# The comparative phenomenology of pregnancy and depression

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**Abstract**

This thesis proposes that the adoption of the phenomenological perspective has potential to cultivate a uniquely rich sort of self-understanding in women throughout pregnancy and early motherhood. I argue that contemporary reductionist theories of consciousness in both philosophy and psychiatry fail to recognise the irreducibility of the subject, and in turn, the relationship between mind, body, and world. From this, I defend the adoption of a moderately naturalised phenomenological perspective on changes to the structure of experience in pregnancy. I then offer an analysis of the phenomenology of pregnancy and early motherhood, working with existing literature on the phenomenology of illness, with particular focus on depression. I explore some factors that might influence certain women's vulnerability to depression-like experience in pregnancy, proposing that for such vulnerable individuals, the way in which experience can alter in pregnancy can involve phenomenologically-rich structural similarities to the ways in which experience can alter in illness. Finally, I argue that the dominance of the reductionist paradigm that I resisted results in various types of epistemic injustices being committed against such women in the clinical encounter. From this, I suggest how the adoption of the phenomenological perspective might work to mitigate the effects of these injustices, facilitating self-understanding and resilience in the women in question.

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## Author's declaration

I, Eleanor Byrne, declare that this thesis is a presentation of original work and that I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as references.

## Introduction

I begin by discussing problems with the standard conceptions of consciousness in both philosophy and psychiatry. I show how these conceptions are leading both disciplines down a dark path in their efforts to understand consciousness and place it in a meaningful context (§1-2). For philosophers of mind, this often shows itself in a commitment to a reductionist study of consciousness with an insensitivity to the significance and irreducibility of subjectivity, but in which latent Cartesianism can be identified. Similarly for psychiatry, a view of the mind that navigates under a biological paradigm has resulted in aspects of patient experience with meaning and significance being isolated, and dismissed, unless they can be explained on a neurophysiological basis in line with the reductionist picture (§3). I explore an undesirable consequence of this conception, namely its impact on understanding of illness, including depression, and in turn, pregnancy (§4-5). I defend a holistic, phenomenological perspective in contrast to the aforementioned positions, and in particular, a form of phenomenology that is open to a weak scientific naturalisation such that phenomenology can be integrated with scientific resources, but without requiring that phenomenological data is constrained by a reductionist methodology (§6-8).

My second chapter offers an analysis of the phenomenology of pregnancy and early motherhood with specific focus on vulnerability to depression-experience. The account I present is largely influenced by existing accounts of the phenomenology of illness, with particular focus on depression. Existing literature on the phenomenology of illness is opened up to an analysis of pregnancy by the recognition of the phenomenological similarity in some women between an experience of pregnancy and an experience of illness (§1). From this, I explore various ways in which the pregnant woman's experience might be altered in pregnancy such that it might dispose her towards depressive experience, also discussing factors that influence this vulnerability (§2-8). What is key in each of these ways that

experience is altered is the disruption to the standard experience of the lived body [*Leib*] through which all aspects of phenomenal consciousness arise.

My third and final chapter focuses on the problem of inadequate sensitivity to the subjective experience of women in pregnancy and early motherhood in healthcare, namely the kind of experience outlined in the preceding chapter that is often dismissed as a result of the dominance of the paradigm that is operated within as outlined in the first chapter (§1). This complaint is cashed out in terms of epistemic injustice against pregnant women, developed from existing narratives about epistemic injustice against ill persons in the clinical encounter (§2-4). This chapter aims to illustrate how the phenomenological approach I have put forward might facilitate better self-understanding, and therefore resilience, in the women in question (§5-7). This points towards a way of mitigating the effects of the said epistemic injustices.

# Chapter 1

## *Naturalising Phenomenology*

### 1. Context

The transcendental aspirations characteristic of classical phenomenology, found principally in Husserl (1931, 1954), seem to suggest that phenomenology's incorporation with the natural sciences is unattainable, and ultimately undesirable. However, it is not at all clear that this ought to be the case. Here I will work to defend a moderate scientific naturalism through which there can be compatibility between phenomenology and science. On my view, there is potential for phenomenology and the sciences to share explananda to a certain extent, however, this need not necessitate a dismissal of irreducible phenomenological data. On this picture, the resistance to dogmatic naturalism that is characteristic of phenomenological literature is maintained, but we are left with the promise of a cooperative project.

Some phenomenologists have faced accusations of misrepresenting what a scientific naturalisation requires, as well as conflating different forms of naturalism (Ferry-Danini, forthcoming; Sholl, 2015) [1]. I will be referring to scientific naturalism defined as the view that the empirical sciences are metaphysically *and* epistemologically privileged over all other forms of enquiry, and so anything we take to be real should be incorporated into the account of reality we have as provided through science (Ratcliffe, 2013a, p. 67). While some defending contemporary theories of mind, such as Daniel Dennett, demote the role of phenomenology to a sort of complementing decoration for third-person scientific

[1] The complaint is typically that such philosophers are guilty of conflating metaphysical and epistemological naturalism. I am not convinced that this is representative of the literature, though I will say little more about it here. For now, see the following definition of scientific naturalism provided by Ratcliffe, which identifies both epistemological and metaphysical naturalism as relevant to the concern.

explanations of consciousness localised in the brain, I want to insist that phenomenological descriptions can be valuable regardless of whether they should, or can, be reduced.

## 2. Husserl and Merleau-Ponty

The school of phenomenology with which I am primarily concerned here is that which has its foundations in the work of Husserl and the later Merleau-Ponty. Husserl's development of phenomenology took great inspiration from the work of Descartes, and Husserl was especially influenced by Descartes' mode of philosophical reflection, that is, his methodology as a process of establishing philosophy as a science grounded on an absolute foundation, namely conscious experience. This attention to the objects of consciousness orientates us towards the *ego cogito* as the 'apodictically certain' basis for judgements; the basis on which, according to Husserl, philosophy *and* the sciences ought to be grounded (Husserl, 1964, p. 18). In the introduction to his *Cartesian Meditations,* Husserl writes that, although one must come to reject near enough the entirety of Cartesian philosophy, Descartes' influence on what would become transcendental phenomenology was so great that one might be justified in understanding it as a form of neo-Cartesianism (*ibid*).

Husserl's phenomenology proposes a philosophical methodology by which all presuppositions about the world must be abandoned in order to establish the starting point by which subsequent tasks, in natural science as well as in philosophy, can be carried out. A key methodological principle in Husserl's phenomenology is *presuppositionlessness*, often discussed in tandem with critique of the natural sciences and their failure to adopt a 'pure', presuppositionless methodology. The characteristic criticism found in Husserl is that scientific practice is loaded with such presuppositions; it takes a lot for granted, and as a consequence of this, forgets the world that it is grounded in and becomes mere abstraction. Ultimately, however, the goal of phenomenology is to establish a phenomenologically-

grounded, and therefore 'apodictically certain', foundation for science: Husserl in the *Crisis*, for example, describes his project as serving to provide a *preparatory reflection* for science (Husserl, 1970, p.122). With this we will not only be in a better position to ascertain meaningful results in science, but it will also become clearer what sort of scientific tasks we ought to be engaged in.

For Husserl, presuppositionlessness meant that one ought only to be concerned with the facts of natural existence, which is exclusively that which we can arrive at through conscious first-person experience. Our philosophical inquiry therefore, with its foundations in conscious experience, provides a radical starting point for all subsequent philosophical and scientific inquiry, and one that is free of theoretical baggage, or 'dogma'. Finding oneself at this starting point necessitates engagement in the *phenomenological reduction*, i.e., a reduction to pure consciousness, to the 'transcendental-phenomenological ego' (Husserl, 1964, p. 26). The reduction involves the suspension of all judgements and beliefs about the world, and the exclusion of assertions which cannot be realised, in their entirety, phenomenologically (Farber, 1966, p. 30).

Merleau-Ponty's subsequent development of Husserl's phenomenology differs significantly in various ways. First, Merleau-Ponty and Husserl are typically understood to have had held different views regarding phenomenology's status as a transcendental philosophy. Although Merleau-Ponty reported to be engaging in a transcendental project, as in Husserl, some have argued that his position fails to meet the conditions for a transcendental analysis because of the extent to which his analysis incorporates the findings of the empirical sciences (Inkpin, 2017). However, what is required by the transcendental for Husserl is not unanimously agreed upon either; in fact Julia Jansen proposes that Husserl was advocating a much more open attitude to the transcendental than is often attributed to him, one that simply identifies

"from one's own explicit historical and cultural standpoint, salient philosophical "motifs" to clarify and enrich one's own account" (2017, p. 36).

In the same vein, on at least some interpretations (of which there are many), Husserl and Merleau-Ponty appear to adopt different positions regarding phenomenology's ontological commitments, or whether phenomenology defends a form of realism or idealism. Sebastian Gardner defends a reading of Merleau-Ponty as endorsing a form of transcendental idealism whereby the arguments in the *Phenomenology of Perception* carry metaphysical implications (Gardner, 2015).[2] Keith Allen, however, points out that Merleau-Ponty later wrote of his dissatisfaction with his treatment of idealism in the *Phenomenology*, and later attempted to clarify his rejection of it.[3] With this in mind, Allen interprets Merleau-Ponty as defending a form of naïve realism about perception, but one that nevertheless retains its transcendental nature (Allen, forthcoming). As with Merleau-Ponty, there is dispute over whether Husserl defended phenomenology as fundamentally realist or idealist, interestingly, a dispute which Husserl himself deemed fruitless (Husserl, 1930, p. 563). An interpretation of Husserl and Merleau-Ponty's positions on this is not something I wish to establish here, for as the brief survey of plausible interpretations of Merleau-Ponty above suggests, phenomenology can sit comfortably with multiple metaphysical views.

More importantly for my purposes here, I note another way in which Merleau-Ponty's phenomenology diverged significantly from Husserl's. Merleau-Ponty greatly enriched the phenomenological account of the role of the body in perception, and our embeddedness in the world through the body, using the concept of being-in-the-world to facilitate a more

[2] Gardner defends this interpretation of Merleau-Ponty in contrast to what he calls the 'psychological interpretation', whereby one can make claims about the nature of perceptual experience independently of any transcendental or metaphysical presuppositions.
[3] Merleau-Ponty's discussion of the 'flesh' in *The Visible and the Invisible* (1964/1968) was intended to work to rectify this.

comprehensive account of Husserl's life-world [*Lebenswelt*]. Merleau-Ponty writes in the introduction to part two of the *Phenomenology of Perception*: 'the theory of the body is already a theory of perception' (1962, p. 209). We can understand ourselves as *being* bodies as opposed to just 'having' bodies, or being in some other relation to them, making Husserl's concept of the *transcendental ego* redundant. We are embodied creatures embedded in the world, and so it makes little sense to conceive of ourselves as pure egos in some 'external' relation to our bodies, as Husserl had outlined the relationship. Rather, it makes more sense to hold that the body has a constitutive role in experience (Carman, 1999, p. 208). In this sense, on Merleau-Ponty's account, experience is grounded in the lived body.

### 3. Reductionist accounts of consciousness

In stark contrast to the picture sketched above, which I will later return to, a popular and particularly problematic perspective on consciousness in contemporary philosophy of mind holds that a proper explanation of consciousness can be provided through a study of the brain. Dennett (2001) defends this view.[4] On this view, a third-person perspective in natural science can fully explain consciousness without anything philosophically significant left to explain. This perspective is not a new one; in fact some sixty years earlier, Merleau-Ponty warned against the very sort of view Dennett proposes in his criticism of psychologists, where he writes that 'our experience, already besieged by physics and biology, would be entirely dissolved by objective knowledge when the system of the sciences was complete' (1962, p. 97).

Dennett acknowledges that his view is likely to be met with a visceral resistance, though he writes that what is important is that one ought not to attribute any value to this feeling: the

[4] Similar positions can be found in other reductionists and functionalists about consciousness (see Churchland 1986).

fact that we feel this way (Dennett calls it the 'Zombic Hunch') doesn't constitute a reasonable motivation for revolutionising how we look at consciousness. He writes:

> 'I feel it [the gut intuition that a third-person perspective in natural science cannot answer all questions of consciousness without philosophically significant residue], but I don't credit it' (Dennett, 2001).

Dennett's work on consciousness involves direct criticism of phenomenology, according to which criticism, phenomenological methodology does not and cannot qualify as a sound scientific method. Phenomenological descriptions express the subject's beliefs, are 'stories', and in no way reflect the 'real facts' about consciousness. Phenomenological descriptions can be useful, say, in predicting behaviour, if it is found that what is given in such descriptions matches up to what is really going on in the brain. Crucially, if such descriptions do not match up with the results of brain research, we can dismiss them, and conclude that the subject who expressed the beliefs in question was mistaken. So, for Dennett, phenomenology offers no reason to change the way we look at consciousness because it has no role beyond being a sort of descriptive preliminary to the truly 'scientific' study of the mind that we currently adopt, i.e., one that is neurocentric, objective and reliable. This reflects the view that a comprehensive account of consciousness can and should be reductionist; this pervasive perspective is something I will argue against throughout the chapter.

Another aspect of Dennett's criticism of phenomenology that is worth swift address is the accusation that it employs an introspectionist methodology, which is inherently unreliable. Phenomenologists, according to Dennett, seek to gain access to their minds by some 'introspectionist bit of mental gymnastics' (1989, p. 153).[5] This accusation demonstrates a

[5] Tim Bayne has also written that the phenomenologist's commitment to the claim that phenomenological method is distinct from introspection remains improperly defended (2004). My response to Dennett also speaks to Bayne's concern.

misinterpretation of the phenomenological positions set out in *at least* both Husserl and Merleau-Ponty. For instance, Husserl writes that the notion that everything must be either physical or psychical ought to be rejected (Husserl, 1966, p.338), and the idea of an introspective methodology is something that tacitly endorses the existence of this divide (Zahavi, 2007, p. 29). Similarly, Merleau-Ponty wrote that 'inside and outside are inseparable. The world is wholly inside and I am wholly outside myself' (1962, p. 407). Phenomenology straightforwardly rejects the view that consciousness is something that lives only inside the mind, separately from the world, and therefore straightforwardly rejects the accusation that the phenomenologist employs an introspective methodology.

Let us return to Dennett's claim that phenomenology offers no compelling reason to change the way we investigate consciousness. Do we have good grounds for revolutionising the science of consciousness? This depends on what our account of consciousness endeavours to do. I argue that if we want it to have meaningful context, and therefore sensitivity to the subject's embeddedness in the world, then it should. Some research in the medical sciences and psychiatry has criticised the unwavering commitment to an exclusively third-person methodology. Such debate is not entirely isolated from the problems with the rise of proponents of both physicalist and dualist perspectives. Those who belong to the former camp are encouraged by the promise of rigour and reliability in scientific method, where those who belong to the latter camp characteristically seek to defend the significance of first-person experience that cannot be accounted for on the physicalist's picture. The popular physicalist perspective in the medical sciences feeds these views in philosophy that either the physicalist picture gives us everything we need, or that the picture is still incomplete, and so there remains 'mind-stuff', or 'qualia', left over, which neither the natural scientist nor the non-religious person is expected to find meaningful. Neither position accommodates the subject's embeddedness in the world.

Amongst the ample physicalist theories within the philosophy of mind that attempt to overcome the Cartesian divide (functionalism, epiphenomenalism, eliminativism, etc.), the foundation of the mind shrinks to the brain (Fuchs, 2011, p.199). Alternatively, the dualist who commits himself to maintaining a defence of non-reducible mind-stuff is left with an inadequate toolkit when they attempt to explain their qualia, which works to undermine the meaningfulness of this 'feeling' aspect, providing convincing grounds for Dennett's 'zombic hunch'. In none of these options is the meaningful relationship between mind and life accommodated, and so the 'hard problem' of consciousness, as put forward by David Chalmers (1995), cannot be meaningfully solved. It will of course continue to be unsolvable as long as mind and life are conceptualised in such a way that they intrinsically exclude one another (Fuchs, *ibid*). The dynamic character of consciousness cannot be understood as long as we continue to work within the framework that individual conscious states can be translated into corresponding brain states. However, we seem to function in both the philosophy of mind and psychiatry as though they can in failing to accommodate the fact that the neurocognitive system and our experiential world are not one and the same, but are constitutively related.

Thomas Fuchs has highlighted and criticised contemporary psychiatric practice's operation within a 'biological paradigm', writing that psychotherapies that focus on understanding and empathy as opposed to any localised pathology are considered to be taking elaborate and unnecessary detours (2015). In addition, there is a pressure to obtain measurable results as is done in other medical disciplines, as opposed to having to support diagnoses on so-called 'soft' subjective data. Fuchs lists four crucial ways in which the biological paradigm in psychiatry shows itself (2015, *my translation*):

1. Reductionism: On a reductionist model, psychiatric problems are investigated at the neurobiological level, and so consciousness is seen in terms of neural mechanisms alone.

Fuchs highlights that on this picture, the sense of free will becomes something of an illusion – I will say more about this later.

2. Reification: Mental or subjective states are sought to be localised in the brain, and so once it is known where in the brain depression, for example, is caused, it is then taken that it is more effective to treat the patient pharmacologically, as opposed to attempting to understand and treat the subject's psychological condition.

3. Isolation: This perspective tends to separate the individual and their condition from their relationship with the world and their environment within which their condition was created and maintained.

4. Medicalisation: Once conceptualised as brain-processes, psychiatric disorders are interpreted as exclusively medical territory. On this picture, for example, shyness and introversion may be interpreted clinically as social phobias. This we might call 'pathologising' behaviour. This attitude has resulted in an increasing number of psychiatric diagnoses in the international classification systems.

This biological paradigm sets itself firmly within the third-person perspective which operates as the standard scientific approach, valuing reliability and quantifiability. Psychiatry in this way limits itself to capturing particular symptoms and behavioural markers (that might be considered reliable subjective experiences), endeavouring to classify specific abnormal behaviours and link them up with neurophysiological dysfunctions i.e. sub-personal causes. This is the kind of perspective that Dennett puts his faith in. On this picture, there is a failure to capture the experience of the patient as one *coherent whole*. Vital, meaningful aspects of human experience are nowhere to be seen in diagnostic materials, and consequently, we have lost the vocabulary to express and describe these phenomena. I will say more about this in chapter three.

The phenomenological concept that we are embodied beings in the world offers us a more plausible perspective on consciousness as an all-encompassing process, offering a more comprehensive account of the gap between mind, body and world that is grounded in bodily intentionality. As Merleau-Ponty wrote:

> 'Reflex, insofar as it opens itself to the sense of a situation, and perception, insofar as it does not first of all posit an object of knowledge and insofar as it is an intention of our total being, are modalities of a pre-objective perspective that we call 'being in the world' (1962, p. 81).

On this picture, consciousness ought not to be conceived of as some object localisable in the anatomical body (as a Dennettian approach would argue), nor a sort of purely mental state (as a traditional dualist might think), but as a process undergone through our relation to the world. That is, consciousness is an achievement that is *enacted.* We can make progress with our study of consciousness in the philosophy of mind and the medical sciences if we conceive of consciousness from a phenomenological perspective: as something that we live and enact through our feeling bodies.

Here we return to the concept of the *lived body* [*Leib*]. In rejecting the presupposition of mind and body as two fundamentally separate entities, the concept of the lived body offers a coherent perspective on the problem of the 'epistemic gap' that other conceptions are committed to fruitlessly trying to explain in an attempt to map physical properties on to phenomenal experience. This more holistic conception of consciousness puts emphasis back on the importance of how we as embodied subjects find ourselves in the world, and how the body is inextricably related to the life of the mind. Husserl, for example, writes that our lived body is never absent from the perceptual field, and that our organs of perception play a

constant role in consciousness. Our lived body is what grounds our stream of consciousness, our 'I-ness' [*Leibliche Ichlichkeit*] (Husserl, 1970, p.105-9).

## 4. Mental and physical illness

Such a distinction typically made between the mind and the body, or the mental and the physical, pervades our understanding of human experience. The experience of illness is a paradigm example. The reductionist distinction between mental and physical illness has its roots largely in Cartesian dualism of the 18th century, as well as in the introduction of the York Retreat as established by William Tuke of the Quaker community. The York Retreat introduced so-called 'moral treatment', as opposed to the typical inhumane treatment of 'lunatics' at the time. The lunatic's affliction was considered to be beyond the scope of the physician, but requiring a radically different type of medical intervention than would be received in cases of conditions with more obviously bodily symptomatology for which the subject was not considered to be afflicted by 'madness'. The successes of the York Retreat and the corresponding 'Period of Humane Reform' largely positively influenced public opinion in its unique and non-medical treatment of madness, or disorders of the mind (Kendell, 2001; Kibria & Metcalfe, 2016). From the success of this and similar facilities that followed, the view that mental illness was radically different in kind from physical illness in that it required non-medical, 'philosophical' treatment was consolidated.

With the sophistication of modern medicine since then, mental illness has since begun to be considered medical territory once more. However, for pragmatic reasons, the distinction continues to be employed, leading to a complicated and unhelpful picture of the nature of and relationship between mental and physical illness. Current medical materials, namely the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association,

1995), though they admit that the distinction is superficial and that boundaries between illnesses are 'porous', continue to use it because it allows for ease of use, and moreover, because there is no apparent appropriate substitute. Kendell proposes that the word 'mental' ought to be replaced with 'psychiatric' (2001). I find it difficult to see in what sense this replacement is helpful beyond replacing a word that has come to carry negative connotations, since beyond the stigmatising connotations one might associate with the word 'mental', the two words are largely synonymous. Even if this would prove to be a helpful step in that regard, still, use of either word continues to perpetuate the assumption that the two are radically different in kind.

As I will demonstrate in the following chapter, any consistent qualitative difference between the two is difficult to identify.[6] Regardless, there remains public opinion that symptoms of so-called mental illness such as depression are in some sense 'less real' than symptoms of straightforwardly physical illness. To suffer a mental illness seems to indicate that the sufferer of mental illness has more control over their condition, and so they are suffering as a result of some sort of lack of 'moral fibre' as opposed to any physiological lesion over which the subject has no control (Kendell, 2001, p. 492).

A revolt against this trivialising of mental illness can be found latching onto the cerebrocentric perspective that attempts to localise the physiological foundations of a mental illness in the brain. This is particularly prominent in cases of depressive illness. Though there are some physiologically localisable changes in the brain in cases of mental illness, since the subject's embeddedness in the world is entirely absent from such analyses, these identifiable physiological changes do not represent a complete explanation of the depression. This

[6] Kendell (2001) writes that the difference between mental and physical illness is 'quantitative' rather than 'qualitative'. I am taking this to mean that both so-called mental and physical illness are likely to *feel* similar, and are therefore often indistinguishable on these grounds, but it is the physiological basis of an illness that informs its labelling as one rather than the other.

approach, therefore, is still problematic in that in trying to remove blame, it eliminates responsibility, resulting in a sense of compromised free will on the part of the sufferer. On this picture, mental illness becomes a disease of the brain, and so the role of the self, and therefore of the subject's agency, is compromised: subjectivity and intentionality's reduction to physical descriptions therefore results in the subject's impotence (Fuchs, 2017). When such affective phenomena are reduced down to processes of the brain, there comes an identification of the self with the brain which naturally leads to the view of self as an illusion. Here the brain, the locus of our perception, merely feeds us representations of the world, and our position in the world is reduced to perceiving representations of the way that things 'really are', much like prisoners in Plato's cave.[7] The nature of experience cannot be represented in objective facts without loss, not because of elusive 'mind-stuff' or 'qualia' that is meaningfully distinct from the body, but because of the nature of 'subjectivity itself' of which the lived body, as opposed to the anatomical body, is the medium (Fuchs, 2017, p. 35). Since subjectivity is irreducible, it is not possible to develop a comprehensive picture of consciousness under a reductionist framework.

It is true that the agency of the self is important in cases of both so-called mental and physical illness. There is good evidence to believe that one's affective states can generate physiological changes that play a role in the creation and maintenance of so-called somatic illnesses with localisable pathology (2001, p. 491). Research on stress and immunology is an encouragingly striking example of this. The past twenty years has seen a strong body of evidence suggest that increased levels of inflammation identified in a significant number of patients diagnosed with neurologically localisable clinical depression has its origins in exposure to stress in childhood, or even in the womb, just as much as it does in direct exposure to inflammation (Pariante, 2017). It is not therefore the mind that becomes diseased in so-called mental illness, nor is it

[7] There are plenty of examples of this sort of view this in Metzinger (e.g. 2009)

the body that becomes diseased in so-called physical illness, but in both cases it is the entire self, the whole organism and its subjective world, that is afflicted.

As long as we continue to use these distinguishing terms, we remain held back by a confused hybrid of physicalism (as a result of 'cerebrocentric' medicalisation of mental illness) and idealism (as a result of defending the substantial difference in kind between the two) that prevents us from conceiving of illness as something that afflicts the entire self. As Fuchs writes:

> 'Materialism and subjective idealism paradoxically extend hands to each other as they ascertain the point they have in common: namely, that the subject has no part in the world' (Fuchs, 2017, p. 30).

An example of this is the commonly held cerebrocentric view that for example, a pain that is experienced as being in one specific part of the body is an illusion created by the brain. The conception of the lived body allows us to avoid this: the subjective space of one's pain and the objective space of where the pain is felt do not belong to two separate worlds which communicate with one another only through the brain, rather, the subjective and objective space of the body synoptically coincide (*ibid*). Merleau-Ponty makes a similar point:

> 'The patient bitten by a mosquito need not look for the point of the bite; he finds it immediately, because it is not for him a matter of situating it in relation to axes of coordinates in objective space, but rather of reaching with his phenomenal hand a certain painful place on his phenomenal body… a lived relation is given in the natural system of one's own body.' (1962, p.108)

I can meaningfully state both that I am experiencing a pain in my leg, as an affliction to my lived, feeling body, *and* refer to the same space in my objective body in which the pain is experienced in medical treatment (Fuchs, 2017). The lived body encompasses synoptically

both the subjective, feeling body, and the objective body. This embodied perspective offers a more comprehensive way of understanding illness, that is, as a disruption to the whole self.

## 5. Significance for understandings of pregnancy

For pregnancy and early motherhood, which will become the main focus for this thesis, there are similarly undesirable consequences of the adoption of the reductionist paradigm in the medical sciences discussed above, namely the belief that the reality of one's situation is detached from its subjective, embodied experience. That is, that proper knowledge about one's situation is to be gained from the medical perspective as opposed to from what is given through first-person experience. Though what is given from the first-person perspective might correlate with what is thought to be 'really' going on at the naturalistic level, it is perceived to be a less reliable guide to the reality of one's situation. The naturalistic explanation therefore has epistemic priority.

This kind of perspective compromises the pregnant woman's agency in medical situations, undermining the woman's confidence in interpreting her own experience since medical knowledge is perceived to be the most legitimate sort of knowledge about one's condition. This perspective has been criticised for fostering reliance on the visual paradigm of knowledge of one's pregnancy, under which one perceives one's objective body *as an object* (Freeman, 2014, p. 2-3). This too feeds the belief that knowledge derived from other sense modalities is less informative, which works to invalidate the legitimacy of women's embodied experience (*ibid*). It is the dominance of an epistemology based on the visual sense that reinforces the view that our embodied experience is less significant than what we can see from a medical scan (Fuchs, 2017, p. 31). Though medical information is informative and useful for predictions (and an ultrasound scan, for example, might be personally meaningful to those interested in the life of the baby), what is harmful is the paradigm that the

information that is gained under the reductionist, naturalistic paradigm is the most meaningful sort of information. On this picture, embodied experience is demoted, and such 'feeling' experiences are attributed to the illusory sensations that are produced by the brain.

Moreover, this perceived asymmetry between the legitimacy of knowledge gained through embodied experience and that which is gained through the standard third-person naturalistic perspective in medicine can work to undermine the relationship between patient and physician. Where it is thought that the only way for the woman in question to gain 'real' knowledge about her condition is to be told about it by a physician, should what she is told is 'really going on' not converge with her embodied experience, the woman may feel as though she is left with an inadequate toolkit for attempting to understand the way that her experience presents itself to her. I will say more about this in chapter three.

**6. A motive for a moderately naturalised phenomenology**

As we know, if we want to take the concept of the lived body seriously, it is clear that we must show that there is something missing from a reductionist study of the body. My complaint so far has been that it is misguided to base our understanding of our bodily experience exclusively on what is able to be determined by a study of the purely anatomical body. Crucially, since the body is the medium of our engagement with the world, it makes little sense to study the body from an objective, third-person perspective, and as a separate project, investigate it in its relation to the world (Zahavi, 2002, p. 21).

However, it should be clear that this complaint is not intent on rejecting the achievements and findings of a paradigmatic naturalistic study of the body, which is good at and for many things. Rather, it is a call for a scientific method that is prepared to meaningfully incorporate the lived body into its scope of concern should it wish to identify an approach that is truly holistic, which in psychiatry, it surely should. This necessarily requires engagement with the

first-person perspective. I will show that in light of this, there is good reason to suggest that the most promising way of encouraging psychiatry to incorporate the subjective into their methodology, is to be open to the prospect of a moderately naturalised phenomenology.

First, it is important to note that a common worry for contemporary phenomenologists is that phenomenology as an exercise in transcendental philosophy makes the idea of fruitful engagement with the positivistic sciences seem unattainable, or that conversely, whatever naturalistic phenomenological resources we might establish in the sciences lose the right to be called philosophical phenomenology (Moran, 2013). Characteristically, in undergoing transcendental phenomenology we are seeking to expose fundamental structures of experience available through my first-person perspective as given to me in 'prescientific life', as you find it, having bracketed objective scientific opinions characteristic of the 'naturalistic attitude' (Husserl, 1970, p.122). On this picture, being an advocate of a naturalised phenomenology carries a sense of compromised loyalty to classical phenomenology's transcendental aspirations. The worry here is then that in naturalising phenomenology we are abandoning the core of the phenomenological method and therefore abandoning that which has philosophical significance. Or as summed up succinctly, and ominously, by Zahavi:

> '[Naturalised phenomenology] is not phenomenology understood as a philosophical discipline, tradition, or method' (2004, p.340).

I am sceptical that this has to be the case. Whether it is true or not is dependent on what is, or ought to be, required by naturalisation. Zahavi (2004) offers four perspectives with varying degrees of hostility to phenomenology's interaction with scientific naturalism that the phenomenologist might adopt. The fourth of these perspectives proposes that there can be fruitful exchange between transcendental phenomenology and the empirical sciences. As follows:

> ‘Perhaps it can even be naturalized in the sense of “contributing to the project of naturalization.” But of course, if this view is advocated it has to be realized that such a naturalization will not only lead to a modification of transcendental phenomenology, at the same time it will also transform the very concept of naturalization…’ (2004, p.343)

Here the thought is that we might still be able to naturalise phenomenology without doing some of the other things to it that are typically, and misguidedly, associated with naturalisation, namely the reducing and objectifying that is characteristic of the dominant paradigm. I would argue that this approach to the relationship between phenomenology and the natural sciences has potential to cultivate the best results, and is much compatible with the resources that have so far been developed - which I will say more about shortly. My conviction is that we can offer good arguments in favour of a transcendental phenomenology that can be engaged in mutually enriching practice with empirical science, *so long as* we can secure an attitudinal shift in scientific approaches to consciousness whereby we recognise that subjectivity is irreducible, and therefore that phenomenological explanations do not need to be reduced to physiological processes in order to be complete. We can engage constructively with the empirical sciences, *and* retain value in subjective phenomenological descriptions.

Importantly, the picture of phenomenology we have here is still philosophically significant. For example, as defended by Zahavi, Merleau-Pontian phenomenology requires confrontation with the empirical sciences if it is to develop properly, and that this can happen without reducing phenomenology to another ‘positive science’ (2004, p. 342). This is of course not to propose a form of naturalised phenomenology whereby phenomena can be ‘mathematised’. Rather, it is to propose a form of naturalised phenomenology whereby the accounts provided by the empirical scientist and the phenomenologist are different but intrinsically joined, i.e.

the two are *cooperative*. For the phenomenologist to adhere to the naturalist's framework as it is often offered, as objectivistic and reductionist, undoubtedly necessitates a sacrifice of the subjective. However, crucially, naturalism need not, and indeed should not, be reductionist.

**7. Existing resources**

There are good existing examples of this proposal. In recent years, more contemporary phenomenologically-motivated medical materials have come to be established.[8] The Examination of Anomalous Self-Experience (EASE) developed by Josef Parnas et al (2005) is a prime example of this. The EASE is a semi-structured resource, principally inspired by philosophical phenomenology,[9] used for targeting disorders of subjective experience such as schizophrenia. This psychometric resource, now in practice in Denmark, requires conceptual understanding of the nature of disruptions to the self as provided by the inherently philosophical sort of phenomenology. The EASE highlights the legitimacy of the wider project of philosophical phenomenology inspiring and motivating frameworks for medical resources that are sensitive to, directly concerned with, and crucially, informed by, subjective experience. Of course this initiative does not reject all standard naturalistic approaches to psychiatric disorders such as schizophrenia, for, say, the development of antipsychotic medication necessarily requires the employment of a reductionist methodology for at least some aspect of its development: what is resisted is that a comprehensive grasp of the patient's disorder can be entirely realised through the employment of reductionist methodology i.e. appeals to reductionist neuroscience.[10]

[8] See Carel (2011) for discussion of other recent resources of this kind.
[9] The mid-20th century also saw Husserl and Heidegger's phenomenology influence practice in psychoanalysis, inspiring a form of anthropological psychiatry that would later be called *Daseinsanalyse.* In having functioned largely in blissful isolation from what would now be considered natural scientific approaches, this branch of psychoanalysis bares little on my argument here, but remains interesting (see Binswanger, 1968).
[10] For more on types of reductionism and appeals to neuroscience in psychiatry see Schaffner (2013).

There has also been compelling research examining whether mindfulness-based cognitive therapy is effective in preventing relapses in chronic depression, and moreover, how the therapeutic process is experienced by the patients (Malpass et al, 2012). The study was able to identify shifts in the way that patients come to experience the self and their illness, as well as points in treatment at which patients are most likely to experience difficulties.

In both of these cases, the phenomenological accounts are meaningfully incorporated into a scientific, but not a reductionist, framework. The perceived legitimacy of 'subjective' data is not dependent on the scope of a pre-established reductionist scientific methodology. Such resources recognise that subjective experience, simply by virtue of being subjective, cannot and should not be reduced to objectivist explanation.

The types of resources above may be considered successful tasks in naturalised phenomenology: the phenomenologist and the empirical scientist here are engaging in a mutually-enriching enterprise, offering different but complementing approaches.[11] It would also seem as though little of what is philosophical about phenomenology has been compromised as a result. In both pieces of research the phenomenological data, encompassing idiosyncrasies between subjects, is guiding. Of course, here the phenomenological data itself has not been reduced, and I do not see convincing grounds for thinking that this is problematic.

## 8. Irreducible phenomenological data

'Neurophenomenology' might be regarded as a prime example of undergoing a stronger naturalisation of phenomenology, whereby in our study of consciousness, the phenomena of experience and cognitive science are mutual constraints on one another (Varela, 1996). The

[11] We might think of this as an example of 'explanatory pluralism' (see Kendler, 2005).

neurophenomenologist claims that the naturalisation of phenomenological descriptions necessitates their mathematisation, and that the recent progress of science has shown that Husserl's case against the naturalisation of phenomena is now invalid (Petitot, 1999). This is a misrepresentation of the foundations of Husserl's philosophically motivated anti-naturalism: Husserl staunchly opposed the mathematisation of philosophy on the grounds that philosophy cannot be defined mathematically simply by virtue of its philosophical nature (Husserl, 1983). Husserl's anti-naturalism was not grounded in the complaint that scientific methodology is not yet sophisticated enough to mathematise experience without loss, but that the very nature of the naturalistic project already excludes subjective experience. It is missing the point to insist that in order to make progress, phenomenology ought to abandon its criticism of naturalism and just "get comfortable with it" (Ferry-Danini, forthcoming). The phenomenologist is not necessarily opposed to the sciences or cooperative engagement with the sciences, but is necessarily opposed to the view that the products of a phenomenological investigation might be reduced to objective explanation without loss.

It is hopefully clear that the phenomenologists are not resistant to the sciences *per se*; it is instead the case that phenomenological literature attacks methodological shortcomings that are characteristic of scientific investigation. I am resisting the view that phenomenological data is valuable only once it has been 'validated' by reductionist, natural scientific investigation. We can be open to a weak naturalisation of phenomenology, and yet still maintain that phenomenological data has value independently of its correlation with a reductionist and objectivist natural scientific explanation. Dennett's complaint that if the phenomenological descriptions do not 'match' the third-person evidence we have cause to deem them mistaken much bypasses this point: phenomenological data is of value to us simply by virtue of the fact that what is reported informs us about the nature of the subjective experience. How phenomena are presented to us is a constituent part of the nature of

consciousness. No account of consciousness can or should be considered complete that does not accommodate the subjective.

It is possible to remain critical of scientific practice, but be open to the idea of engagement with the natural sciences in order to engage in a mutually illuminating dialogue between the two. Here we go some way in satisfying Merleau-Ponty's call for phenomenology to understand its relationship with non-phenomenology. When phenomenology and naturalism can share the same explanandum, phenomenology can become problem-orientated in line with the wider naturalistic project, and therefore make progress with practical issues such as those in psychiatry.

I have so far tried to show that the phenomenological conception of mind is preferable to its most popular competitor approaches in the philosophy of mind and psychiatry. Here we have a philosophy that is both appropriately faithful to subjective experience and that can speak meaningfully to natural scientific investigations. Chalmers has written that the science of consciousness can be 'robust' and successful without us having to have a solution to the mind/body problem: he proposes that we can remain neutral on such philosophical questions with our science of consciousness unaffected (2004, p.11). This, I think, is a mistake: for a comprehensive account of consciousness, our philosophical positions regarding the mind should to some extent accommodate our scientific positions regarding the mind and *vice versa*. For this, I have suggested that the phenomenologist needs to be open to a weak naturalisation just as the scientist, or in our case here the psychiatrist, needs to adjust their attitude towards consciousness so as to accommodate the subjective. I echo Ratcliffe's sentiment here that ideally, the foundations of consciousness studies would be wholly recharacterised as to better accommodate the phenomenological view of the relationship between mind, body and world. Practically, though, if we want to make headway with issues such as those in psychiatry, we ought to rather aim for an *attitudinal shift* (2013a). A similar

position can be found in Carel's *Phenomenology of Illness* (2016), in which she discusses the need for phenomenology as a 'supplement', a vital part of which being an attitudinal shift by which experiences of illness are better recognised and understood by clinicians. This brings me on to my second chapter, which is concerned with illuminating the nature of experience amongst women throughout pregnancy and early motherhood.

## Chapter 2

### *The Phenomenology of Pregnancy and Illness*

### 1. Pregnancy and illness

This chapter will examine the phenomenology of pregnancy and early motherhood, particularly in women suffering from, or vulnerable to suffering from, depression (or something phenomenologically similar to it). This account does not intend to represent the experience of all such women, nor is it concerned only with those women who have received a clinical diagnosis of ante or postnatal depression. Indeed it is possible for one to have poor health but be undiagnosed, whether that is due to lack of consultation or because consultation concluded that the state is not sufficiently severe for diagnosis.

My account is interested in structures of experience in such women that are phenomenologically like depression (or indeed other illness) experiences. I use the term 'depression', in order to refer to 'depression-like experience'. For my task at least, it does not seem necessary, or even desirable, to seek to identify the presence of some physiological basis, or cause, (such as a bio-marker) in order to distinguish a depression-like experience from a symptom of clinical depression. Indeed it is unclear how one ought to differentiate between a 'healthy' or 'normal' pregnancy experience that is nevertheless depression-like,[12] and an instance of depression that is caused in some way by pregnancy.[13]

[12] There is a lot to be said about norms in health, though I do not have the space to discuss it here (see De Block & Sholl, forthcoming; Ryle, 1947)

[13] The same argument runs for many other conditions: for example, chronic fatigue experienced as a symptom of anaemia may give rise to depressive symptoms, but it is unclear whether or not one ought to hold that depression is a symptom of anaemia.

One plausible possibility might be that, though the nature of experience throughout pregnancy may not be in itself sufficient for depression, it may predispose the woman towards phenomenological changes that are.[14] Another possibility might be simply that the ways in which experience alters in depression and in pregnancy can be similar. With this in mind, my aim here is to study phenomenological changes in various forms of illness experience, especially depression, and explore how pregnancy may involve similar shifts in experience. By studying the phenomenology of illness, structures of experience in pregnancy with phenomenologically-rich structural similarities can be illuminated such that we can develop a better understanding of vulnerabilities to depression during and following pregnancy.

To begin with, it is worth providing a defence of what might seem to be an uncomfortable equation between pregnancy and illness. I work here from the picture of illness as involving:

> '…the experience of one's symptoms and bodily changes, but also the experience of receiving healthcare and experiencing social attitudes towards illness and disability, pain, grappling with one's mortality, and negotiating what may become a hostile world' (Carel, 2017, p. 17)

'Illness' here is concerned with its *experience*, its qualitative dimension, rather than any 'facts of disease', since the two can come apart (*ibid*). With this in mind, this definition seems plausible.[15] However, it seems as though, on Carel's picture, the pregnant woman is likely to qualify as being in a state of illness in at least some stage of her pregnancy. In pregnancy, the woman is sure to experience bodily change, some drastic and some more

[14] See Ratcliffe (2015) for more on this discussion with regards to depression and somatic illness.
[15] It is not clear, however, whether these are sufficient or necessary conditions for illness, though Carel did not intend to offer such an account. It seems obvious enough that one could be ill but not be in pain, and conversely that one could be in pain and not be ill. Moreover, there are arguably cases of illness where one is not forced to confront one's mortality, and again, there seem to be people who do, who are not ill. This just about scratches the surface of the great difficulty in attributing illness to a subject.

elusive, as well as pain or discomfort, again, some more intense and some more subtle - as does the person we might more readily attribute illness to. Some loss of normally assumed ability is common too, which requires adjusting to in pregnancy as it does in illness. Moreover, navigating social attitudes and adjusting to changes in how one is treated and perceived by others is a pressure felt by both pregnant women and people with more obvious cases of illness.

Adopting the position that pregnant women's experience is an illness experience seems like an unattractive position, and so one might think here that the definition of illness needs tightening in order to exclude illness experience being likened to the experience of pregnant women and consequently pathologising pregnancy. The problem comes in trying to identify loose ends in the definition: since we are interested in the experience, the 'feeling' dimension, we cannot distinguish between illness and health on biological or physiological grounds, so one must work to distinguish the two phenomenologically.[16]

One straightforward potential avenue for distinction might be that illness is experienced as negative where, for many women, pregnancy is a positive experience. There is a commonly-held perspective that illness is a meaningless experience of suffering, representing compensationless disruption, suffering and incapacity; indeed it is unclear to many what the value or the purpose of an illness experience is (Kidd, 2012, p. 503). This is of course not true of pregnancy – at least in most cases. It is true to say that the contemporary public opinion is that pregnancy is a largely positive experience in the sense that it is not a 'disaster that strikes' as we often think illness is (Carel, 2017, p. 131); rather we look forward to it, plan it,

[16] See Carel (2017) for discussion on 'disease-illness coupling'. Carel notes that though illness and disease do usually come together, the two can and do come apart: indeed it seems that one can be ill without being diseased, and diseased without being ill. Since it appears that one can be ill without being diseased, i.e. without any identifiable physiological basis for an illness experience, our account of illness should hold independently of whether any disease-illness coupling holds.

volunteer for it. It is a positive experience in that it is *for* something, due to the fact that it is experienced in anticipation of the birth of a child which is also widely thought to be valuable.[17] In this sense at least, it looks as though the two experiences are intrinsically phenomenologically different. I will argue, however, that this is not necessarily the case, and so this distinction does not get us very far.[18]

The belief that illness experience must be experienced as negative rests upon a pathophobic conception of illness that can and ought to be challenged (Carel, 2017, p. 131). This standard conception even has its roots in the etymology of the word 'ill', describing something harmful, unfortunate or even evil. Building on the work of Kidd (2012) and Carel (2017), I defend the view that illness can be compatible with well-being, and can in fact afford edification. Once we examine and undermine the standard conception of illness experience as necessarily negative, we can more comfortably investigate the phenomenologically-rich structural similarities between illness and pregnancy.

There is a strong body of empirical research that suggests that for a number of reasons, illness need not, and often does not, result in any significant decrease in well-being. It appears to be the case that we are more resilient to distress than we might anticipate when we are in good health. One of these pieces of research studied levels of psychological and physical distress amongst cancer patients, finding that psychological distress or 'symptoms' did not automatically accompany physical distress (de Haes et al, 1990, p. 1036). We are able to say more than just that illness does not necessarily decrease levels of well-being in those who experience it. It is not just the case that well-being can persist through illness, it is reasonable

[17] There are certainly philosophical positions which defend the view that coming into existence is bad for us (see Belshaw, 2012), but this view is uncommonly held, and so I will say no more about it here.
[18] What might be said about cases of rape if one favours this distinction, for example? There seem to be many bad reasons for holding that the woman pregnant through rape, as well as other cases of unplanned pregnancy, is ill where the woman pregnant through choice is not.

to think that illness can in fact afford growth, flourishing and edification (Carel, 2017, p. 131). An experience of illness may, for example, afford me with a new sense of courage or appreciation for life or relationships which in my previous good health I lacked.[19]

For now, I will suggest that pregnancy can involve similar experiences to those in illness (that are compatible with wellness), including depression-like experience (which is less compatible with wellness). I also wish to claim that disposition to this, with particular focus on the latter, can be dependent on the interpretation of experience, which is heavily influenced by psychological as well as cultural and social context (Carel, 2017, p. 132).[20]

We can therefore say that pregnancy is 'like' illness in terms of the essential structural properties of the experience; the two experiences, then, can be alike in a phenomenologically-rich structural sense. Without asserting that pregnancy *is* an instance of illness, we are nonetheless able to investigate their likeness in order to illuminate the structure of pregnancy experience. I will now focus on illuminating the phenomenology of more straightforwardly 'somatic' illness in order to illustrate how similar shifts in experience may affect pregnant women.

## 2. The intentional arc and possibility space

I first explore how specific changes as part of an experience of illness influence the entirety of one's conscious life. For this I turn to Merleau-Ponty's description of the intentional arc. The intentional arc can be thought of as a pre-intentional, though changeable, state of being that determines what kind of perceptual experience is possible. It dictates the way that we find ourselves in the world, that is, our sense of being in the world. As Merleau-Ponty writes,

[19] Kidd's discussion of virtue ethics helps to flesh out the thought that illness facilitates opportunities for the cultivation of virtues, which in turn, can improve one's chances of coping with changes (Kidd, 2012, p. 502).
[20] Such factors might be thought of as indicating the subject's vulnerability. Ratcliffe entertains a similar thought in his discussion of those 'prone to wobbles in the sense of reality' (2013a).

consciousness's intentional structure determines 'what our reflexes and perceptions will be able to aim at in the world, the area of our possible operations, the scope of our life' (1962, p.92). Each localised disruption, for example in illness, affects consciousness in its entirety, since consciousness is an activity of projection, the nature of which is established by its previous actions in the world. Though we can say that in illness, there are often specific lesions or changes on the physiological level, the whole of consciousness becomes vulnerable (*ibid*, p. 138).

Ratcliffe's discussion of existential feelings is helpful in making explicit how bodily feelings and disruptions to consciousness are linked. 'Existential feeling' is a unifying term used to refer to a distinct form of affective phenomena which our existing labels, i.e. emotion, mood or feeling, would split up. They are not the same as bodily feelings, though the body is often very much involved in them as the medium through which they are most strikingly experienced. There are instances in which some existential feelings might be felt almost entirely as a bodily experience, such as an experience of severe anxiety that is constituted by a sense of bodily tightness or confinement, where, for example, all that the world seems to offer is threat (Ratcliffe, 2015, p. 59).

Here one's orientation in the world, and the way of being in it as a whole faces disruption, and the subsequent experience of anxiety is very much a bodily experience. In cases like anxiety, the experience is such that what the world offers is restricted. This is one example of a shift in existential feeling that restricts possibilities. It is a disruption to both the self and one's relation to the world. As I will demonstrate, possibility structure is deeply embedded into human experience, and shifts in existential feeling affect what possibility space we can inhabit. That is, changes in existential feeling are experienced as what possibilities are open to experience. Much like in other cases of illness experience, in pregnancy and early motherhood, one experiences, or is at least disposed to experiencing, a restriction of

possibilities. Moreover, so I will show, this restriction of possibility can be felt most strikingly as an experience of the lived body.

## 3. Bodily doubt

One particularly striking case of bodily feeling in the restriction of possibility space is Carel's notion of bodily doubt in illness. In good health, she argues, we have a tacit sense of bodily certainty that characterises our normal everyday experience as embodied subjects. We have trust in this relationship, though as healthy subjects, it is not the subject of our explicit reflection (Carel, 2013, p. 2). We have implicit faith that our bodies will do as we intend, for example, that our legs will support us when we walk up the stairs, or that we can bend to put on our shoes without pain or discomfort. This is not something that we meditate over and justify, rather, we do not think about it at all. We possess an in-built trust that our body will respond to our action in a certain way, a way that is harmonious and familiar. In this healthy state, mind and body are integrated with one another such that bodily processes are transparent to the world (Fuchs, 2005, p. 95). Conversely, in illness, for example, where bodily certainty is disrupted and replaced with bodily doubt, that transparency is compromised.

Where bodily certainty is disrupted, attention is withdrawn from the world and thrust onto the body (Carel, 2013, p.6). The faith in one's body that had previously gone unquestioned is now under scrutiny, and one is forced to confront the reality that one's bodily scope is restricted. That is, the scope of one's bodily movement and engagement with the environment becomes narrower. With restriction of bodily scope, comes a restriction of worldly possibilities. This inability to engage with the world in a way which was once habitual frustrates bodily intentionality, and creates the feeling of bodily failure. The notion of frustrated bodily intentionality is clear in Merleau-Ponty, where he writes: 'consciousness can

be seen attempting to maintain its superstructures even though their foundation has collapsed. It mimics its customary operations, but without the power of obtaining their intuitive realization and without the power of hiding the strange deficiency that steals from them their full sense' (1962, p. 139).

Merleau-Ponty identifies our sense of being in the world as involving a bodily sense of 'I-can' (1962, p.146). This sense of 'I-can' has authority over what possibilities in the world are open or closed to us. On this model, we can see the sense of doubt in the subject's ability to perform normal tasks, as a negation of this 'I-can' structure, where possibilities that for the healthy subject had not previously been even considered possibilities are now closed, or feel out of reach. Examples of this in pregnancy might include nausea and dizziness, and the corresponding inability to attempt and complete tasks which had previously been anticipated and completed without hesitation.[21] With the closure of worldly possibilities, focus turns inward, and the intentional impulse of the subject's experience is compromised. As long as focus is inwardly-directed as opposed to world-directed, an anxious fixation on the body is maintained.

Since body and world are inextricably linked, this feeling of distrust in the body bleeds into a distrust of one's world. One's sense of being in the world finds itself under threat, and engaging with the world, and with others, becomes difficult. Here the habitual, confident anticipation and actualisation of possibilities that is so integral to a feeling of comfortably being in the world is compromised (Ratcliffe, 2015, p. 68). Since this sense of bodily certainty exists tacitly for us, one only becomes aware of the sense of bodily transparency

[21] For discussion of similar obstacles in other illnesses, see Carel (2016) on breathlessness. One might also think that one might undergo similar experiences in other cases that are perhaps more obviously not cases of illness, such as loss of practice in sport, rapid weight gain or loss, or puberty. Though I would resist equating such cases with cases of illness, the possibility of phenomenological similarity between the two experiences may still be recognised. There may, therefore, still be scope for opening up the existing literature on the phenomenology of illness to the analysis of such phenomena. Whether this encourages a revision of how we characterise illness remains subject matter for further research.

that once was when it is lost, and conversely in good health, it ceases to be an object of reflection or us; as Jessica Friedmann writes in her essays on postnatal depression, 'when I am well, the body wants to forget' (Friedmann, 2017, p. 99).

A comparable case of this might be the experience of navigating the world with a bad back. Here one might be required to move gingerly or avoid certain 'normal' bodily movements in an effort not to cause pain to the site of the discomfort. Here then engaging with the world in the 'normal' way is difficult, and one is required to make adjustments to the auto-pilot way in which actions are aimed at. This involves a change in one's orientation in the world. I will now explore in more depth how such phenomenological changes might arise as part of an experience of pregnancy.

### 4. Habit and the body schema

I propose that struggling to adjust to changes in the body schema can be partially responsible for experiences of bodily doubt. This would apply most notably to changes affecting the inhabited bodily space, such as illnesses that involve use of a wheelchair or the loss of a limb, and importantly here, to changes to the extension and spatiality of the body in pregnancy. Here the healthy body as transparent, as an 'indivisible possession', may find itself under threat. Merleau-Ponty refers to this transparency of the lived body in health as the 'darkness of the theatre required for clarity of the performance' (1962, p. 103).[22] In this sense, the body as transparent is necessary for the good health of the lived body and therefore appropriate engagement with the world. In other words, one might say that a case of a struggle to adjust

[22] It is worth recognising that feminist critiques of Merleau-Ponty have accused his account of the body of being insensitive to certain peculiarities of the body that are prescribed by gender (see Sullivan 1997). One such complaint is that, for women, it may be the case that even in good health, the body is never fully transparent as it is for men. My view is that this can be true with us still able to defend the view that anomalous experience thrusts the body under the spotlight in a way that differs significantly from how the body is standardly experienced. I also do not think that Merleau-Ponty's theory of the body necessarily fails to accommodate such peculiarities (see Stoller, 2000).

to the changes to the body schema in pregnancy can result in a failure to incorporate the pregnant body into one's overall bodily plan (1962, p.101).

Merleau-Ponty's concept of habit will help to flesh out this thought. In the acquisition of habit, the body has 'understood' the body's motricity, where understanding here refers to experiencing the accord between that which is aimed at and that which is given (1962, p.146). To use Merleau-Ponty's example, where the blind man has acquired the habit of using a cane to navigate his environment, things immediately appear passable or impassable for the body and its appendages. By virtue of this, the cane has become part of the blind man's body schema. To habituate oneself to something is to 'take up residence in it', that is, for it to become part of one's bodily space (1962, p. 144-6).

Iris Marion Young is critical of Merleau-Ponty's identification of the healthy body as a transparent, indivisible possession. She volunteers pregnancy as a paradigm case whereby the body can be enjoyed as a physical object without suffering a breakdown of one's relationship with the world that carries a corresponding sense of alienation or estrangement. Young does however write that in pregnancy, the effort and resistance characteristic of all movement is felt strikingly and consistently (Young, 2005, p.50-53). I would argue that though one need not necessarily suffer here, the relationship with one's world here is still radically altered. Young's own descriptions seem to suggest that this is true:

> '…the solid inertia and demands of my body call me to my limits not as an obstacle to action, but only as a fleshy relation to the earth. As the months proceed, the most ordinary efforts of human existence, such as sitting, bending and walking, which I formerly took for granted, become apparent as the projects they themselves are… in the experience of the pregnant woman, this weight and materiality often produce a sense of power, solidity, and validity'

> ‘In pregnancy I do not have a firm sense of where my body ends and the world begins. My automatic body habits become dislodged; the continuity between my customary body and my body at this moment is broken’
>
> (*ibid*)

This is consistent with my claims above that pregnancy is not necessarily experienced as negative, but that pregnancy includes, or can include, many of the phenomenological changes that are characteristic of illness experience. I will say more shortly about the factors that might influence the interpretation of such experience as negative or threatening.

Regardless of their interpretation as threatening or enjoyable, bodily changes in pregnancy can highlight the difficulty in adjusting to one’s altered body schema. Discussions on online fora about difficulties with spatial awareness and judging one’s bump are in line with this thought, with women reporting a tendency to misjudge small gaps, walking into things, and people, even though they ‘know’ that their pregnant stomach protrudes out in front of them. Pregnant women have also been able to articulate that they are prone to moving in the world as though they still have their pre-pregnant body, which might involve sucking in one’s stomach in order to let people past, or attempting to squeeze through small spaces. Young’s own description is very similar:

> ‘I move as if I could squeeze around chairs and through crowds as I could seven months before, only to find my way blocked by my own body sticking out in front of me – but yet not me, since I did not expect it to block my passage.’ (Young, 2005, p. 50)

In pregnancy, change in body shape and size is so alien and rapid that the sort of pre-reflective constant adjustment that is usually engaged in in skill-acquisition may not take

place, and therefore the changes to the body do not take on significance. In other words, the experience is such that it does not afford the opportunity to properly employ one's 'practical wisdom'.[23] The pregnant body, then, may not be incorporated into the body schema of the pre-pregnant body, and so one continues to act in the world as though through that pre-pregnant body: 'the prepregnant body image does not entirely leave my movements and expectations, yet it is with the pregnant body that I must move' (Young, 2005, p. 50). As is echoed in the reports above, although the change in size and shape of their objective bodies is open to perception, and is 'known', the lived body has not incorporated the pregnant body into its schema. Where for the blind man, the cane becomes a 'sensitive zone' used for touch in a way much indistinguishable from the hands, the women here are struggling to 'habituate' themselves to the pregnant body, for habit does not reside in thought nor in the objective body (1962, p.144-6).

This is reminiscent of a claim made by Toombs, a phenomenologist who suffers from chronic progressive multiple sclerosis, that illness involves a sort of ambiguity of *own body*, stemming from a transformation from lived body to object body (Toombs, 1988). Experiences of being looked at as an ill person have been described as forcing the subject towards a recognition of the brute fact of being 'physico-biological stuff' *(ibid,* p. 216). Toombs writes that experiencing this facticity of the self, in existing for the other as the object-body under scrutiny, the body as 'other than me', is an experience of alienation. There is a felt tension in being both at once the lived, feeling 'own-body', and the brute anatomical 'object-body' that is highlighted in illness. Although I have acknowledged that in pregnancy this experience of the body as object does not necessarily afford alienation (though it surely can), the pregnant woman's experience of the clinical encounter in pregnancy can be

[23] See Gehrman (2016) for discussion on absorbed coping and practical wisdom.

recognised as one environment that might make women particularly vulnerable to this feeling: one is aware both of what it is like to be the feeling subject carrying a baby, but is led in the understanding of one's situation by medical information provided by clinicians. Lauren Freeman discusses a similar problem that she calls 'panoptics of the womb' (2014), whereby the power of clinicians to provide information about women's experience puts the women into a state of epistemic powerlessness. I will focus on this particular sort of problem in chapter three.

So far I have painted a picture of the phenomenology of illness as one that can have influence over ones affective states, using words like 'alienation', 'frustration' 'anxiety' and 'doubt' in descriptions of experience characteristic of illness. Though illness can be compatible with well-being, it is clear that illness experience, and depression experience in particular, can have a profoundly destructive influence over our affective life. This brings me to the investigation of the ways in which pregnancy experience can feel like depression experience, particularly in women who have had a depression-like experience in the past.

### 5. Temporality

Notice in the above discussion of possibilities the reference to the *anticipation* of possibilities as well as the restriction of their actualisation. In illness we can identify a disturbance to the anticipatory structure experience, the 'if-then' structure which is so deeply rooted in the lived body. In good health, one acts in light of goals that relate to future possibilities (Toombs, 1988, p. 212). In illness, and with the particular kind of disruption to the lived body that is characteristic of illness, one is restricted by their condition so that they become confined to the present, preoccupied with the demands of their current state. Toombs writes, 'life projects must be abandoned, postponed or modified' (*ibid*). In these conditions, the scope for goal-directed anticipation is constricted as future possibilities seem beyond reach, and the

character of the future has been altered as a result of the change in the character of the present. All of this influences the way in which one exists in the world.

The character of temporality is integral to an experience of bodily doubt. The experience of bodily doubt may be less pervasively world-altering where there is an understanding that one's experience is temporary (Carel, 2013, p. 7). Longer lasting experience, or experiences that have an unpredictable duration, may involve a more severe case of bodily doubt, and therefore require adjustment to a more radical transformation of one's existential orientation in the world that threatens to be permanent.

In a case of common influenza, for example, the subject has an understanding that whatever the illness experience is like, it will not be this way for long, and one's experience will soon return to normal. In other words, the timescale of such a disturbance is relatively predictable (Ratcliffe, 2013b, p. 213). In this sense, one's habitual body, and in turn one's orientation in a habitual world, is not compromised; the experienced changes are not such that they require any radical existential adjustment to. Whatever disruptions to the body are experienced, the subject's relationship with their body is not questioned. Implicit in the subject's existential orientation is the tacit sense that this illness experience is a period to be endured. This anticipatory structure is still intact; the subject here still exists in sight of the fulfilment of future possibilities, goals and commitments. Crudely, it is 'put up with', with faith in the relationship with one's body remaining intact.

By contrast, consider an illness that is phenomenally similar to common flu, but chronic. In a case of chronic fatigue syndrome, where the period of recovery from fatigue is long and slow, the subject's faith in their relationship with their body can be thrust into the spotlight and challenged. One's ability to easily and successfully undertake simple daily tasks becomes penetrated with a sense of doubt that transforms the subject's orientation in the world.

This sort of change in existential orientation is characteristic of depression experience. On that line of thought, I propose that depression experience might be akin, at least phenomenologically, with chronic illness experience in that in both cases, in the face of pervasive shifts in one's orientation in the world, one is vulnerable to the experience of a loss of the sense that there could be any meaningful change (Ratcliffe, 2015, p. 66). The phenomenology of pregnancy experience, in its potential similarity with the experience of a more chronic 'somatic' illness, might involve these same experiential changes that are associated with depression experience, or at the very least can be interpreted as being so. This is, I think, important when considering vulnerability to depression in subjects who have previously suffered, and who are therefore more vulnerable to experiences of depression in and after pregnancy. Though the pregnancy itself is understood to be temporary, with a fairly predictable timeline, women here may interpret the experienced shifts in orientation throughout pregnancy as threatening to be endless, thus restricting the possibility of meaningful change in a way that is phenomenologically alike depression experience.

### 6. The self

This threat of the endlessness of an experience of illness can have implications for the sense of self in at least two distinct but related ways. The first way in which I suggest that this can happen is through a sense of failure to engage in 'me-projects'. This involves a disruption to the ordinarily presupposed set of capacities and commitments which the sense of the self incorporates.

One's sense of self might, though perhaps implicitly, include a set of activities in which one regularly engages, and an experience that prevents one from attending to such activities might lead to a sense of a compromised self. One, for example, might act in the world with an implicit sense of self that involves commitment to one's career, regularly exercising or

socialising. A disruption to one's ability to engage in such projects as part of an illness experience might be a source of distress that carries a sense of compromised selfhood; as Toombs writes, illness is not just a threat to the body, but is also a threat to the self in seeing oneself as 'less of a person' (Toombs, 1987, p. 230). Pregnancy experience, as well as post-pregnancy, might be instances which can prevent one from engaging in the kind of activities discussed above that over time come to form part of the sense of self, resulting in one's sense of self finding itself under threat, for example, a restricted work and or social life.

I am proposing that, in a way similar to in illness, the experience of pregnancy and early motherhood might threaten to compromise a set of values which the subject ascribes to herself. For example, one's self-ascription of the value of physical strength might find itself under threat in both pregnancy and illness when the subject finds themselves unable to carry out certain tasks. There is also surely something to be said about the influence of societal and medical conceptions of both pregnancy and illness here. The ill body is often equated with the inferior body, seen as a disabled body, or one requiring treatment. One might think that the experience of paternalistic medical attitudes might result in a similarly negatively impacted sense of self in pregnancy; indeed Young has suggested that internalising such attitudes might lead the pregnant woman to interpret such normal variations to her body as indications of weakness (Young, 2005, p. 57).

Western cultural attitudes to female sexuality might produce a similar effect. In the strict separation of pregnancy from sexuality, it is to be expected that the pregnant woman may experience her pregnant body as unattractive as a result of its exclusion from the kind of sexual 'gaze' that is ubiquitous in contemporary Western society, and consequently, for some women to various degrees, from the source of self-worth that has been reinforced since her adolescence. Conversely, though, Young has suggested that for some women, the pregnant body frees the woman from the relentless sexualisation of the female body in which she has

been immersed. Young describes this as the possibility of a release from an alienating gaze, allowing an 'innocent narcissism' (*ibid*, p. 53).

In drastic shifts in experience sometimes associated with chronic illness experience or depression, one is faced with the threat that these shifts in experience represent their new orientation in the world that requires adjustment to. A constituent aspect of the experience of depression, for example, is a feeling that it will be endless, that there is no sense that the future offers anything different from what is currently experienced. In his discussion of the shifts in possibility space in depression, Ratcliffe writes that, in depression, the habitual, confident anticipation of significant possibilities is dissolved (2015, p.68). In other words, these experiences are no longer perceived as temporary changes that have struck the self, but as permanent changes to self and world, and so as integral to the self. With this can come ambiguity as to what experience can be attributable to one's illness as opposed to part of the self, or perhaps more insidiously in experiences of depression, as part of the 'real self' which one is forced to confront. Recognition of this is valuable to my project as one might see a similar pattern in the pregnant woman, or new mother, who is experiencing a sense of a disrupted self in confrontation with intrusive thoughts. As Friedmann writes in her description of her experience of intrusive thoughts in early motherhood:

> '…the thoughts running through our minds are compulsive and unrelentingly terrifying. I wonder how many women do realise that these thoughts are a symptom, though so insidious that they feel like us, our secret selves' (Friedmann, 2017, p. 63)

I suggest that obsessive, intrusive thoughts lend themselves to interpretation as integral to the self. That is in contrast to symptoms which are instead experienced as parasitic on the self[24],

[24] In similar context, Ratcliffe (2013b) describes influenza as a 'foreign invader' that inflicts symptoms on the sufferer from the outside, in contrast to typical depression narratives.

but not threatening it, such as the aforementioned bout of influenza that is relatively predictable. Intrusive thoughts are commonly experienced in pregnancy and early motherhood, though more severe in cases of depression or other episodes of mental ill-health. Fairbrother (2008) found that every woman in their sample (100 women) experienced some thoughts of harm to the new-born baby, with one in five of those women experiencing thoughts of intentional harm. Suffering from intrusive thoughts, one might struggle in attempts to 'detach themselves' from the experience as might be more straightforwardly done with an experience that was interpreted as being more obviously bodily, such as a pain. Intrusive thoughts are more likely to be experienced as 'from within', are more obviously part of one's psychological life, concerned with one's emotions, personality and values, as opposed to that which is understood to be a symptom of illness, experienced as something which attacks from the outside.

### 7. Familiarity and interpretation

In continuation of the discussion of the nature of temporality in illness above, the significance of the past can be understood as taking on a particularly intimidating character in illness such that the memory of a past experience of illness comes to be perceived as threatening (Toombs, 1988). Here, the past pervades the present, and one lives in fear of the reoccurrence of an experience of illness. Identifying oneself as vulnerable is key in influencing the subject's interpretation of their experience.

The interpretation of one's experience plays a large part in the creation and maintenance of phenomenological changes. In illness, whether certain phenomenological changes are interpreted as attributable to the illness, and moreover, if so, whether they are attributable to somatic or psychiatric illness, carries particular weight. For pregnant women, it is important whether phenomenological changes are interpreted as attributable to a *normal* experience

characteristic of pregnancy, or an *abnormal* case of illness, somatic or psychiatric, i.e., where something has 'gone wrong'. What is of particular importance here is the idea that the nature of the response to one's state has power to influence it. On this line of thought, one can see how past experience of health problems may further increase vulnerability to depression-like experience in pregnancy, should normal changes characteristic of pregnancy be interpreted as signs that something has gone wrong again, due to phenomenological similarity between the normal pregnancy experience and a past experience of illness in which something was abnormal.

Empirical study has shown that a previous history of depression is a strong predictor of subsequent postnatal depression (Beck, 2001), and a literature review on postnatal depression published by the World Health Organisation identified a history of depression as a strong risk factor for mothers (Stewart, 2003). Moreover, online fora frequently express pregnant women's concerns about a history of depression making suffering from postnatal depression inevitable. These statistics are well-known, and an awareness of this risk itself can be a source of anxiety for women who identify themselves as vulnerable (Carel, 2017, p. 17).

An anxious expectation that the kind of experience associated with some previous struggle with depression may resurface, sustains the inward, anxious focus on the body, and consequently, may have an influence on the way that the normal changes in pregnancy are experienced. In such cases, the 'normal' phenomenological changes characteristic of pregnancy may be interpreted as signs that something 'isn't quite right'.[25] The elusive nature of these shifts in experience might contribute to the feeling that an episode of depression might be threatening to reoccur. For example, one pregnant woman on an internet forum described how the fear of intrusive thoughts, and of coming to lose touch with reality, has

[25] This is reminiscent of Jaspers' delusional atmosphere, to which an elusive 'sense of unreality' is integral (Stanghellini & Fuchs, 2013).

begun to make her feel ill. Reports like this illustrate the influence of anxiety about one's condition over the nature of experience itself in the context of a pregnant woman, in which normal phenomenological changes in pregnancy might be interpreted differently once they are set in a particular psychological context, namely that in which the woman is, or considers herself to be, vulnerable to depression. Ratcliffe has suggested that a diagnosis of depression might dispose one to emphasise symptoms that can be more easily ignored when the phenomenological changes are attributable to influenza or some other infection (Ratcliffe, 2013b, p. 207); conversely, I propose that a *self-diagnosis* of depression, or at least of experiencing depressive symptoms, might dispose the pregnant woman to amplify, and perceive as threatening, particular aspects of pregnancy experience that would not be considered threatening in the same way in a different psychological context, namely one that does not carry the threat of an episode of mental ill-health. One might then confuse 'normal' experience as being indicative of slipping into a depressive episode.

It is easy to see how women with a past history of depressive experience might be particularly vulnerable to this. For such women, the phenomenology of that very slipping into a depressive episode may feel so familiar as to be indistinguishable from it. One might think that the kinds of experience characteristic of depression are particularly intelligible as such in certain contexts. The context of somatic illness is a good candidate for this, i.e. where the subject's body is already 'drained of its vitality' (Ratcliffe, 2013b, p. 212). One might think that if the experience of pregnancy can be similar to an experience of somatic illness, then one is already in a context that makes depression experience more tangible. Moreover, if the woman in question, with a past history of depression, recognises the phenomena from a previous bout of depression, the psychological context of the experience becomes even more threatening.

## 8. Depersonalisation

The study of depersonalisation is relevant to present purposes in two related ways. First, existing literature from the study of depersonalisation might provide another angle from which to look at the risk of depression experience in pregnancy. Second, a study of depersonalisation in relation to the phenomenology of pregnancy might help to illuminate the heterogeneity of depersonalisation experience.

One might standardly describe depersonalisation as follows:

> '…a pervasive and distressing feeling of estrangement…in which feelings of unreality and a loss of conviction of one's own identity and of a sense of identification with and control over one's body are the principal symptoms.'
>
> (Noyes & Kolb, 1939/1964, p. 84)

Phenomenological analyses of depersonalisation have so far attempted to illuminate the structure of the experience, typically as a symptom of depression or schizophrenia, through accounts of bodily feeling. Such accounts typically describe the sufferer's loss of the feeling of the body as that through which the world is experienced. The breakdown of this transparency leads to an involuntary awareness of one's body as a brute physical object, or *Körper*, where the physical, 'thing-like' properties of the body are involuntarily thrust into awareness (Ratcliffe, 2012a). This might be thought of as a breakdown in noetic bodily feeling, that is, feeling *through* the body, which gives rise to involuntary instances of noematic bodily feeling, that is, where the body itself is the object of awareness (Ratcliffe, 2012a).

Fuchs uses the term 'corporealisation' to describe the breakdown of the transparency of the lived body that is characteristic of a depersonalisation experience in depression. In this case,

the light, transparent body is transformed into a heavy physical object that becomes an obstacle to bodily intentionality. The physicality of the body that usually goes unnoticed, much like in the earlier description of bodily certainty, is now thrust into awareness and 'felt painfully' (Fuchs, 2005, p. 99). This change in the relationship with the body has also been associated with self-directed obsessional behaviours, principally compulsive rumination and self-scrutiny over one's body; a sort of 'exaggerated hyperawareness of one's self' (Simeon & Abugel, 2006, p. 62-3).

So far these analyses have focused on depersonalisation experience in the context of a wider depression experience. There is high co-morbidity between depression and depersonalisation, although the causes and triggers of a depersonalisation episode are thought to be highly dynamic. Severe stress, episodes of other mental illness and childhood trauma have all been associated with the onset and severity of a depersonalisation experience (Simeon & Abugel 2006, p. 103).[26]

Strikingly, though, episodes of depersonalisation have been known to be triggered by 'joyous' experience. Paradoxically, what seemed to throw one patient (with a very dysfunctional family life as a child) into bouts of depersonalisation was the promise of something exciting and positive about to happen in his life. Of course, what is overwhelming for one person may not be for the next, because what we experience is charged with unique personal meaning. So it seems that overwhelming experience of any kind can trigger chronic depersonalisation disorder in individuals who may be vulnerable to it (*ibid.* p. 95-6).

Turning back to how I propose that this is relevant to the experience of pregnancy. The similarity between Young's description of the change in her relationship with her body and the above discussion of depersonalisation disorder is immediately striking. Young described

[26] Of course the influence of these factors is not unique to depersonalisation disorder.

her pregnant body as causing her to view herself as 'herself and yet not herself', where the experience of pregnancy reveals a body subjectivity that is 'decentred' and 'myself in the mode of not being myself' (Young, 2005, p. 46-9). Crucially though, for Young, this experience is not attributed any unpleasantness or suffering, and conversely, was described as an experience of empowerment and validation.

Let us turn back to Young's argument against the breakdown of noetic bodily feeling and the corresponding bodily transparency as necessitating ill-health. Young's account of the changes to the experience of her body during pregnancy seem much akin to the descriptions of experience in depersonalisation disorder, only without any melancholic feeling or distress. From this, it seems that one can plausibly maintain either that pregnancy can be an instance where this breakdown of noetic bodily feeling is possible without distress, *or* that in such a case there is an extent to which one has not really lost grip of the former sense of the body as that through which the world is experienced in the same way. In both cases, we can still recognise that such an experience might become a source of distress as in standard conceptions of depersonalisation disorder in at least some women, dependent on their personal disposition. Recognition of this striking phenomenological similarity illuminates another angle from which we might make sense of depression-like experience in pregnancy and early motherhood.

# Chapter 3

## Phenomenology and epistemic injustice

### 1. The problem

This chapter is concerned with highlighting the importance of recognition of the subjective dimension of experience through pregnancy and early motherhood, focusing on depressive experience through these periods in particular. It is true that contemporary healthcare practice more generally faces accusations of a lack of sensitivity to patient experience, with priority often given to the biological, third-person foundations of their condition. Initiatives in person-centred medicine have attempted to remedy these shortcomings in medical attitudes (Mezzich, 2010, 2015). However, I argue that sensitivity to the phenomenological approach is essential for such initiatives to fulfil their potential. We do not necessarily need phenomenology in order to identify epistemic injustices but we may find it useful in our attempts to tackle them. A phenomenological investigation of pregnancy might allow us to better understand the experiences such that we can put ourselves in a better position to be able to mitigate the effects of epistemic injustices, for example in providing such women with the epistemic validation that they may lack.

I am focusing here on the problem of inadequate sensitivity to the subjective experience of women in pregnancy and early motherhood in healthcare. From this, I will highlight the need for the adoption of the phenomenological stance (Ratcliffe, 2012c), both by the subject (i.e. the woman in question), and in interactions between the subject and others in appropriate relation to the subject. The adoption of the phenomenological stance in these ways, I argue, has great potential to improve self-understanding and resilience in women throughout

pregnancy and early motherhood, working to ameliorate some of the effects of the problems discussed.

I will first look at the problem of epistemic injustice against ill persons in the clinical encounter (Fricker, 2007; Kidd & Carel, 2017), and show how in a similar way, injustices may be committed against pregnant women. I will then show how adopting the phenomenological stance can facilitate a richer understanding of the nature of women's lived experience, and can therefore mitigate some of the effects of these injustices. I also explore how adopting a phenomenological approach might facilitate clarity of expression, allowing pre-reflective lived experience to come to the forefront of conscious thought, i.e., to become reflective. I argue this in support of the broader claim that a rich understanding of the experiences of pregnancy and early motherhood can serve as a therapeutic resource for the women in question.

To begin, I will discuss some problems that result from the insensitivity to the nature of lived experience that is common in contemporary attitudes towards maternal health. The main culprit here is epistemic injustice in the clinical encounter. I will discuss various aspects of epistemic injustice in order to demonstrate how current attitudes can be detrimental to the well-being of women throughout pregnancy and early motherhood.

## 2. The derivatised subject and testimonial injustice

One notable way in which epistemic injustice might be committed against women in the clinical encounter is when the patient is treated as a *derivatised subject*, that is, a subject 'whose capacities are reduced to attending only to what stems from the others' perspective' (Kidd & Carel, 2017, p.107), or who is 'relegated to the role of epistemic other, being treated as though the range of one's subject capacities is merely derivative of another's' (Pohlhaus,

2013, p. 107). In pregnancy the 'derivatiser' is usually the medical practitioner or healthcare professional.

This is an aspect of the wider problem of testimonial injustice. In cases where the patient is treated as a derivatised subject, the patient's testimony is only valued if it is of a certain nature, i.e., the type of information that she provides reflects what is understood to be part of the 'dominantly experienced world' (*ibid*). Factual information that fits within existing frameworks and medical practices is considered appropriate, and is therefore epistemically valuable, carrying sufficient weight to inform care. On the other hand, patient testimony that involves expressions of the private lived experience of one's condition, in falling out of such frameworks, often goes unacknowledged. The subject in this case, in failing to be seen fully as a subject in a position of epistemic privilege, is not welcomed to contribute uniquely to the epistemic community in a way that might highlight the need to redirect practice (*ibid*). Testimony of this kind therefore systematically fails to be recognised as valuable in the clinical encounter.

Testimonial injustices can also arise as a consequence of certain prejudices that are held against the subject, leading her to be perceived to be a less credible source of testimony than she would otherwise be. This has been described elsewhere as 'credibility deficit' (Fricker, 2007, p. 17). I propose that pregnant women are particularly vulnerable to this in much the same way as the ill person. For example, the stereotypical description of the ill person as over-emotional, and therefore having a skewed perception of a situation, might affect the listener's confidence in whether she is a reliable source of testimony about the nature of her experience, just as it would the pregnant woman. Take, for example, pregnant women's testimony about their experience of pain. Such prejudices about pregnant women as overwhelmed by their situation and therefore unable to reliably report the level of pain that

they are experiencing might facilitate testimonial injustice in the form of not listening to the woman's beliefs about the appropriate pain relief.

Moreover, the historical inequality that women have faced regarding power relations is well-documented, and is standardly articulated by those interested in epistemic injustice as a failure to be reciprocally recognised as epistemic peers, or as equal epistemic subjects. For pregnant women as victims of testimonial injustice, women's descriptions of experiences of their bodies not being given adequate 'status' in the clinical encounter can result in the woman ceasing to feel as though she has epistemic privilege over herself and her body, and is therefore unable to properly exercise her agency, for example, in making choices about the nature of the birth. This ultimately threatens the relationship that women have with their bodies, which can result in a feeling of alienation from the self.

Throughout clinical encounters in pregnancy, this sense of alienation might also be exacerbated by an uncomfortable transition from autonomous agent to patient, further removing the subject from the acknowledgement of herself *as a subject,* then coming to be conceived of as an 'object'. Here women can come to depend upon third-person knowledge in order to understand and interpret their bodies under the feeling of pressure that they ought to defer to medical judgement in order to make sense of their experience. A change to (one's relation to) one's body is incredibly influential over one's sense of self and the way that one exists in the world and with others, and it has even been suggested that this sense of alienation can hinder the mother's ability to bond with her new baby (Freeman, 2014). Being subject to epistemic injustice in this way can foster compromised epistemic, and in turn social, confidence, resulting in one's sense of being in the world, and being in the world *with others,* finding itself under threat.

## 3. Participatory prejudice

There is a growing body of research evaluating the problem of ill persons being subject to *participatory prejudices* (Hookway, 2010; Kidd & Carel, 2017; Jackson, 2017). In the face of such prejudice, a subject's participation in discussion about their condition is restricted by the nature of current medical attitudes and resources.[27] For example, a patient's participation in a discussion about their condition may involve just confirming basic biographical details or reporting symptoms, since they are not recognised as a subject with the capacity to redirect the discussion in an appropriate way. In the case of pregnancy, as in testimonial injustice, exposure to participatory prejudice can result in a woman's description of the nature of her subjective experience not being considered clinically relevant. Descriptions of the woman's subjective experience might include expressions of her sense of detachment from her body or the way in which her environment feels indescribably altered. Descriptions of this kind are often attributed little value in a medical context, for what action they ought to trigger is unclear. As a result, such existential changes that might accompany a woman's experience are not recognised, and the woman's experience is not 'epistemically validated' (Freeman, 2014, p. 18). This felt absence of epistemic validation can create feelings of self-doubt, isolation and compromised autonomy.

It is becoming increasingly well-documented that there is insufficient attention paid to maternal mental health in practitioner training, a consequence of this being that women are often not invited to discuss the intricacies of their experience.[28] Just 39.7% of maternal support workers responding to a survey by the Royal College of Midwives (2014) reported

[27] I specify *medical* attitudes and resources since I am concerned predominantly with the clinical encounter here. It should, however, be noted that there might be things to be said about epistemic injustice against pregnant women in the wider social community. This is also certainly true of illness; Jackson (2017) addresses this in the context of the social experience of depression.

[28] It is of course appropriate to note the very real impact of practical constraints; the nature of care that can be provided is restricted by time pressures that the vast majority of health workers face.

that they felt as though they have enough time to support women with their mental well-being. One student midwife in the report suggested that women tend not do feel able to declare their low mood because time constraints that the midwives face make it difficult to create the appropriate environment for discussion. Such time pressures of course influence the type of discussion that midwives are able to facilitate.[29]

Should the circumstances allow women to go into some detail about their experience, though, the practitioner's lack of confidence in handling such information means that these descriptions are less likely to be given the appropriate status than they would be if sensitivity to such descriptions was better incorporated in training. In the same RCM report, 26.7% of third-year student midwives said they were not confident in their ability to recognise mental health issues in women, with 24.1% putting this down to insufficient theoretical knowledge in training. Some midwives have reported that they rely more on their own life experiences and intuitions than they do on their training in discussing mental health with women in their care (see McGlone et al, 2016). As it stands, with these deficiencies in sensitivity to maternal mental health in midwife training, the weight that the woman's descriptions of her experience carry and the response the woman will receive depends largely on the personal dispositions of the maternal health worker in question.

Women have reported that experiences of this kind, that is, the sorts of epistemic injustices detailed above, contributed directly to the creation and maintenance of their experiences of postnatal depression and related illnesses (see Boots Family Trust, 2013). We can remain confident that attention to how such aspects of experience might be approached in the clinical encounter remains important for protecting the well-being of the women in question. It is

[29] This particular constraint is acknowledged to be a problem in medical care more widely (e.g. Kidd & Carel, 2017, p.182).

essential, therefore, to develop an approach through which the negative effects of the clinical encounter can be alleviated.

## 4. Hermeneutical injustice

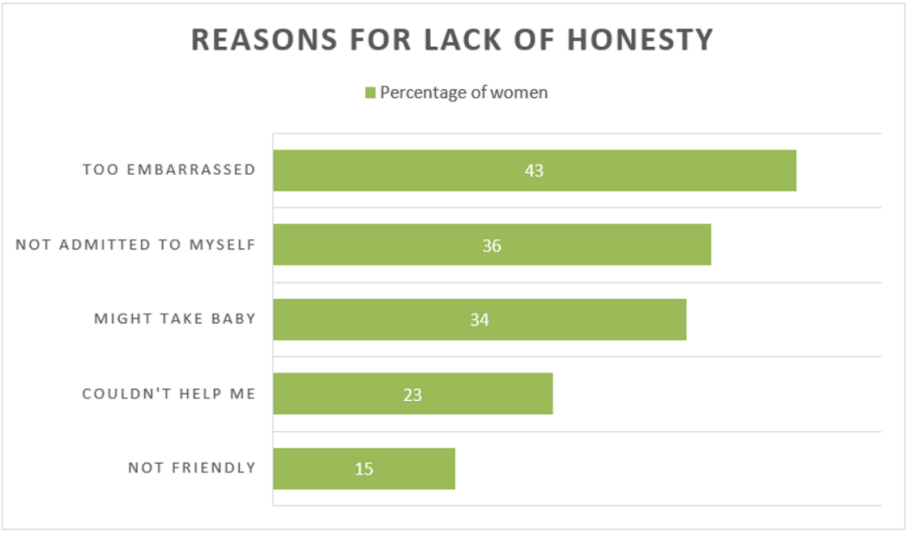
It is first worth highlighting the role that the collective lack of understanding plays in this reported feeling of marginalisation. The discussed epistemic injustices committed by individuals are constitutively related to a bigger, structural injustice: what Fricker calls *hermeneutical injustice*. Hermeneutical injustice arises when a group of people struggle to understand their experience because of some inadequacy in the resources that are required to understand them, resulting in a marginalisation of that group (Fricker, 2007, p. 153).

It is easy to identify an inadequacy in resources for understanding reports of lived experience in maternal healthcare. Strikingly, a report by the Maternal Mental Health Alliance (MMHA) cited research showing that 23% of maternity professionals had received no education on maternal mental health (2013, p. 6). Low levels of confidence in dealing with mothers who expressed poor mental health were also identified in maternity professionals as a result of this lack of appropriate training.

Importantly, hermeneutical injustice does not only affect the marginalised group in question, but it also negatively affects the 'hermeneutically unjust group', since this lack in resources results in a collective inadequacy of understanding. Both parties suffer from *cognitive disablement*, but the victim is prevented from understanding her *own* experience (Fricker, 2007, p.151). Fricker has written that such disablement prevents the victim of the injustice from understanding 'a patch of experience which it is strongly in her interests to understand, for without that understanding she is left troubled, confused, and isolated' (*ibid*). Conversely,

the consequences of cognitive disablement for the 'unjust group' are clear to see in this particular context, as the quality of care that maternity professionals are equipped to carry out is negatively affected by the lack of appropriate resources for understanding that are provided in training. The same MMHA report also highlighted evidence that midwives have shown resistance against asking women about their mental health because they are concerned that they could discover issues that they would not know how to resolve. Of course, then, this perpetuates the injustices being committed against the women in question.

Hermeneutical injustices can also play a role in the stigmatising of illness (Kidd & Carel, 2017, p. 184). In the case of maternal mental health, it seems as though where frankness about potential mental distress has 'no pay off', since talking about them can be difficult and embarrassing, women are more likely to be dishonest about the way that they feel. There is evidence to show that embarrassment is the biggest obstacle for women feeling able to disclose information about their mental health with their midwife or health worker. Figure 1 below charts this and other reported reasons for women not being fully honest about their mental health in conversation with midwives and health visitors:




(Figure 1 - Data from Boots Family Trust, 2013)

The effects of epistemic injustice in maternal mental healthcare show themselves in the other documented reasons. The woman's belief that the healthcare professional would not be able to help her speaks to the problems discussed earlier as a result of exposure to participatory prejudice: even if the information is offered, it may not be understood or accepted, nor is it guaranteed to trigger any positive action. There is little obvious up-side to volunteering information about such experiences where no positive action will be made.

Both mothers and healthcare professionals have described discussions of mental health as something of a 'tick-box exercise', with criticism of health workers and midwives too heavily relying on the two Whooley questions, a closed-question screening resource (see McGlone et al, 2016). In interactions of this kind it is easy for women to 'play down' or lie about potentially distressing aspects of their experience in order to avoid anticipated complications. Moreover, this mutual reluctance to discuss the intricacies of the woman's lived experience may also be related to the fear that disclosing a state of mind that might raise concerns of mental illness could trigger investigation from social services, potentially resulting in the removal of the baby from the mother's care. Better resources for understanding experience might help to lessen the stigma surrounding mental ill-health, particularly in new mothers, allowing women to feel comfortable recognising and addressing the dynamic changes in experience that they face.

Importantly here, such a high percentage of women putting their lack of honesty down to not having admitted to themselves that they were ill exposes the urgent need for resources for self-understanding throughout pregnancy (as in illness more generally): indeed there is a large volume of first-person reports suggesting that many women only become aware of the way that they felt retrospectively. More research into women's experience in pregnancy and early motherhood is essential in order to change this. I will draw on this in the next section in

discussion of phenomenological self-reflection, in support of Kidd & Carel's (2017) claim that offering new explanatory and ameliorative resources for ill persons is an essential task.

## 5. Phenomenological self-reflection

I propose here that the adoption of a phenomenological stance can facilitate understanding and interpretation of the lived experience of pregnancy and early motherhood. Though they come hand in hand with one another, I argue that the phenomenological stance has the potential to be beneficial in both independent self-reflection and in interaction with others.

First, I will discuss how phenomenological self-reflection can provide a unique insight into the experience of this group of women, and suggest that such self-reflection might have therapeutic value. When taking part in phenomenological self-reflection, the subject is engaging in independent first-hand phenomenology. I acknowledge, however, that it is unrealistic to expect that everyone could or would want to engage in this way. With this in mind, I will then discuss foundational ways in which the phenomenological stance might be employed in what can be called cooperative phenomenology (see Spiegelberg, 1975, p.26), where others can engage with the methodology and the language of the phenomenological tradition to encourage first-hand phenomenological self-reflection in women.

Recent work in various areas of applied phenomenology has stressed the value of phenomenological self-reflection for people with various anomalous experiences, and I argue that the value of this sort of phenomenological self-reflection extends to pregnancy and early motherhood. Phenomenological self-reflection involves using oneself as an object of study, with the thought that attending to subtle shifts in one's experience can disclose information about the wider structure of that experience. I am suggesting then, that for the women in question here, engaging in such reflection can provide a unique epistemic route to self-knowledge (Freeman, 2014, p.4). Crucially, the sort of self-knowledge that can be revealed

through phenomenological self-reflection is that which cannot be accessed through the dominant third-person perspective, for example, knowledge about their experience of their bodies as mysterious or otherwise unpredictable, or how their interpretation of various phenomenological changes influences the way that they come to experience them.

The primary way that one might engage in phenomenological self-reflection is through performance of the *phenomenological reduction.* The phenomenological reduction involves the bracketing of our familiar acceptance with the world and of ourselves as beings within it. In this particular case, the pregnant women in question would be invited to distance themselves from conventional, typically third-person understandings of pregnancy and maternal mental health, understandings which to an extent, women have become reliant on to interpret their experience. Engaging in the reduction allows one to distance oneself from dogmatic attitudes that come to form perception, redirecting focus onto the nature of being, rather than objective, naturalistic ideas about one's experience that are without context.

For the pregnant woman, this might involve bracketing information about, say, hormonal changes that are typical in pregnancy and their supposed influence on mood, and instead directing attention solely onto the way that the experience is given, potentially illuminating aspects of the experience that had previously gone unrecognised. Bracketing what understanding is facilitated through the dominance of the 'natural attitude' opens up a new way of experiencing, disclosing the experience's structure and essential features (Carel, 2011, p. 10). In this sense, performance of the reduction provides some autonomy in light of the extent to which women's understanding of their experience is influenced by the dominant naturalistic attitude outlined in the first chapter, the very concern raised in discussion of hermeneutical injustice.

A virtue of engaging in phenomenological self-reflection in this way is that it emphasises the meaningfulness of experience beyond the meanings generated by the natural attitude. Not unlike episodes of ill-health more generally, excessive rumination over one's condition is common in women who are experiencing mental health problems throughout pregnancy and early motherhood (Alfaraj et al, 2009). Anomalous experience naturally forces us to reflect on our condition, and as Merleau-Ponty said, reflection 'slackens the intentional threads which attach us to the world and thus bring them to our notice' (1962, p.viii). I suggest that phenomenological self-reflection might help to provide autonomy for the pregnant woman, with which she can develop the epistemic confidence to reflect on her experience without the influence of the naturalistic attitude, and find meaning in her experience as it presents itself to her.

Phenomenological self-reflection provides a framework for engaging with that which is brought to our attention. This is markedly different from encouraging simple 'rumination', characterised as persistent self-focused attention, which is thought to have an overall negative influence on mood (Alfaraj et al, 2009). In this case, attention is fixated in one direction, whereas as we established in chapter one, phenomenological self-reflection is not exclusively 'inwardly' self-focused, but also world-focused, and promises to provide tools to be able to reflect in such a way that discloses hidden aspects of the whole of experience that the internalised natural attitude might work to suppress.

As part of her work on phenomenology as a resource for patients of illness more generally, Carel outlines the content of a workshop focusing on phenomenological self-reflection in illness (2011). She proposes the use of visual and sensual samples, as well as discussion of phenomenological texts, intended to initiate such self-reflection. Much like what I am suggesting, this workshop on phenomenological self-reflection serves as a support tool for

patients in aiding them in their understanding of their condition as it is experienced by them, rather than as it is posited by the medical perspective.

By no means is this the only way in which insights from phenomenology might be applied to a therapeutic context: phenomenological insights into the body and its relationship with affect have been used to develop dance and movement therapies for patients that focus on shifting attention to different aspects of experience (Koch, 2013). One way in which this is thought to aid understanding is by shifting attention towards preverbal responses and making them explicit, consequently bringing together pre-reflective experience with reflective experience to help form a more comprehensive picture of how experience is given.

Moreover, in coming to recognise oneself as a being in the world, phenomenological self-reflection highlights the importance of immersion in the world, something which simple rumination does not achieve. It is in this sense that phenomenological self-reflection does not just offer a framework for thought, but also for action. The proposition is not so radical as to suggest that the potential therapeutic value of the phenomenological approach is such that it will prevent anxiousness or the tendency to fret and so on. Rather, the thought is that it can provide a way of thinking about experience, as the women in question are disposed to do, that is useful, and indeed guiding, where standard episodes of rumination seem not to be. It is useful in emphasising the importance of recognising ourselves as beings in the world, and so crucially, in what follows, meaningfully recognising that our consciousness requires immersion in that world: "…it is not *because* I think being that I am certain of existing, but rather the certainty that I have of my thoughts derives from their actual existence." (1962, p.402)

## 6. The role of others

Carel has acknowledged that participants for the type of workshop she proposed are likely to be few and self-selecting (2011). The same concern applies to my proposition. How accessible is this material, and how realistic is it to expect that every new mother will want to or be able to engage in phenomenological self-reflection independently? I suggest that it is not necessarily just the subject who ought to engage in phenomenological methodology. There are ways in which interaction with others, through *their* engagement with phenomenological methodology, can facilitate the kind of phenomenological self-reflection discussed above. Engaging in phenomenological methodology need not be an isolating exercise, indeed it can be a cooperative one. It is worth noting at this point that I leave it open as to who exactly constitutes 'the other': as used here, the other could be anyone in appropriate relation to the woman in question, be that a partner, family member or healthcare practitioner.[30]

The role of the other here can be to facilitate the woman's engagement with phenomenological methodology by engaging in what might be called second-person phenomenology; that is, the other here adopts a *phenomenological stance.* The other engages with phenomenological methodology in order to disclose features of the woman's experience that might be otherwise closed to her, in much the same way as in phenomenological self-reflection. That this is possible rests upon the view that phenomenological reflection is initially uncommitted over whether it can be directed towards first-person or second-person experience (Ratcliffe, 2012c, p. 486).

[30] On the same line of thought, I also do not wish to make too bold a claim on how exactly this might look in practical terms – that is beyond my remit here. Establishing phenomenology's incorporation into the healthcare system requires both careful cultivation and interdisciplinary collaborative work.

Research that has been conducted on interviewing women from a feminist phenomenological perspective is a prime example of an adoption of the phenomenological stance whereby the other engages in second-person phenomenology in order to facilitate the employment of phenomenological methodology in the subject. For example, Louise Levesque-Lopman has conducted research to support the idea that interviewing women about their experiences from a feminist phenomenological perspective, that is, 'starting from women's experiences', allows women to engage with the nature of their experience such that they are able to reveal to themselves their own insight into their lived experience, in their own words and from their own perspective (Levesque-Lopman, 2000, p. 103). The thought here is that in communicating one's perspective to the phenomenological analyst, the subject is provided with novel insight into the structure of their experience, facilitating a unique extension of their own perspective (Spiegelberg, 1975, p. 123). This sort of phenomenological enquiry carried out with pregnant women, and the interpersonal relationship that is integral to such an enquiry, establishes a sort of mutuality between the woman and the other: this is an exercise in challenging the feeling of diminished epistemic privilege discussed earlier. When the woman begins to feel as though her lived experience is equally as valuable as, though of course different in kind to, the sort of third-person knowledge that tends to dominate, she and the other can become 'epistemic peers' (Freeman, 2012).

The phenomenological stance provides a framework for a distinctive kind of access to the woman's lived experience, facilitating what might be called *radical empathy* in the enquirer (Ratcliffe, 2012c). What is distinctive about radical empathy as opposed to typical understandings of empathy, is that it requires openness to reject presuppositions of aspects of what is perhaps implicitly thought to be part of the 'shared world', psychological context, or

backdrop against which experience is set.[31] Typical understandings of empathy might suggest that one's emotional state is felt by another as if through a sort of 'contagion', in which case, the emotional state perceived might just be carried over into the perceiver's psychological context, with the same set of presuppositions and orientation in the world as before. Engaging in radical empathy requires a suspension of our habitual acceptance of the world in order to illuminate the possibility of a structurally different way of finding oneself in the world, with an openness to the degree of phenomenological difference that is possible between subjects.

The concern may be raised here that in providing practitioners with this insight, there is a chance that the existing epistemic injustices might become deeper and more destructive. The worry might be that the nature of the patient's subjective experience becomes another addition to the list of things which the practitioner has authority over, should they think that they are engaging in radical empathy with the subject. This is of course an important concern and something that, should this sort of thing be put in place, would require great care to protect against. Indeed this same issue stands with any professional with a duty of care, and so it does not seem to be a sufficient reason to warn against such initiatives. It would be dubious to suggest that since careless teaching could confuse and mislead students, teachers ought not to be given the power to teach; likewise with poor practice from a psychiatrist, GP or midwife. Rather, just like in all other cases, care is required to protect against this problem.

Much like phenomenological self-reflection, this sort of phenomenological enquiry has therapeutic significance for the woman. The unique way in which the phenomenological stance, and importantly the language involved in it, can assist the enquirer, the other, in tapping in to the subjective dimension of the patient is a powerful tool for assisting their reconnection with others, and in turn, with themselves (Ratcliffe, 2012c, p. 474). This works

[31] A similar process of engagement has elsewhere been called 'imaginative self-transposal', where phenomenology is said to be done through vicarious experience (see Spiegelberg, 1975, p.120).

to validate the first-person experience of the woman, providing the courage to address phenomenological changes and their significance without deferring to dominant naturalistic explanations.

## 7. Language as transformative

This leads me to defend the importance of the use of language in engaging in phenomenology, arguing for the position that the process of expressing one's experience through language can transform the very experience expressed, and consequently, as above, facilitate self-understanding and resilience in the face of unique and potentially challenging shifts in experience. I am resisting the view that it is the case that a phenomenological insight into the nature of some experience must be able to be characterised verbally, but maintaining that there can be some unique value in doing so.

Language can be a powerful tool for self-understanding. Expressing oneself through language can work to pre-reflective lived experience to the forefront of consciousness, i.e., make it *reflective*. It is worth noting that this is not to say that every use of self-expression through language has this transformative effect, since there are of course instances where language is used merely as a descriptive tool: if I describe what I had for lunch yesterday, then language here has served merely to report what I am probably already aware of. What is important is that self-expression through language has the potential to transform certain types of experience that might otherwise be elusive, namely here the types of experiences in pregnancy discussed in the previous chapter that naturalistic explanation excludes.

How can self-expression through language make pre-reflective experience reflective? Expression through language can transform lived experience in that it can give pre-reflective experiences a new sense of precision (see James 1890, p. 254–5). What is crucial here is the recognition that an experience can be significant even if, because of its elusiveness, it feels

indistinct; that is to say that the 'fuzziness' of an experience ought not to be confused with its meaninglessness. A 'fuzzy' experience might be described as lacking what Colombetti has called 'affective specificity' (Colombetti, 2009, p. 8). For example, an experience of bodily doubt in pregnancy may not be such that one is able to distinguish it sufficiently to attribute it to any specific emotion, and so an affective experience of this kind might be pre-reflectively experienced merely as an detachment or anxiety, that is otherwise pre-reflective beyond vague terms like these. Expressing one's experience through language here, for example in discussion of the lived body, its transparency, and the breakdown of that transparency, can act as a sort of lasso that works to establish the boundaries of an experience and make it less threatening. In this way, labelling one's experience is a way of enhancing it so that it can be studied; by adopting a richer vocabulary for describing the nature of experience, the experience itself can be illuminated so that the subject is in a better position to navigate it.

Much of the literature on affective enhancement through language is concerned with patients with abnormally limited emotional ranges such as patients with alexithymia, which has been described as a sort of 'emotional blindness', where the subject has extraordinary difficulty detecting their own emotion life. It might seem suspect to claim that the kind of affective experiences typical in people with, or susceptible to, mental ill-health in pregnancy, even with reports of 'affective flattening' common in depression, are instances of the same kind, and so warrant the same approach. One might similarly question the value in a methodology concerned with *enhancing* experience. Intuitively, it might seem as though in cases of say, anxiety, helplessness, or rumination, the goal ought to be to relieve whatever the feelings are that are associated with an experience, rather than to accentuate them as to examine them.

I suggest that over-indulgence of this hesitation might handicap the ability to understand the complexity of one's experience in such a way that may have a negative effect on self-understanding and tools for future coping. Moreover, a failure to address the meaningfulness

of experience as it appears from the first-person perspective might also work to consolidate the sort of problem fostered by hermeneutical injustice, namely the belief that information about one's condition is best informed by the naturalised, medical, third-person perspective. The ability to better express the nature of one's experience allows a better understanding of the intricacies of the nature of those experiences, which equips us better to reflect on and navigate them. Hence, a richer vocabulary for expressing the nature of our experience is an essential task.

A potential objection ought to be addressed here. One might think that trying to make sense of a complex experience through language might facilitate a distorted representation of the nature of the experience, since certain experiences are often thought to be beyond description, incapable of being fully accommodated by language. One might therefore think that language can in fact be an obstacle to reaching an authentic understanding of the nature of one's experience. This view however, depends on the truth of the view that thought exists independently of language, and that we can engage in what might be called 'pure thought'. I resist this in favour of the Merleau-Pontian view that thought does not exist independently of the world, and therefore of language. On this view, language, or (internal or external) speech, is a constituent part of the experience of thinking (1962, p.206). A thought truly independent of language is devoid of distinctive character, and is not much more than an urge or desire sunk into the unconscious. The view that thought exists independently of language, as Merleau-Ponty argues, rests upon the illusion of a silent inner life (1962, p.213). Our thoughts are in fact loaded with 'inner language' which we privately engage with, that provides our thoughts with their sense of determinacy. Language is already a constituent part of thought, and so an exercise in enriching our language as to enrich our thought seems a fine task.

In enriching our language to better reflect the nature of experience, we are equipping ourselves with resources to understand the way that experience directly presents itself to us. This, as I have shown, is particularly important for resilience in the face of anomalous experiences, throughout which the way that experience alters can be challenging, particularly for vulnerable individuals. The discussion of the forms of epistemic injustice committed against pregnant women and the motivations for ameliorating their effects that I have provided, should, I hope, make explicit the grounds on which the development of phenomenological resources promise to be valuable. This too, I hope, highlights the need for further research into the development of tools through which pregnant women's experience can become epistemically validated.

## Conclusion

Here I have argued in favour of a formulation of phenomenology whereby we phenomenology is moderately naturalised in order to make phenomenologically-sensitive progress in the sciences, granted that some work is done to recharacterise what the natural scientist, specifically the psychiatrist, incorporates into his scope of concern. This perspective is open-minded to the idea of fruitful engagement between phenomenology and the natural sciences, yet still faithful to the spirit of the phenomenologist's anti-naturalism, maintaining that 'naturalistic explanations of human experience are impoverished, confused or – perhaps – both.' (Ratcliffe, 2013a, p. 19) Working to address this allows us to create healthy projects in the sciences, and crucially, without having to be restricted to the sort of view that non-naturalised phenomenological descriptions are consequently redundant. This position resists the view that third-person data has to check and justify first-person data (cf. Chalmers, 2004, p.16). Rather, we can still attend to phenomenological descriptions that the Dennettian might consider 'fallible', and consider them valuable and informative – since all that fallible means here is that they don't map onto any existing, objectifying scientific explanation. We can be open to the incorporation of phenomenology into our scientific methodology, *and* preserve the idea that there is value in phenomenological descriptions themselves, independently of their naturalisation.

I have also offered an account of the phenomenology of pregnancy and early motherhood, focusing on the risk of depression-like experience in certain women during this period. The account I offered builds upon existing research in the phenomenology of illness. Following a discussion about the nature of both illness and pregnancy, I work to illuminate the structure of pregnancy experience, investigating phenomenologically-rich similarities that can hold between pregnancy and illness, particularly depression. The focus of this chapter is the

proposal that the phenomenological approach (of the sort that I defended in chapter one) is a strong candidate for offering a uniquely rich understanding of the experience of pregnancy and early motherhood, and that this might provide a way in which women vulnerable to illness, particularly depression, might develop resilience.

My final chapter illustrated how current attitudes in healthcare obstruct the sort of understanding of pregnancy and early motherhood that I introduced and celebrated in chapter two. My approach to this builds upon existing literature on epistemic injustice, and I suggest that such epistemic injustices are constitutively linked to the paradigmatic approach to the mind and brain that I discussed and resisted in chapter one. Crucially, this chapter offers a defence of how and why a phenomenologically-informed understanding might be beneficial, and therefore how the effects of the epistemic injustices discussed may be mitigated. My intention is to shed light on an avenue for further sensitive research in applied phenomenology that is concerned with the philosophy of pregnancy and early motherhood.

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