personal and not selected, nor chosen, nor decided. In the psychopathological realm we observe many emotions, like fear, rage, panic, etc. In all of them the subject is no more the owner of his answers.

The *feeling* is the communication between my personal reality and a particular aspect of the external reality, which has a sense, a special meaning for me. Like in emotions, also in the case of feelings the otherness is always present, but in a much more elaborated form. In fact emotions appear very early in our life, while feelings only

start in the puberty or perhaps in adolescence. Love is a good example of feeling, because I can somehow manage it and I can also construct through love my life “with the other”. Different is to fall in love. There I am not completely free and in it emotion predominates over the feeling. Insofar, there are strictly speaking no pathological feelings. Sadness is a negative feeling, but not a pathological one. In sadness we experience the loss of something important in our life and this experience belongs to the essence of human being, as religion founders and poets - in special Rainer Maria Rilke (1st, 9th and 10th Duino Elegies, 1922/1955) - have repeatedly stated and demonstrated. Feelings can however become pathological, as it occurs in severe depressions, for example, and this happens when in the experience of lost we feel that we have lost not one, but all the possibilities of our life. And this is the last fundament of suicide.

The global affective states embrace the person as a totality: the relationship to oneself, to the others and to the world. They are not founded in the meaning (for me) of a given situation, but in the transformation of the whole person-world relationship. If somebody is in bad humor, this does not mean that he is angry with a determined person or because of a particular issue. He is angry with the world in general and with himself. Three forms of global affective states can be differentiated: the humor, the mood and the temper. Dysphoria belongs to one of these global affective states: the humor. Other forms of humors are: the anxious, the paranoid, the melancholic and the expansive humors. And these humor forms are different from a phenomenological point of view with respect to moods (depressive, expansive) and to the tempers (anxious, insecure, resented, delusional, etc.).

Humor has to do with the spatial dimension in human life. It affectively configures the vital ambit of realization of my life. It corresponds to the question “How are you?” ... in the world, naturally. In the realm of psychopathology humors embody different ways of spatiality that somehow make difficult the process of appropriation of reality in the sense of Husserl’s life-world (*Lebenswelt*).

Mood has to do with the temporal dimension

of human life. Mood embodies the temporal structures of the interactions dynamics. It corresponds to the question: “How are you doing?” This question does not refer to the experience of oneself as body, as in humor, but to the actions, to the plans, to the future. The mood is specifically altered in depression and in mania, though in completely opposite ways. In depression, the future becomes progressively close and actions more and more difficult. In mania, on the contrary, everything is possible and the future is completely open.

Temper refers to the consistence of the person-world relationship. Temper corresponds to the question: “How do you feel in the world?” or “How are you managing your life?” It embodies the way it is experienced the correlation between the available resources in the external world and the own inner resources for facing challenges and tasks. Somebody with a “good temper” is able to resist the difficulties and to overcome failures or disgraces. In the psychopathological sphere, temper is related to more or less vulnerability and/or resilience of a person.

And what is then dysphoria? Following Pelegrina (2016), we can say that dysphoria represents a pathologic form of humor and insofar it has to do with the spatial dimension of existence. In dysphoria the patient experiences the world as oppressive and invasive of his/her intimacy. The others are lived as persons demanding answers or actions he/she is not able to fulfill. Irritability - as Kraepelin taught us more than 100 years ago - is the most frequent psychic condition of these patients. The humor is very instable and depending, above all, on the interpersonal relationships. It is a typical humor of premenstrual disorder, but also of the borderline personalities, as Stanghellini and Rosfort (2013) have so clearly showed. As we saw previously, dysphoria was described by Kraepelin in an unsurpassed way, even though he did not use this term. We have also observed dysphoria in two other conditions, depression and mania, though with different nuances in the form of presentation.

In depression, above all in recurrent cases treated by us during many years, we could state the appearance of typical dysphoric humor in the pre-depressive situation, just when the depres-

sive episode menaces to overwhelm the person and his world. We have interpreted this peculiar reaction as a defense against the retardation and the incapacity, which characterizes this condition. The hyperactivity and irritability represent the last effort done by these patients – mostly bipolar, but also unipolar – for avoiding the fall in the abyss of the disease. With a certain frequency the patients succeed and the episode vanishes, like a storm. In other cases this effort fails and we observe how this irritability disappears behind the silence, the sadness and the incapacity proper of melancholic depression.

Manic patients present very often dysphoric states as described also by Kraepelin. The mechanism of the emergence of dysphoria in manic and depressed patients is completely different. Manic patients get impatient and irritable because the world, and particularly the others, are not able to think and act with the velocity they estimate as normal. Their pretensions in every ambit do not know any measure, any limit and to face this denegation in satisfying their demands – from the side of the world – becomes for them something unbearable. Irritability is a common manifestation of mania; this is however a very unspecific symptom. It should be the challenge of a phenomenological psychopathology to find the way for discovering the essential features of a given disorder. This will allow not only a more adequate diagnostic process, but also a better interpersonal approach.

Finally, we would like to show how the different features characterizing emotion in general, which we derived at the beginning from the etymology of the word, are present in dysphoria.

1. The *movement*, the dynamic element of every emotion, appears in dysphoria as the corporal restlessness always accompanying irritability. The dysphoric state is the opposite of being at peace with oneself and with the world, from serenity. It is being under pressure, urgency, loss of control, impulsivity. All these characteristics are observed in outstanding form in the affective life of borderline patients, but also in manic and in depressive patients (in the last ones, prior to falling into a full depressive episode).

2. The second element peculiar to emotion is, as we saw, *passivity*: the subject cannot decide to be

in one state or the other: dysphoria happens without notice and invades the subject who is unable to defend himself against it. The patients with premenstrual syndrome bitterly complain of this state which is so disturbing for the relations with others and that they cannot manage. Something similar occurs with depressive patients at the beginning of a phase. Borderline patients are unable to take distance from their emotional states and particularly from dysphoria, with which in a certain way they identify themselves, blaming others for the consequent discomforts.

3. The third element peculiar to every emotion is *transitoriness*. This feature is observed with particular evidence in premenstrual dysphoria. Menstruation begins and the state disappears. Something similar occurs with what we described previously as pre-depressive dysphoria: it is enough that inhibition, insomnia and the rest of the depressive symptoms appear, for pre-depressive dysphoria to disappear. In manias, by contrast, dysphoria only diminishes with the treatment and in the case of borderline patients this state of effervescence, discomfort and irritability generally fades when changes are produced in significant interpersonal relationships, usually when the other cedes or concedes.

4. The last element we infer from the etymology of “emotion” is *commotion*, that is, its permanent reference to the other. This is something expressly suggested by Pelegrina in his classification of the affective states, when he refers to the characteristics of emotions and feelings. This active participation of the other in the dynamic of dysphoria is particularly evident, as we just said, in borderline personalities. It is also observed in depressive and manic dysphoria but not in the premenstrual syndrome, which course is independent from the relationship with others.

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