Melancholia, Temporal Disruption, and the Torment of Being both Unable to Live and Unable to Die

Emily Hughes

Philosophy, Psychiatry, & Psychology, Volume 27, Number 3, September 2020, pp. 203-213 (Article)

Published by Johns Hopkins University Press
DOI: https://doi.org/10.1353/ppp.2020.0024

Melancholia, Temporal Disruption, and the Torment of Being both Unable to Live and Unable to Die

Emily Hughes

Abstract: Melancholia is an attunement of despair and despondency that can involve radical disruptions to temporal experience. In this article, I extrapolate from the existing analyses of melancholic time to examine some of the important existential implications of these temporal disruptions. In particular, I focus on the way in which the desynchronization of melancholic time can complicate the melancholic's relation to death and, consequently, to the meaning and significance of their life. Drawing on Heidegger's distinction between death and demise, I argue that melancholic time leaves the melancholic in an impossible state of existing, where they are both unable to live and unable to die. Turning to the role of the physician, I consider the significant role that clinical interventions might have in resynchronizing the melancholic with time and examine these ideas further through a case study on physician-assisted suicide. In so doing, I demonstrate that the desynchronization of melancholic time should indeed be understood as a matter of life and death.

Keywords: melancholy; death; temporality; suicide; Heidegger

> This despair achieves final form in those melancholics who are tortured with the fact that, unable to live, they are also unable to die.
> Hubertus Tellenbach in *Melancholy* (Tellenbach, 1980, pp. 165–66).

Melancholia is an attunement of despair and despondency that can involve radical disruptions to temporal experience. As existential and phenomenological studies in psychiatry and psychology have demonstrated, temporal disruptions in melancholic time can vary in intensity, but are almost always inducive of significant suffering and distress. The future can collapse such that the past becomes fixed. As a result, temporal momentum can falter and stagnate to the point of stasis. At a standstill, time can become impoverished and empty such that one finds oneself detached from temporality altogether, beyond or outside of time. In its most extreme contortions, then, melancholic time can

culminate in atemporality, a condition that can be defined as schizoid or desynchronized time.

In this article, I extrapolate from the existing analyses of melancholic time to examine some of the important existential *implications* of these radical disruptions to temporality. In particular, I focus on the way in which melancholic time can complicate the melancholic's relation to their death and, consequently, to the meaning and significance of their life.

First, I give an account of the descriptive interpretations of melancholic time given in existential and phenomenological psychiatry, with particular focus on the extreme experience of atemporality captured by Minkowski's concept of schizoidism and Fuchs' concept of desynchronization.

Second, I give an account of Heidegger's interpretation of death, composed as it is of the distinction between demising (one's experience of their terminal biophysical deterioration) and dying (one's experience of the non-terminal collapse of their intelligible world). I then argue that the desynchronization of melancholic time significantly complicates both the melancholic's experience of death, which is experienced as infinite, and demise, which is experienced as impossible. Melancholic time thus leaves the melancholic in an impossible state of existing where they are paradoxically both unable to live and unable die. Detached from their finite temporality, the capacity of death and demise to be transformative of the meaning and significance of one's life (as it is in Heidegger's account), is significantly diminished in melancholia.

Third, I consider how it is that various clinical interventions, for example, electric convulsive therapy or psychotherapy, might be effective (or ineffective) in helping the melancholic to resynchronize with their finite temporality. If this resynchronization can be attained, then I argue it is theoretically possible that the revelatory capacities of death and demise to transform the meaning and significance of the melancholic's life might be restored.

Fourth, I argue that these existential implications have important ramifications for the way we understand therapeutic interventions into melancholia, particularly in relation to death related issues like physician-assisted suicide. I argue that desynchronized from time, it is questionable that the melancholic is capable of making decisions about their life and death, which are so temporally dependent. Further, because suicide deprives the melancholic of death's capacity to transform the meaning and significance of their life, I argue that the role of the physician should be focused upon resynchronizing the melancholic with time rather than assisting in bringing about their demise.

Melancholic Time

The disruptions to temporality in the attunement of melancholia have been a significant focus in existential and phenomenological psychiatry and psychology throughout the twentieth and twenty-first centuries.[1] Although these disruptions can be heterogeneous,[2] I would argue that, as melancholic time unravels and becomes increasingly severe, there is a trajectory to which it can often be seen to conform. Initially, as Wyllie emphasizes, melancholia commonly modifies temporality by withholding or closing off the future (Wyllie, 2005, p. 180). As Straus writes, the blocking off of the future then intensifies the "determining violence of the past," which becomes fixed and unchanging. This means, that "[t]he more firmly the future is closed off to the depressive, the more strongly he feels overcome by and tied to the past. The malady that he experiences is decided, indeed determined irrevocably and unalterably, by the past" (Straus, 2012, p. 212). In the withdrawal of the future and the intensification of the past, the momentum of the lived present falters to the extent that time "slows down, stalls and finally comes to a stop" (p. 210). Melancholic situations thus come to be defined by what Tellenbach calls "remanence": namely an "inhibition of the 'basic movement of life'" which "*can slow the course of existence and bring it to the verge of stagnation*" (Tellenbach, 1980, p. 148). This means, as von Gebsattel writes, that "the process of becoming" is "brought to halt" (von Gebsattel, 2012, p. 217). Static and failing to extend, melancholic time becomes empty and impoverished.

At its most extreme, this empty impoverishment of time can lead to a radical disconnection from time itself. Minkowski and Fuchs interpret this detachment from time as the coming apart of subjective and inter-subjective time (Minkowski)

or ego and world time (Fuchs). On these views, a subject is for the most part synchronized with inter-subjective world time, such that they resonate with the temporal momentum of the world in which they are immersed. Minkowski defines this as "syntony," a concept that "alludes to the principle that allows us to vibrate in unison with the environment" (Minkowski, 1970, p. 73). Melancholic time, however, is *schizoid* time, which means that subjective time has become de-coupled from inter-subjective time. In making this idea of schizoidism concrete, Minkowski's 1923 paper titled "Findings in a Case of Schizophrenic Depression" details his extensive work with a 66-year-old patient who presents with depressive psychosis. In his case notes, Minkowski observes of the patient that he is aware of time as an abstract, objective construct, as something that elapses monotonously and uniformly through the passing of the days. Nevertheless, Minkowski argues, the patient's relation to time is a schizoid one. He writes:

> As day after day went by, a certain rhythm became evident to him: on Monday the silver was polished; on Tuesday the barber came to cut his hair; on Wednesday, the gardener mowed the lawn, etc. There was no action or desire which, emanating from the present, reached out to the future, spanning the dull, similar days. As a result, each day kept an unusual independence, failing to be immersed in the perception of any life continuity; each day life began anew, like a solitary island in a gray sea of passing time. What had been done, lived, and spoken no longer played the same role as in our life because there seemed to be no wish to go further; every day was an exasperating monotony of the same words, the same complaints, until one felt that this being had lost all sense of necessary continuity. Such was the march of time for him. (Minkowski, 2004, pp. 132–133)

Time is thus an arbitrary structure, which the patient views as if from the outside. This account resonates with some of Ratcliffe's research into the heterogeneity of temporal experiences in depression more generally. According to Ratcliffe, some respondents, "report a feeling of detachment from time—they are outside time; it has become irrelevant, insignificant, or meaningless" (Ratcliffe, 2015, p. 176), an experience which is captured in the following response:

> #271. When I'm depressed, for the most part there is no time. The concept of time no longer exists. It's like living outside of time. There is no concern or even awareness of schedules, day or night, normality, commitments, birthdays, events, nothing. It's like being in a box with no holes or light—time just disappears. (p. 184)

This further concurs with the autobiographical account given by the influential British psychiatrist Maudsley, himself a sufferer of melancholic depression. Maudsley writes that in melancholia:

> There is a feeling of eternity, no feeling of time, in relation to it. Of the worst grief there is always, when in health, a tacit or subconscious instinct of ending; but here an all-absorbing feeling of misery so usurps the being that there is no real succession of feelings and thoughts, no sense of time therefore, a sense only of an everlasting is and is to be. (In Broome, 2005, p. 187)

Taking these studies together, melancholic time can be seen to denote a radical break-down of the coherence of one's temporal situatedness. At the same time, there is an oft distressing awareness of world time, as an abstract, arbitrary construct from which they finds themselves excluded. This disjuncture can thus be understood as involving a transition from "implicit" to "explicit" temporality. Here one's absorption in the becoming of lived time (implicit temporality) is interrupted by a shock, pain, or loss, such that lived time becomes a segmental time that is consciously experienced (explicit temporality) (see Fuchs, 2005, 2013). As Fuchs (2001) writes:

> With increasing inhibition, the basic movement of life finally comes to a standstill . . . the depressive has fallen out of common time and has become, as it were, a living anachronism. He literally lives in another, sluggish time. Nevertheless, the external, intersubjective time runs on for him, i.e. it passes him by. Because of this uncoupling, it appears as an empty, only transient time that he cannot fill or shape any more. (Fuchs, 2001, pp. 183–184)

From the withdrawal of the future to stagnation and stasis, melancholic time at its most severe can be seen to culminate in comprehensive desynchronization where, as a living anachronism, one is abandoned to a schizoid relation to time. As Straus writes, in desynchronized or schizoid melancholic time, "a temporal vacuum is created"

(Straus, 2012, p. 213), such that one finds oneself abandoned to an atemporal, timeless abyss.

To interpret the significance of these radical disruptions to temporal experience, I now want to consider how it is that the schizoidism or desynchronization of melancholic time affects the way in which the melancholic relates to the possibility of their death and, correlatively, to the meaning and significance of their life. Wyllie gives some insight into how we might interpret these existential implications of melancholic time in the article "Lived Time and Psychopathology." According to Wyllie, the atemporality of melancholic time condemns the melancholic to a "'negative eternity.'" This negative eternity then "leaves the individual in an impossible state of existing" because "*one cannot become in a void*" (Wyllie, 2005, p. 182). As Wyllie writes:

> For those "immortal" persons suffering from "advanced states of melancholia," their suffering may be unbearable and infinite, and it is unbearable because it is infinite. With the absence of temporal movement and the presence of suffering, suffering becomes perpetual suffering. Perpetual suffering is suffering with a beginning but no end. Suffering is perpetual if it began, and in so beginning stops temporal movement. Suffering without temporality is suffering that will not end. (p. 182)

Abandoned to the atemporality of melancholic time, the melancholic is forced to suffer an existence of *lived impossibility as such*, where one's suffering becomes infinite. According to Wyllie, the reason the melancholic cannot become in a void, that they cannot strive towards meaningful projects and possibilities, is that they are *immortal*. What does this mean? How is it that infinitude might correlate with immortality? To understand how it is that temporality, life and death are so integrally interconnected, we need to have a coherent understanding of the "ontological" conception of (life and) death, which we can find in the philosophy of Martin Heidegger, to whom Wyllie is no doubt indebted.

Melancholic Time and the Complication of Death and Demise

In his masterwork *Being and Time* (1927), Heidegger sets out what is one of the most paradigmatic and influential examples of an "ontological" interpretation of death; ontological because it considers the way in which death relates the question of Being. Heidegger's conception of death is important but difficult, and the exact role that death plays in his philosophical project remains controversial (see Thomson, 2013, p. 260). Commenters such as Aho (2016), Blattner (1994), and Thomson (2013) rightly emphasize, however, that to grasp the significance of Heidegger's concept of death it is critical to understand his distinction between "demising" (*Ableben*) and "dying" (*Sterben*).[3]

For Heidegger, demising and dying represent two different yet compatible means through which the radical "finitude" of human existence or "Dasein" is disclosed.[4] That is, both demising and dying reveal the fact that Dasein's existence is constrained by the limit or end of a finite temporality. Although demising is "ontic," meaning it refers to the concrete reality of a particular human being, dying is "ontological," which means it refers to the structure of Dasein's being as such. Yet, as Thomson emphasizes, both demising and dying are indicative of the end of Dasein, as Dasein's ownmost, non-relational, certain and yet indefinite possibility that cannot be outstripped or surpassed (Thomson, 2013, pp. 275–276). Thus, although demising is ontic and dying is ontological, both concepts are disclosive of the uttermost limits of Dasein's being, of the groundlessness of its existence, and thus of its radical finitude, and can be seen to map onto each other in a coherent way.

Demising is an ontic phenomenon which refers to way in which human beings as Dasein ("being-there") *relate* to their inevitable biological deterioration. That is, the way we "affectively experience, interpret, and give meaning to our impending

physical death" (Aho, 2016, p. 58). Dasein's relation to its own demise is predominantly defined by a fear that one day its intelligible world will eventually suffer a *terminal collapse* (see Thomson, 2013, p. 264).

Dying, by contrast, is an ontological phenomenon which, according to Heidegger's idiosyncratic definition, refers to the *non-terminal* collapse of our intelligible world, wherein Dasein is "temporarily cut off from the world in terms of which it usually understands itself" (Thomson, 2013, p. 266). Understood as a comprehensive yet non-terminal world-collapse, death is the most radical of "limit situations" which "defines the limits of Dasein's ability-to-be," its capacity to understand itself in terms of its meaningful projects and possibilities (Blattner, 1994, p. 67). Dasein finds itself confronted with this limit situation when, attuned by anxiety, it is withdrawn from the world of its concern, as the structures of signification or intelligibility fall away. Distressed and overwhelmed, Dasein is consumed by the unsettling feeling of radically being-not-at-home in the world. In the midst of its homelessness, Dasein finds itself confronted with *non*-being. Death thus unconceals what Aho describes as the "structural vulnerability" or "structural frailty" (Aho, 2016) that is inherent to Dasein's being, the groundless ground of its existence.

Understood as the non-terminal collapse of Dasein's intelligible world, death is not an event for Heidegger. It is not the moment in time at which biological life comes to an end (as in demise). Rather, death is understood as the "possibility of the absolute impossibility of Dasein" which Dasein "takes over as soon as it is" (Heidegger, 1962, p. 294/GA, SZ, 250). As the possibility of the impossibility of Dasein, ontological death is understood as the "possibility of the impossibility" of "every way of existing" (p. 307/GA, SZ, 262), of every way of understanding itself in terms of meaningful projects and possibilities.

In contrast with demise, which is terminal, ontological death is something that Dasein paradoxically *lives through*. As Thomson writes

> When my being-possible becomes impossible, I still am; my ability-to-be becomes insubstantial, unable to connect to the world, but not inert. My projects collapse and I no longer have a concrete self I can be, but I still *am* this inability to be. (Thomson, 2013, p. 271)

This means that to suffer death is to endure one's own inability to *be* amidst the collapse of their intelligible world. However, by reckoning with the groundlessness of its existence, with non-being, Heidegger argues that Dasein comes to realize that that which is at stake in death is nothing less than the meaning and significance of its existence, its being-in-the-world, for which it alone is responsible. By resolutely taking over the possibility of its own impossibility in "Being-towards-death," Dasein recognizes *that it is*, and thus that it is a being for whom Being is an issue. Essential to this realization is Dasein's recognition that its being-in-the-world is grounded in *finitude*, and structured by a finite temporality. As Thomson writes,

> When Dasein experiences itself as desperately unable to project into the worldly projects in terms of which it usually understands itself, then "the future itself is closed" for Dasein (even though objectively "time goes on"). Bereft of all its worldly projects, Dasein can fully grasp itself in its own "finitude" for the first time—and thereby come to understand itself as a "primordial existential projecting." (2013, p. 266)

This finitude is therefore what makes it possible for the possibility of death to consolidate the possibilities of one's life into meaningful projects in such an urgent, and often radical way.

Following Aho, I would argue that, along with trauma, loss, or serious illness, major (or melancholic) depression can be understood as a paradigmatic example of the limit situation of ontological death. As Aho writes, in major depression "activities and projects that used to be pleasurable lose all significance, future events are stripped of their emotional resonance, and the motivation to move forward and engage with the world breaks down" (Aho, 2016, p. 59). Understood as such, major depression can be interpreted as a non-terminal world-collapse, in which one experiences the possibility of the impossibility of every way of existing, and traumatically endures their own death. On a Heideggerian account, this distressing experience of death and the confrontation with the groundlessness of one's existence makes possible

the radical transformation of the meaning and significance of one's life. However, in considering the way in which melancholia *temporalizes*, I want to argue that melancholic time can be seen to significantly complicate Heidegger's account of death and demise, and its capacity to transform one's life in a revelatory way.

As discussed above, as the temporality of melancholia unfolds, the future can collapse such that the past becomes fixed. As a result, temporal momentum can falter and stagnate to the point of stasis. At a standstill, time can become impoverished and empty such that one finds oneself detached from temporality altogether, beyond or outside of time. At its most extreme, therefore, melancholic time involves a schizoid or desynchronized relation to time such that one finds oneself abandoned to an atemporal, timeless abyss. With desynchronization, melancholic time brings Heidegger's interpretation of death and demise to a paradoxical impasse.

Having experienced the collapse of their intelligible world, of any possible way of existing, the melancholic is in the midst of their own death. Yet, utterly detached from time, the melancholic experiences their death, the non-terminal collapse of their intelligible world, as being infinite; no longer temporary, but permanent. Correlatively, the melancholic experiences their demise, their terminal biophysical deterioration, as being impossible rather than inevitable. Melancholic time thus leaves the melancholic in an impossible state of existing, caught in an irresolvable strife wherein they have already died but can no longer demise. Normally contiguous, death and demise are splintered apart in melancholic time, which gives us the means through which to understand Tellenbach's claim that "despair achieves final form in those melancholics who are tortured with the fact that, unable to live, they are also unable to die" (Tellenbach, 1980, pp. 165–166). Paradoxically unable to live and unable to die, the melancholic's suffering and despair are immortalized.

As long as they are desynchronized from time, the melancholic is unable to ground themselves in the finitude that is essential if their experience of death and demise is to be transformative of the meaning and significance of their life, an integral component of Heidegger's interpretation. The question then arises as to whether there are any means through which to address the radical ways in which melancholia disrupts time and to thus restore the melancholic's relation to both their death and their life. This is where clinical interventions into melancholia become absolutely critical.

Clinical Interventions

Because finite temporality is that which makes it possible for Dasein to relate to its death and thereby take up the meaning and significance of its life, it is essential that therapeutic interventions focus upon restoring and supporting "the missing processes of synchronization" (Fuchs, 2001, p. 184). Yet, although significant research has been undertaken on the breakdown of temporal situatedness in melancholia, far less research has been done on how to approach the question of resynchronization following such a breakdown in either theory or practice. Fuchs makes one such attempt in his article "Melancholia as desynchronization: Towards a Psychopathology of Interpersonal Time" (2001). Here Fuchs suggests that both biological interventions (such as pharmacological and electroconvulsive therapy [ECT], sleep deprivation or light exposure) and psychotherapeutic interventions might be used in restoring the patient's relation to time, but only focuses on the importance of the latter in his discussion.

If we consider one particular biological intervention to which Fuchs alludes, that of ECT, there is evidence to suggest that this treatment may potentially aggravate rather than alleviate the problem of desynchronization in melancholic time. The possible memory loss associated with ECT in the form of the erasure of autobiographical memories or retrograde amnesia, continues to be a controversial issue, in part because there is very little consensus between medical practitioners and patient advocacy groups around the precise cause of the memory problems (i.e., is the memory loss caused by ECT or is it a side effect of the depressive illness itself) and the severity of the memory problems (data varies significantly depending on how long after the treatment the assessment is made for example, or whether the patient received

unilateral or bilateral treatment) that are experienced by those who have undergone ECT.[5] Yet, regardless of the lack of clarity around the data, the significant distress and suffering experienced by those who *do* report profound and persistent memory loss is concerning, as autobiographical accounts make compelling clear.[6] Because memory is grounded in the ecstasis of the past, the erasure of autobiographical memories or retrograde amnesia would almost certainly exacerbate the melancholic's feeling of detachment from time. In so doing, ECT may have the unintended consequence of intensifying the desynchronization of melancholic time such that the melancholic's distorted relation to death and demise becomes significantly prolonged (perpetually in the case of ongoing treatment plans such as maintenance ECT). These potential consequences should be kept in mind when considering biological treatment options such as ECT for patients who are experiencing temporal desynchronization. Further research could interrogate whether treatments such as repetitive transcranial magnetic stimulation, transcranial direct current stimulation, or ketamine have a less deleterious impact on the patient's temporal situatedness.

Although they should not be considered in isolation from biological interventions, Fuchs' brief discussion of possible psychotherapeutic interventions into melancholic time is to my mind more promising, not least because these are grounded in inter-personal relationships, which are inherently temporal. First, Fuchs suggests constructing a "spatial and temporal frame" or "time-out" within which the recovery might take place. Depending on the severity of the patient's symptoms, this spatial and temporal frame could either be constructed around a time-limited in-patient hospital stay or a frequent schedule of out-patient appointments. Second, Fuchs emphasizes the importance of recreating the rhythm of everyday life "since it helps the patient to gain a stand against fleeting time." Whether the patient is an in-patient or an out-patient, this rhythm could be re-created around everyday activities such as getting up at a similar time each day, making a coffee, reading the newspaper, walking outside to check the mail box, attending therapy sessions, and so on and so forth. Third, Fuchs suggests that it is critical to work on the patient's protensivity, or their orientation toward future goals. This involves discussion of the patient's projects and possibilities which, in the beginning could be as seemingly straightforward as planning to meet a friend for coffee the following week. As the patient's sense of protensivity is consolidated, these projects may increase in complexity and weight, returning to university to take up studies that one has long wanted to pursue, for example. Fourth, Fuchs argues that protensivity then makes possible "a degree of activation and stimulation," a filling of idle-time, which he calls "optimal resynchronization." In the case of planning to meet for coffee, this could involve thinking about bus timetables or filling up the car with petrol, and preparing some clean clothes to wear. In the case of the more demanding plan to return to university, this could involve fulfilling administrative tasks, obtaining and revising text-books, communicating with lecturers and arranging to be on campus on particular days, and so on. Finally, once the acute depressive episode is in remission, Fuchs suggests that it is important to further the processes of resynchronization by working through the things that caused the desynchronization in the first place, for example grief or significant change (Fuchs, 2001, p. 185). This is when some of the most important psychotherapeutic work can be done in the context of regular therapy sessions. It is anticipated that, as the patient's depression moves into remission, the initially contrived rhythm that was re-created to structure their everyday life will increasingly give way to the temporal momentum and flow of lived time itself. Having resynchronized the melancholic with their finite temporality, psychotherapy can then support the patient in recreating new structures of signification, such that they can re-situate themselves within a newly intelligible world within which to take up meaningful projects and possibilities. In so doing, it would then be theoretically possible for the patient to reckon with the experience of their death and demise and the way in which these experiences might help them transform the meaning and significance of their life. On Heidegger's account, this is done by reckoning with the groundlessness of one's exis-

tence, with the non-being that death disclosed. Through this confrontation, the melancholic can come to realize that that which is at stake in death is nothing less than the meaning and significance of their existence, their being-in-the-world, for which they alone are responsible. By resolutely taking over the possibility of their own impossibility in "Being-towards-death," the melancholic can be helped to recognize *that they are*, and thus that they are a being for whom Being is an issue.

Although this only constitutes a preliminary sketch of how psychotherapeutic interventions might attempt to restore the melancholic's re-synchronization with their finite temporality, the above provides a point of departure for further research. It should be emphasized, though, that although Fuchs' psychotherapeutic intervention into melancholic time is the most promising with regards to temporal desynchronization, it presupposes that the melancholic patient is able to sustain a meaningful engagement in the therapeutic process. Keeping in mind the practical realities of clinical care, it may be that for the most severely depressed patients, treatment with ECT (or repetitive transcranial magnetic stimulation, transcranial direct current stimulation, or ketamine) is necessary in the short term—despite the risk of potentially significant side effects—if the patient is to be capable of even commencing psychotherapy in the medium and long term. It is also the case that ongoing pharmacotherapy may be required in conjunction with psychotherapy to help the patient sustain their mood throughout the therapeutic process.

Case Study: Physician-Assisted Suicide and Major Depressive Disorder

Following on from this discussion of clinical interventions into melancholic time, I want to consider how it is that the case study of physician-assisted suicide in the instance of major depressive disorder might help us to understand the significance of what is at stake in this interpretation of melancholia, temporal disruption, and the torment of being both unable to live and unable to die. In so doing, I hope to make clear that the radical disruptions to temporal experience in psychiatric conditions such as major depressive disorder are not merely of abstract philosophical interest, but can be seen to impact the questions of life and death in a way that has very real consequences for both the melancholic patient and the physician responsible for their care.

The idea that melancholic time paradoxically involves both the inability to live (the experience of death as infinite) and the inability to die (the experience of demise as impossible) has important ramifications for the way in which we understand the complex relation between melancholia and death-related phenomena such as physician-assisted suicide. Legal in Belgium and the Netherlands, physician-assisted suicide on the grounds of unbearable suffering caused by a refractory psychiatric illness is a controversial issue within the "Assisted Death" discourse. The most commonly cited psychiatric illness is "treatment resistant major depressive disorder," of which melancholia is often an important feature. As Berghmans, Widdershoven, and Widdershoven-Heerding (2013, p. 436) note, for physician-assisted suicide more generally to be considered acceptable medical practice in the Netherlands, the physician must:

a. be satisfied that the patient's request is voluntary and well-considered;
b. be satisfied that the patient's suffering is unbearable, and with no prospect of improvement;
c. inform the patient about his or her situation and prognosis;
d. have come to the conclusion together with the patient that there is no reasonable alternative in the patient's situation;
e. consult at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled; and
f. exercise due medical care and attention in terminating the patient's life or assisting in suicide.

When the specific reason for requesting a physician-assisted suicide is a psychiatric illness such as treatment resistant major depressive disorder, then these ostensibly well-defined criteria become somewhat less clear. Complex debates intersect medicine, psychiatry, psychology, psychotherapy, law, ethics, and philosophy, and revolve, in part, around the following issues: the cognitive com-

petency of a severely depressed person to make a well-considered, informed decision to die; the rationality or irrationality of the desire to die, especially when suicidal ideation is considered a pathological symptom of psychiatric illnesses such as major depressive disorder; whether or not a psychiatric illness can ever be unequivocally defined as "treatment resistant," such that the prospect of improvement can be definitively excluded; the conflict between the physician or psychiatrist's duty of care and the depressed persons autonomy.[7] These critical debates are important in considering the epistemological, ethical and legal implications of physician-assisted suicide in the case of psychiatric illnesses such as treatment resistant major depressive disorder. Yet, if we consider the question of physician-assisted suicide in the context of melancholic time and Heidegger's distinction between death and demise, then we are given an entirely unique vantage through which to understand what is at stake in melancholic depression.

Desynchronized from time, the melancholic is paradoxically both unable to live and unable to die. As such, it is comprehensible that the melancholic may attempt to clutch their finitude back by bringing about their own destruction. That is, by actualizing their demise in their own annihilation. By attempting to bring about their demise (their terminal biophysical deterioration), which is permanent, the melancholic demonstrates a lack of insight into the fact that they are in the midst of experiencing their own death (the non-terminal collapse of their intelligible world), which is temporary. This misunderstanding is a direct consequence of their desynchronization. In actualizing their demise, however, the melancholic irrevocably undermines the revelatory capacity that the experience of death has in transforming the meaning and significance of life. This is a possibility that they are demonstrably incapable of grasping, because it is grounded in the finitude that they have become detached from. As Heidegger writes in *The History of the Concept of Time*:

> I have already indicated that the relationship of being to a possibility must be such that it lets the possibility stand as a possibility, and not such that the possibility becomes reality, perhaps by causing my own death in suicide. By suicide I surrender the possibility precisely as possibility; it is radically reversed, for it becomes a reality. The possibility is, however, just what it is only when it is left standing, that is, when it is left standing before us as impending. (Heidegger, 1985, p. 317/GA, 20, 439)

This means, as Heidegger writes in *Being and Time*, that if Dasein were to concern itself with "actualizing what is thus possible," by "'bringing about [its'] own demise,'" then it "would deprive itself of the very ground for an existing Being-toward-death" (Heidegger, 1962, p. 305/GA, SZ, p. 261). That is, Dasein would deprive itself of death's capacity to transform the meaning and significance of its life.

Physician-assisted suicide is concerned with alleviating suffering by bringing about the melancholic's demise, their immanent biological deterioration. Yet, given the way in which melancholia temporalizes, and the way in which melancholic time complicates the melancholic's relation to death and demise, can it be considered acceptable medical practice? It is undeniable that the melancholic's desire to bring about their own demise through annihilation is understandable. It may be voluntary, well-considered, logically coherent, and even rational. For those who are tormented by it, melancholic suffering *is* an anguished despair that is utterly unbearable, and which excludes the possibility of any improvement or reasonable alternative. Nevertheless, on the criteria stipulated above I would suggest that physician-assisted suicide in the case of major depressions that include significant temporal disruption are not acceptable. Desynchronized from time, it is highly questionable as to whether the melancholic patient can be judged competent to make assessments about their own life and death ("no prospect of improvement," "prognosis," "reasonable alternative," etc.) that are so *temporally dependent*. Without being grounded in finite temporality, the mere idea that one's suffering might be made bearable, might improve, or might give way to an alternative situation, is utterly incomprehensible because there is no intact future in which these changes could possibly take place. The underlying temporal structure upon which this possibility depends has utterly collapsed.

Given this, rather than assisting the melancholic in bringing about their own demise, I would argue that the long-term aim of the physician should be to resynchronize the melancholic with their finite temporality. As discussed in the previous section, this may necessarily involve the short-term use of ECT, repetitive transcranial magnetic stimulation, transcranial direct current stimulation, or ketamine until such time that the patient is able to engage in psychotherapy, at which point the long-term use of pharmacotherapy may also be required. Throughout the therapeutic process, the physician should work toward giving the patient insight into the fact that their suffering is possibly so unbearable because it is unfolding in atemporality or timelessness, which is why it feels irremediable. They should work toward an understanding—however rudimentary—that, although the world-collapse of their death feels like it is infinite, it is in fact non-terminal. And although the biological deterioration of their demise feels like it is impossible, it is in fact an inevitability. Perhaps most important, I would argue that the role of the physician is to sustain the possibility on behalf of the patient that, were they able to resynchronize with their finite temporality, then their restored experience of death and demise might actually be transformative of the meaning and significance of their life.

As long as they are detached from time, both unable to live and unable to die, it is likely that the melancholic is completely incapable of grasping the transformative potential of their death. Indeed, it may not be until they are in full remission and resynchronized with time that they themselves are capable of engaging with these ideas. If, at such time, the melancholic determines that their experience of death does *not* have the potential to transform their life, then it may be necessary to reconsider whether they now legitimately fulfill the criteria for physician-assisted suicide. To assist in their demise *before* such time, however, would be to deprive the melancholic of the potential that their experience of death has, according to Heidegger, in transforming the meaning and significance of their life. Until the melancholic is resynchronized with their finite temporality, therefore, it is my view that the physician has an obligation to hold open this possibility for them.

Notes

1. See in particular (Fuchs, 2001; Minkowski, 1970, 2004; Ratcliffe, 2012, 2013, 2015; Straus, 2012; Tellenbach, 1980; von Gebsattel, 2012; Wyllie, 2005).

2. Ratcliffe is incisive on the heterogeneity of temporal experience in depression. See (Ratcliffe, 2012, 2015).

3. Although I am focusing on the distinction between dying and demise as these are the categories that pertain to Dasein, Heidegger's interpretation of death includes a third category, "perishing" (*Verenden*). Perishing refers to the biological degeneration anything that is alive, such as humans, animals, or plants; the "going-out-of-the-world of that which merely has life" (Heidegger, 1962, pp. 284/GA SZ, 240). See also (Heidegger, 1995).

4. Heidegger uses the term "Dasein" or "being-there" to refer to the fact that the human being is always already thrown into the world as being-in-the-world in such a way that the question of Being is necessarily an issue.

5. See especially Rose, Wykes, Leese, Bindman, and Fleischmann (2003), Bergsholm (2012), Kumar, Han, Tiller, Loo, and Martin (2016), and Brus, Nordanskog, Båve, Cao, Hammar, Landén, Lundberg, and Nordenskjöld (2017).

6. See for example, Donahue (2000).

7. For a good orientation to these debates see the special issue in Volume 36 of the *International Journal of Law and Psychiatry* titled "Suicide, Euthanasia, and Assisted Suicide." See especially Berghmans et al. (2013), Cholbi (2013), Gillett and Chamberlain (2013), Pols and Oak (2013), Schramme (2013), and Wittwer (2013). For a discussion of physician-assisted suicide and treatment resistant major depressive disorder as such, see the following collection of articles in the *Journal of Medical Ethics*: Broome and de Cates (2015), Cowley (2015), Miller (2015), and Schuklenk and Van de Vathorst (2015). See also Blikshavn, Husum, and Magelssen (2017), Dembo, Schuklenk, and Reggler (2018), and Steinbock (2017).

References

Aho, K. A. (2016). Heidegger, ontological death, and the healing professions. *Medicine, Health Care and Philosophy, 19*, 55–63.

Berghmans, R., Widdershoven, G., & Widdershoven-Heerding, I. (2013). Physician-assisted suicide in psychiatry and loss of hope. *International Journal of Law and Psychiatry, 36* (5–6), 436–443.

Bergsholm, P. (2012). Patients' Perspectives on electroconvulsive therapy: A reevaluation of the review by rose et al on memory loss after electroconvulsive therapy. *Journal of ECT, 28* (1), 27–30.

Blattner, W, D. (1994). The concept of death in "Being and Time." *Man and World, 27*, 49–70.

Blikshavn, T., Husum, T. L., & Magelssen, M. (2017). Four reasons why assisted dying should not be offered for depression. *Bioethical Inquiry, 14*, 151–157.

Broome, M. R. (2005). Suffering and eternal recurrence of the same: the neuroscience, psychopathology, and philosophy of time. *Philosophy, Psychiatry & Psychology, 12* (3), 187–194.

Broome, M. R., & de Cates, A. (2015). Choosing death in depression: A commentary on "Treatment-resistant major depressive disorder and assisted dying." *Journal of Medical Ethics, 41* (8), 586–587.

Brus, O., Nordanskog, P., Båve, U., Cao, Y., Hammar, A., Landén, M., . . . Nordenskjöld, A. (2017). Subjective memory immediately following electroconvulsive therapy. *Journal of ECT, 33* (2), 96–103.

Cholbi, M. J. (2013). The terminal, the futile, and the psychiatrically disordered. *International Journal of Law and Psychiatry, 36* (5–6), 498–505.

Cowley, C. (2015). Commentary on "Treatment-resistant major depressive disorder and assisted dying." *Journal of Medical Ethics, 41* (8), 585–586.

Dembo, J., Schuklenk, U., & Reggler, J. (2018). "For their own good": A response to popular arguments against permitting medical assistance in dying (MAID) where mental illness is the sole underlying condition. *Canadian Journal of Psychiatry*, 1–6.

Donahue, A. B. (2000). Electroconvulsive therapy and memory loss: A personal journey. *Journal of ECT, 16* (2), 133–143.

Fuchs, T. (2001). Melancholia as a desynchronisation: Towards a psychopathology of interpersonal time. *Psychopathology, 34* (4), 179–186.

Fuchs, T. (2005). Implicit and explicit temporality. *Philosophy, Psychiatry & Psychology, 12*, 195–198.

Fuchs, T. (2013). Temporality and psychopathology. *Phenomenology and the Cognitive Sciences, 12* (1), 75–104.

Gillett, G., & Chamberlain, J. (2013). The clinician's dilemma: Two dimensions of ethical care. *International Journal of Law and Psychiatry, 36* (5–6), 454–460.

Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). Oxford: Blackwell Publishing.

Heidegger, M. (1985). *History of the concept of time* (T. Kisiel, Trans.). Bloomington: Indiana University Press.

Heidegger, M. (1995). *The fundamental concepts of metaphysics* (W. McNeill & N. Walker, Trans.). Bloomington: Indiana University Press.

Kumar, D., Han, H., Tiller, J., Loo, C., Martin, D. (2016). A brief measure for assessing patient perceptions of cognitive side effects after electroconvulsive therapy: The subjective assessment of memory impairment. *Journal of ECT, 32* (4), 256–261.

Miller, F. G. (2015). Treatment-resistant depression and physician-assisted death. *Journal of Medical Ethics, 41* (8), 885–886.

Minkowski, E. (1970). *Lived time: Phenomenological and psychopathological studies* (N. Metzel, Trans. J. Wild Ed.). Evanston: Northwestern University Press.

Minkowski, E. (2004). Findings in a case of schizophrenic depression. In R. May, E. Angel, & H. Ellenberger (Eds.), *Existence* (pp. 127–138). Lanham, MD: Rowman and Littlefield Publishers, Inc.

Pols, H., & Oak, S. (2013). Physician-assisted dying and psychiatry: Recent developments in the Netherlands. *International Journal of Law and Psychiatry, 36* (5–6), 506–514.

Ratcliffe, M. (2012). Varieties of temporal experience in depression. *Journal of Medicine and Philosophy, 37* (2), 114–138.

Ratcliffe, M. (2013). Why Mood Matters. In M. Wrathall (Ed.), *The Cambridge companion to Heidegger's* Being and Time (pp. 157–176). Cambridge: Cambridge University Press.

Ratcliffe, M. (2015). *Experiences of depression: A study in phenomenology*. Oxford: Oxford University Press.

Rose, D., Wykes, T., Leese, M., Bindman, J., & Fleischmann, P. (2003). Patients' perspectives on electroconvulsive therapy: Systematic review. *British Medical Journal, 326*, 1–5.

Schramme, T. (2013). Rational suicide, assisted suicide, and indirect legal paternalism. *International Journal of Law and Psychiatry, 36* (5–6), 477–484.

Schuklenk, U., & Van de Vathorst, S. (2015). Treatment-resistant major depressive disorder and assisted dying. *Journal of Medical Ethics, 41* (8), 577–583.

Steinbock, B. (2017). Physician-assisted death and severe, treatment-resistant depression. *Hastings Center Report, 47* (5), 30–42.

Straus, E. W. (2012). The experience of time in endogenous depression and in the psychopathic depressive state. In M. Broome, R. Harland, G. Owen, & A. Stringaris (Eds.), *The Maudsley reader in phenomenological psychiatry* (pp., 207–214). Cambridge: Cambridge University Press.

Tellenbach, H. (1980). *Melancholy: History of a problem, endogeneity, typology, pathogenesis, clinical considerations* (E. Eng, Trans. A. Giorgi Ed.). Pittsburgh, PA: Duquesne University Press.

Thomson, I. (2013). Death and Demise in "Being and Time." In M. A. Wrathall (Ed.), *The Cambridge companion to Heidegger's "Being and Time"* (pp. 260–290). Cambridge: Cambridge University Press.

von Gebsattel, V. (2012). Compulsive thought relating to time in melancholia. In M. Broome, R. Harland, G. Owen, & A. Stringaris (Eds.), *The Maudsley reader in phenomenological psychiatry* (pp. 214–218). Cambridge: Cambridge University Press.

Wittwer, H. (2013). The problem of the possible rationality of suicide and the ethics of physician-assisted suicide. *International Journal of Law and Psychiatry, 36* (5–6), 419–426.

Wyllie, M. (2005). Lived time and psychopathology. *Philosophy, Psychiatry and Psychology, 12* (3), 173–185.