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The existential dimension in psychiatry: an enactive framework

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ABSTRACT
In his paper *Psychiatry and religion: Consensus reached!*, Verhagen advocates the relevance of spirituality and religion for the "origins, understanding, and treatment of psychiatric disorders". In this comment, I argue for the broader claim that the existential dimension is important for understanding psychiatric disorders – of which religion can, but must not necessarily be, part. The existential dimension refers to our ability to relate to ourselves, our experiences, and our situation. This evaluative relation can play an important role in psychiatry: it can co-constitute the disorder, be affected by the disorder, and/or modulate the course of the disorder. Given this importance, it makes sense to explicitly recognize the existential dimension in our explanatory model of psychiatric disorders. The biopsychosocial model goes a long way in providing an integrative model, but there is room for improvement, especially when it comes to integration of its aspects, and acknowledging the existential aspect. I briefly introduce the research paradigm of enactivism, and suggest that an enactive framework is well-suited to incorporate this existential dimension – along with the traditional dimensions of the biopsychosocial model.

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In his paper *Psychiatry and religion: Consensus reached!* Verhagen advocates the relevance of spirituality and religion for the "origins, understanding, and treatment of psychiatric disorders" (Verhagen, 2017, p. 518). In this comment, I will argue for the broader claim that the *existential dimension* is important for understanding psychiatric disorders – of which religion can, but must not necessarily be, part. And I will suggest that an enactive framework is well-suited to incorporate this existential dimension – along with the traditional dimensions of the biopsychosocial (BPS) model.

The existential dimension

The "existential dimension" refers to the dimension that opens up due to the capacity to *relate* to our experiences. That is, we do not just experience things but we can also take stance on these experiences, on ourselves and on our situation. This reflexive relation

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has been a central theme in phenomenology and philosophical anthropology and has been taken to be a specific characteristic of human beings. Plessner (1981) called it our "excentric position": we do not coincide with our experiences and the situation here and now. Heidegger (1927/1962) characterises our condition as "the being who is concerned about its being" and who "relates to its being" – thereby following Kierkegaard (1849/2008) who defined the self as relating to itself.

Our existential stance is typically an *evaluative* relation. Just as our experience of the world is not of a neutral collection of objects, but is rather engaged and motivated by our concerns, our stance on ourselves and our situation too is motivated and evaluative. We can be ashamed of present or past wrongs, we can be proud of ourselves, we can lie and feel guilty about lying, we can dread things in the future, or look forward to events in pleasant anticipation.

Although stance-taking presupposes reflective abilities it includes more than just deliberative reflection: stance-taking can also be *unreflective* and *implicit* in our actions. That is, we need not have a well-formulated, thought-through, explicit standpoint on things: our stance on something may be implicit in the way we behave. Sometimes we may not even be aware of our stances. I might for example unreflectively act on certain norms of femininity that I might even reject if I would become aware of them. Or I could feel betrayed by a friend and only then realise what I apparently expect from a friend.

How does this existential dimension relate to the spirituality and religion that Verhagen (2017) writes about? Our capacity for stance-taking opens up an existential dimension to our lives. This includes our capacity to ask "the big questions of life", such as who we are, and what we should do, and what we consider to be a good life. Religions provide specific answers to these questions. As such they provide an important hold for existential sense-making for many people. Non-religious people, however, will answer these big questions differently (i.e., without appealing to the transcendent). Besides, these big questions are just one *aspect* of the existential dimension. Our stance on ourselves, others, and the world is at play much more generally and pervasively in our everyday lives: in what we do and how we do it.[1]

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The existential dimension in psychiatric disorders

This existential stance of relating to oneself, to others, and to one's situation is crucial for understanding psychiatric disorders (de Haan, in press). One could even argue that our ability to take such a stance forms the very precondition for the emergence of psychiatric disorders (Fuchs, 2011). The idea here is that because we do not coincide with ourselves and with our present situation, we can suffer from alienation – which may go on to develop into full-blown psychiatric disorders such as schizophrenia or depression. Besides, according to theorists of the existentialist tradition in psychotherapy (Frankl, 1963; May, 1983; van Deurzen-Smith, 1988; Yalom, 1980), many, or even most, of the problems encountered in psychiatry are the result of existential concerns. Regardless of whether one accepts such aetiological or developmental views, however, the existential dimension, broadly understood is always involved in psychiatric disorders.

First of all, the way in which patients relate to their experiences and their situation may play a *constitutive* role in the disorder. This is, for example, the case in anxiety disorders where the fear of getting a panic attack is an inherent element of the disorder itself.

Such fear for the fear can sometimes even be the most disabling aspect of the disorder Frankl (1946/1955). Secondly, psychiatric disorders can also *include* patients' stance-taking. A depression for instance also affects one's reflective stance on things: it is part of being depressed to have no hope for future change and to have a distorted perception of the past. The degree to which someone is still capable of taking an "objective" stance or a reflective perspective on their own experiences and actions is often a very relevant diagnostic criterion. It marks, for example, the difference between an obsessive-compulsive disorder and an obsessive-compulsive personality disorder. For psychotic disorders too, it makes a big difference whether someone speaks of experiences in an "as if" mode ("It was *as if* my girlfriend could read my thoughts", "It seemed *as if* I could control the traffic at the junction under my window") or rather accepts these experiences as a given.

Thirdly, the existential relation of patients to their experiences and situation can have important *modulatory* effects on the course of the disorder and on patients' well-being. For instance, feelings such as shame and guilt can have an enormous impact on whether or not patients seek help or confide in others. Many patients are ashamed of their experiences and their shame can lead to avoiding social contact – which then adds the adverse effects of social isolation to their problems. Besides, patients need to come to terms not only with their (altered) experiences, but also with being diagnosed with a psychiatric disorder and all that implies or is felt to imply. Getting diagnosed with a psychiatric disorder can bring up fundamental questions about identity and authenticity: is the disorder part of who I am? Or is it rather something external to me? How one relates to one's disorder can in turn affect decisions on treatment: for instance whether or not medication is experienced as bringing back the "real" self, or rather as altering oneself (Karp, 2009; Kramer, 1997). And what are the implications of having such a disorder for the kind of life I want to live? Am I suited for bringing up children? Could I cope with such a demanding job? Who do I inform about the disorder and what will be the implications of that?

In all these ways, the relation of patients to their experiences and their disorder is likely to co-determine the course of their illness, and of their lives in general.

Biopsychosocial is not enough

In his paper, Verhagen (2017) rightly points out that we need "at least a heuristic model" (p. 516) to take into account the role of religion, spirituality, and meaning more broadly for psychiatric disorders. The most holistic model available for psychiatry so far is the well-known BPS model, as introduced by Engel (1977, 1980). It has, however, two major drawbacks, that Verhagen also points to. The first critique is that the BPS model insufficiently integrates its three aspects (Drayson, 2009; Ghaemi, 2009; Van Oudenhove & Cuypers, 2014). Engel relied on Von Bertalanffy's (1950) General Systems Theory to explain and model the relation between the three aspects, but since then Systems Theory has evolved considerably. In particular, Complex Systems Theory, Dynamical Systems Theory, and Network Theory allow us to model complex, interacting, and non-linear processes (Moreno, Ruiz-Mirazo, & Barandiaran, 2011) – the kind of processes most likely to be at stake in psychiatric disorders.

Furthermore, and especially relevant here, the BPS model does not explicitly acknowledge the existential dimension. Admittedly, the way in which patients evaluatively relate to their disorder and their situation, in general, seems to be implicit in the psychological

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aspect: Engel (1980) for instance mentions the relevance of whether or not the patient has *accepted* the reality of his illness (p. 540). But by leaving the psychological aspect thus "undifferentiated" (Verhagen, 2017, p. 516), the BPS model runs the risk of not doing justice to patients' subjective experiences (Brendel, 2007; Verhagen, 2017). Given the special importance of the existential stance for understanding and treating psychiatric disorders, it is helpful to recognise it as a separate dimension.

An enactive framework for psychiatry

The challenge is thus to better integrate not only the biological, psychological, and social dimensions of psychiatric disorders, but their existential dimension too. One promising route is to adopt an *enactive* perspective on psychiatric disorders. Enactivism is a research paradigm for cognitive science that was introduced out of dissatisfaction with the prevailing narrow, cognitivist understanding of cognition (Stewart, Gapenne, & Di Paolo, 2010; Thompson, 2007; Varela, Thompson, & Rosch, 1991). Building on Dynamical Systems Theory, phenomenology, system's biology, and Buddhism, Varela et al. (1991) proposed an understanding of cognition as being a fundamentally embodied and embedded form of action. Cognition should be understood as the *sense-making* activity of an organism in interaction with its environment. This sense-making is a fundamental part of being alive: in order to stay alive, an organism must make sense of its environment-even if only in the very basic sense of distinguishing food from non-food, danger from safety, mates from non-mates, etc.[2] Living beings are dependent on their environment for their survival and this dependence implies the need for some (basic) form of sense-making activity of the organism.

This is the gist of the so called "life-mind-continuity thesis" of enactivism: there can be no living without some form of sense-making (or "cognition", or "mind" – but these have the disadvantage of being nouns rather than verbs) (Di Paolo, 2009; Thompson, 2007). In this way, enactivism avoids opposing a physical realm on the one hand and an experiential realm on the other with the subsequent difficulty of somehow connecting them again. According to the enactive life–mind continuity thesis, with the emergence of life, mind (i.e., sense-making) emerges too – albeit in a very basic variant. In contrast to physical aggregates, biological, living systems show that *matter in specific organisations is minded.*

What makes enactive ideas particularly suited as the basis for developing an integrative account of psychiatric disorders, is that enactivism offers a thoroughly non-reductionist and non-dualist form of naturalism. From a dynamical system's perspective and what could be called a "relational ontology", enactivism contests several traditional dichotomies, such as body versus mind, cognition versus emotion (sense-making rather is affective) (Colombetti, 2014; Colombetti & Thompson, 2008), and, to some extent, even fact versus value (de Haan, in press). The biological, psychological, and social aspects of the BPS model can be reconceived as standing in a part-whole *constitutive* relation rather than a *causal* one. Whereas Engel (1980, p. 537) speaks of the connection between biological, psychological, and social in terms of "information flow across levels", an enactive framework allows us to radically rethink their relation as different aspects of one complex person–world system (de Haan, in press). Much more needs to be said about that, but this falls beyond the scope of this comment: here the focus is on the existential dimension.

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Existential sense-making

Enactive theorists have so far focussed mainly on basic forms of sense-making, but I argue for differentiating the notion of sense-making and distinguishing existential from basic or biological sense-making. With the capacity for stance-taking, a different form of sense-making and meaning arises. For the organism its environment is meaningful in the sense that their biological constitution implies that some things are food, or shelter, and thus become attractive when they are in a specific state (e.g., hungry or tired). Given the striving of the organism to survive, some things are good and others are bad for it. We can speak of "good" and "bad" in a functional sense here: the environment is good *for* something. Biological meaning or "valences" or "natural values" are thus the result of the organism's needs and concerns that come from being a vulnerable being that tries to stay alive. However, as soon as organisms[3] are capable of relating to themselves and their environment, like human beings, this functionality principle is loosened or altered. For it is no longer just survival that counts, but also living a good life. If *valences* result from being a needy creature in relation to an environment, we can say that *values* emerge for those organisms that on top of that can relate to this relation. We do not only have the will to survive, we also have the "will to meaning" as Frankl (1946/1955, 1963) calls it.

It is important to note that these existential meanings or values are not added on top as a layer of icing on a cake: they rather change the whole configuration. The existential sense-making to some extent alters the biological sense-making. Food is not merely food, sex is not merely sex, clothes do not merely keep us warm: all these are imbued with meaning. And this is inescapably so: even if we just wear whatever keeps us warm, than this is what our clothes express about us. Even if we are sceptical of "super foods" and just eat "normal food", there is no neutral terrain to escape to, because what is "normal food" is highly socio-culturally dependent. This existential meaning can even override the functional one: we can, for instance, refrain from eating although we are hungry and there is food available, because of spiritual reasons, or estimations of the social context (wait for the host to eat first), or because we want to lose weight. We can even choose to sacrifice our lives for other people, or for our ideals and convictions.

For organisms then, sense-making discloses a valenced environment. For reflexive beings, however, sense-making discloses a meaningful, value-imbued world.

Psychiatric disorders as disordered patterns of sense-making

What does this imply for psychiatry? Following an enactive framework, we can understand psychiatric disorders as *disordered patterns of sense-making*. It should first of all be pointed out that on an enactive account psychiatric disorders are not of the brain, not even of the body, but pertain to *persons*; that is, to bodily *and reflexive* beings. Persons, moreover, who cannot be understood apart from their socio-cultural worlds. From an enactive perspective then, if we want to understand psychiatric disorders, we should look at persons in interaction with their worlds. Furthermore, as is already implied by the notion of interaction, we need to look at this complex person–world system *over time* in order to understand its dynamics.

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What happens in psychiatric disorders? Do depression, anxiety disorder, schizophrenia, obsessive-compulsive disorder, eating disorder, autism, and other disorders have something in common? From an enactive perspective, psychiatric disorders are *disorders of sense-making*. That is, in psychiatric disorders, the evaluative interactions of a person with her world go astray. These interactions may include a person's thoughts, feelings, and/or behaviour – towards the world and/or to herself. On a very general level, we can say that the way in which the person makes sense of her world is *biased in a specific direction*: the world appears overly threatening, or meaningless, or meaningful, or chaotic. This bias needs to be structural: a single instance of inadequate sense-making does not yet amount to a disorder. Psychiatric disorders thus refer to a more or less stable *pattern* in how someone's sense-making goes astray over time. "Going astray" means that the person's sense-making is not *appropriate* to, or insufficiently grounded in, her situation. Moreover, she will find it difficult to *adjust* her sense-making. This difficulty in adjusting and attuning typically results in overly *rigid patterns of interactions*.

I cannot here further elaborate on the characteristics that mark psychiatric disorders as *disorders* rather than merely innocent variations of sense-making (see de Haan, in press). What is relevant here is that on this enactive account sense-making is central to the nature of psychiatric disorders. It is what makes psychiatric disorders *psychiatric* (rather than somatic) disorders. Psychiatric disorders are disorders of the way in which people relate to themselves, their world, and/or other people: disorders of sense-making. In somatic illnesses, these relations may also be affected, but *secondarily*, as an effect of the illness, whereas in psychiatric disorders these relations are rather *directly* concerned. Moreover, since sense-making necessarily includes existential sense-making, this means that on an enactive account the whole domain of existential values and socio-cultural norms form an inescapable part of psychiatry. Meaning more general is not a peripheral aspect but rather lies at the very heart of the problems that patients and their therapists deal with.

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To conclude

This has been merely a rough sketch of what an enactive framework for psychiatry looks like and what it has to offer. I hope to have made plausible that an enactive framework allows us to properly acknowledge not just the relevance of spirituality and religion, but, even more broadly, the relevance of the existential dimension for understanding and treating psychiatric disorders. Since psychiatric disorders pertain to the way in which one feels, acts, thinks, or makes sense of oneself and one's situation, it should come as no surprise that meaning in its many forms and variations is an essential element of psychiatry.

Notes

1. My use of the term "existential" thus follows the literal meaning of the Latin "ex sistere" or "ex stare": to being or standing outside of something.
2. Note that there is a difference between detecting food and detecting something *as* food. Sense-making in its most basic forms does entail the first but not the second. That is: a bacteria can sense a sucrose gradient – but that does not imply that it senses it *as* a sucrose gradient or *as* being food. In other words: sensing something does not necessarily include *being aware* of

sensing something. These are of course complicated issues and this is not the place to get into them, but see de Haan (in press).

3. Human beings are typically capable of reflection and stance-taking, but there is no principled reason why this has to be an *exclusively human* capacity. That is: I am not interested here in setting apart humans from other organisms, but only in distinguishing reflexive organisms (at least comprising human persons) from non-reflective organisms.

Disclosure statement

No potential conflict of interest was reported by the author.

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