



How do depressed people feel perceived by others? A qualitative study from the patient's perspective

Cecilia Maria Esposito^{a,h,1,*}, Milena Mancini^{b,1}, Andrés Estradé^c, René Rosfort^d, Paolo Fusar-Poli^{a,c,e,i}, Giovanni Stanghellini^{f,g}

^a Department of Brain and Behavioral Sciences, University of Pavia, Pavia, Italy

^b Department of Psychological Sciences, Health, Territory, G. d'Annunzio University of Chieti and Pescara, Chieti, Italy

^c Early Psychosis: Interventions and Clinical-detection (EPIC) Lab, Department of Psychosis Studies, King's College London, UK

^d Søren Kierkegaard Research Centre, University of Copenhagen, Copenhagen, Denmark

^e Outreach and Support in South-London (OASIS) Service, South London and Maudsley (SLaM) NHS Foundation Trust, UK

^f Department of health sciences, University of Florence, Florence, Italy

^g Diego Portales University, Santiago, Chile

^h Department of Neurosciences and Mental Health, IRCCS Fondazione Ca' Granda Ospedale Maggiore Policlinico, Milan, Italy

ⁱ Department of Psychiatry and Psychotherapy, University Hospital, Ludwig-Maximilian-University (LMU), Munich, Germany

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ABSTRACT

Background: Depression is a condition which affects the individuals' entire existence. The difficulty in emotionally tuning in to the environment and the resulting sensation of loneliness have frequently been described as salient points of depressive experience. To our knowledge there are no studies that phenomenologically analyze how depressed people feel perceived by others.

Methods: Aiming to fill this gap, this study builds on a previous work, which carried out a literature screening and a thematic analysis on the subjective experience of depression. The narratives collected in this way were analyzed using a bottom-up qualitative method (Consensual Quality Research).

Results: Four main categories of experience related to perceived social apprehension of depression have been identified: (1) feeling guilty about not meeting others' expectations, (2) feeling socially misunderstood, (3) bringing to light an inconvenient truth that others do not want to see, and (4) hiding from exposure to the judgement of others.

Limitations: A broader and more specific data collection on the topic is missing.

Conclusions: Depressed patients often feel misunderstood by their social environment, which belittles or dramatizes their condition or doesn't realize how otherwise normal requests can instead cost a lot of effort, generating feelings of guilt and inability. This frequently pushes depressed individuals to try to hide their condition by isolating themselves or wearing a social mask. The difficulty in emotional attunement already present in depression can only worsen in the face of this feeling of incomprehension, generating a vicious circle of non-recognition that ends up maintaining the depressive state.

1. Introduction

Depression is a psychopathological condition that not only affects the mood of subjects but distorts their entire experience of the world (Tellenbach, 1991). For this reason, the tradition of clinical phenomenology, starting from the exploration of psychopathological phenomena in themselves, has considered it reductive to refer to the phenomenon of

depression as a simple mood disorder (Kraus, 1991; Stanghellini, 2004; Brencio and Bizzari, 2022). Current nosography describes major depression as a prolonged state of "depressed mood" and "lack of energy". The Diagnostic and Statistical Manual of Mental Disorders 5^o edition (APA, 2013) formulated an operational definition which clearly does not capture the specificity of individual experience and the upheaval effect that depressive phenomena have on the life of affected

* Corresponding author: Dr. Cecilia Maria Esposito, Department of Brain and Behavioral Sciences, University of Pavia, Via Bassi 21, Pavia, Italy.

E-mail address: ceciliam.esposito@hotmail.com (C.M. Esposito).

¹ These authors equally contribute to the study.

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subjects. In fact, depression implies a transformation of the entire experience of the subject's world, which comes to assume specific characteristics in the lived self, body, time, space and others (Stanghellini and Mancini, 2018; Ratcliffe, 2014). The phenomenological literature, as well as empirical research, have confirmed the presence, in depression, of abnormal body phenomena, slowing down of the vital rhythm, sensation that the past invades the future, sense of discontinuity of the self (Kraus, 1996; Stanghellini et al., 2017, 2021; Sik, 2022; Fusar-Poli et al., 2023).

Several phenomenological authors have discussed about the distinctive aspect of depression, proposing different interpretations. Fuchs (2001; 2013) describes the loss of bodily resonance as the central aspect of depression. Other authors place the peculiarity of depression in an alteration of the so-called existential feelings (e.g. hopelessness), the *mode* of the existence which takes over by coloring the experience of the world (Ratcliffe, 2014) and modifying the felt meanings of the world (Smith, 1986); or in an alteration of the *structure* of experience which leads to a mismatch between the world as felt by depressed people and that of non-depressed persons (Svaenau, 2007; 2013; Fernandez, 2014). Without wanting to enter into this complex debate, it seems interesting to underline how these different conceptions of depression highlight the alteration of attunement with the world and with others. In fact, if we understand depression as an alteration of the structure of the existence, we see that it is the structure of "situatedness" (*Befindlichkeit*, in Heideggerian terms) itself that is eroded (Svaenau, 2007; 2013; Fernandez, 2014). This has obvious implications in the relationship with others, with whom attunement alters due to different structural premises. If, however, we focus on the fundamental mood that colors our experience of the world (*Stimmung*, in Heideggerian terms), then the emergence of a given mood (e.g. depressed mood) does not irreparably undermine the possibility of resonance with others (Fernandez, 2014; Ratcliffe, 2014), but still hinders communication between the person in a depressed mood and others. Even if not strictly related to this debate, Fuchs' perspective appears interesting as it places the problem further upstream and bases attunement on bodily resonance, in line with his conception of the bodily self (Fuchs, 2001; 2013). Attunement means a "mood-state" related to our being-in-the-world, by its nature engaged and in relationship with other people (Heidegger, 1927; Svaenau, 2007; 2013). For Fuchs, the sense of participation in the world and in particular the connection with others is inscribed in our lived body. In depression, this bodily resonance is alienated and lost, not allowing the normal unfolding of the experience of affective participation (Fuchs 2001; 2013).

That said, the upheaval of depressed persons' world always implies a detuning to the experience of others (Fuchs, 2001; Fuchs, 2013). In depression, as Osler (2021, 2022) has underlined, the we-experience is lost, that is, the possibility of experiencing the world in a shared way with others. On the one hand, depressed subjects have the feeling that interpersonal stimuli touch them too closely, as if they were "skinless": that's why they often choose social isolation to protect themselves from the feeling of exposure (Fusar-Poli et al., 2023). We could understand this sense of "skinless-ness" as an experience altered tuning (or de-tuning), where depressed people are characterized by hypersensitivity to others' judgement. On the other hand, in conditions of particularly severe depression, a deep apathy prevails, the so-called "feeling of the lack of feelings". This implies the loss not only of positive emotions, but also of negative ones - the sensation of simply be turned off (Schulte, 1961). The feeling of being different from others and having difficulty communicating one's affective state exacerbates the perception of distance from the social environment. Here we could talk about de-tuning from the shared world.

The depressive detuning can be related on the one hand to the alteration of the experience of lived time, on the other to a different conception of values. As far as the experience of time is concerned, a slowing down of vital rhythms and a stagnation of becoming have often been described, implying feelings of desynchronization from other

people and lagging behind on one's social commitments (Tellenbach, 1991; Straus, 1947; Minkowski, 1970; Stanghellini et al., 2017). As far as values are concerned, depression is associated with an alteration of the value perception of the world, which is the subjective perception of values in which we are immersed (Cutting, 2016). Depressed people suffer of a characteristic over-attunement with respect to the external environment, which makes them extremely sensitive to interpersonal contact (Stanghellini 1997; Cutting, 2018). The perception of spiritual values (understood as intellectual and abstract motivations) is disturbed, while that of bodily values (including a sense of togetherness with other people) remains intact (Cutting, 2009; Cusinato, 2018). According to the phenomenological perspective, the changes in lived time and the peculiar structure of values imply an experience of detuning and a consequent feeling of estrangement from the social world (Fuchs, 2001). According to Schelerian theory, values represent indicators of movement that determine the attractiveness or repulsiveness of things in the world (Scheler, 1954-1997). Based on these pre-reflective indications, strictly rooted in corporeality, we build both motor and emotional patterns characterized by predictability (Cusinato, 2018). Sharing these insights with others makes our world familiar and in common with others. Where this sharing is lacking, in the context of detuning, the premises for a shared world are altered and the emotion-regulatory demands are continually disregarded.

Different authors identified a premorbid tendency of depressed people to be absorbed by their social role (Kraus, 1977; Tellenbach, 1991). In particular, a specific type of personality was described – the so-called "typus melancholicus" (TM) – which constitutes a premorbid condition not only for depression but specifically for melancholic depression (Tellenbach, 1991). Melancholic depression is a very severe form of depression, characterized by psychomotor slowing, pronounced anhedonia, "feeling of loss of feelings", and frequently depressive delusions (Tellenbach, 1991; APA, 2013). The characteristic of TM are: orderliness, conscientiousness, hyper/heteronomia, and intolerance of ambiguity (Kraus, 1977; Mundt et al., 1997). By orderliness we mean the need for order and harmony in the surrounding world and in social relationships, which ends up identifying people with their social role. By conscientiousness it is meant the predominant experience of guilt and the continuous effort to prevent it. By hyper/heteronomia is meant the precise and rigid attribution of inflexible meanings to external norms, which are experienced as unquestionable (Tellenbach, 1991). Finally, the intolerance of ambiguity represents the emotional and cognitive incapacity to tolerate the co-presence of different, even opposite, characteristics in the same object (Stanghellini et al., 2006). In this constellation, no space is allowed for the new, the unexpected, the different. The other and the self are experienced as superimposed on their social role, in a search for order that leaves no room for otherness (Kraus, 1977). When this order fails, TM persons are not only displaced from their role, but experience a breakdown in their functioning in the world triggering the depressive episode (Stanghellini et al., 2006).

In this framework, depression takes the form of an experience of otherness within oneself that subjects struggle to recognize as their own (Stanghellini, 2016; Stanghellini et al., 2017). The feeling of alienation with respect to one's own experience is not specific to depression, being found in various other psychopathological conditions (i.e. schizophrenia) (Sass, 2014; Fernández and Bliss, 2016). However, according to Kraus (1991; 1995; 1996), the difficulty in integrating the change into one's identity has been described as a core dimension of depression (Tellenbach, 1991; Stanghellini et al., 2006). Thus, it is precisely the inability to integrate the change, the unforeseen, the unexpected into one's self-understanding that is often the starting point of the depressive condition. This is all the more evident in cases in which a particular rigidity (i.e. TM personality) represents an existential vulnerability, but it can also be explored at different levels in depressive conditions not as severe as melancholy. Following Sartre's argument, we experience ourselves first through the gaze that we perceive upon us, and only secondarily as a self whose boundaries we feel from within (Sartre,

2003). The gaze of others is described as alienating and nailing the subject to her/his facticity and contingency: the body being watched is just a body that does not refer to anything else (Sartre, 2003). Nevertheless, those same gazes which were alienating may become the starting point of an identity-making dialectics (Esposito and Stanghellini, 2021). The encounter with others mediates the experience of recognition which is a fundamental human desire: to feel recognized by the other in one's humanity and absolute particularity (Kojève, 1969; Ricoeur 2007). Whether we consider others' gaze as a cause or as a vicious

circle of a process that has already been triggered, we cannot fail to consider how important it is for depressed subjects how they feel perceived by others.

Many studies have been carried out about the stigma and socio-cultural prejudices that accompany the diagnosis of depression (Cox et al., 2012). On the one hand, there is an external stigma, whereby people distance themselves or assume inauthentic attitudes, often motivated by an attempt to defend themselves from the suffering that the depressive condition brings with it (Suwalska et al., 2016). On the

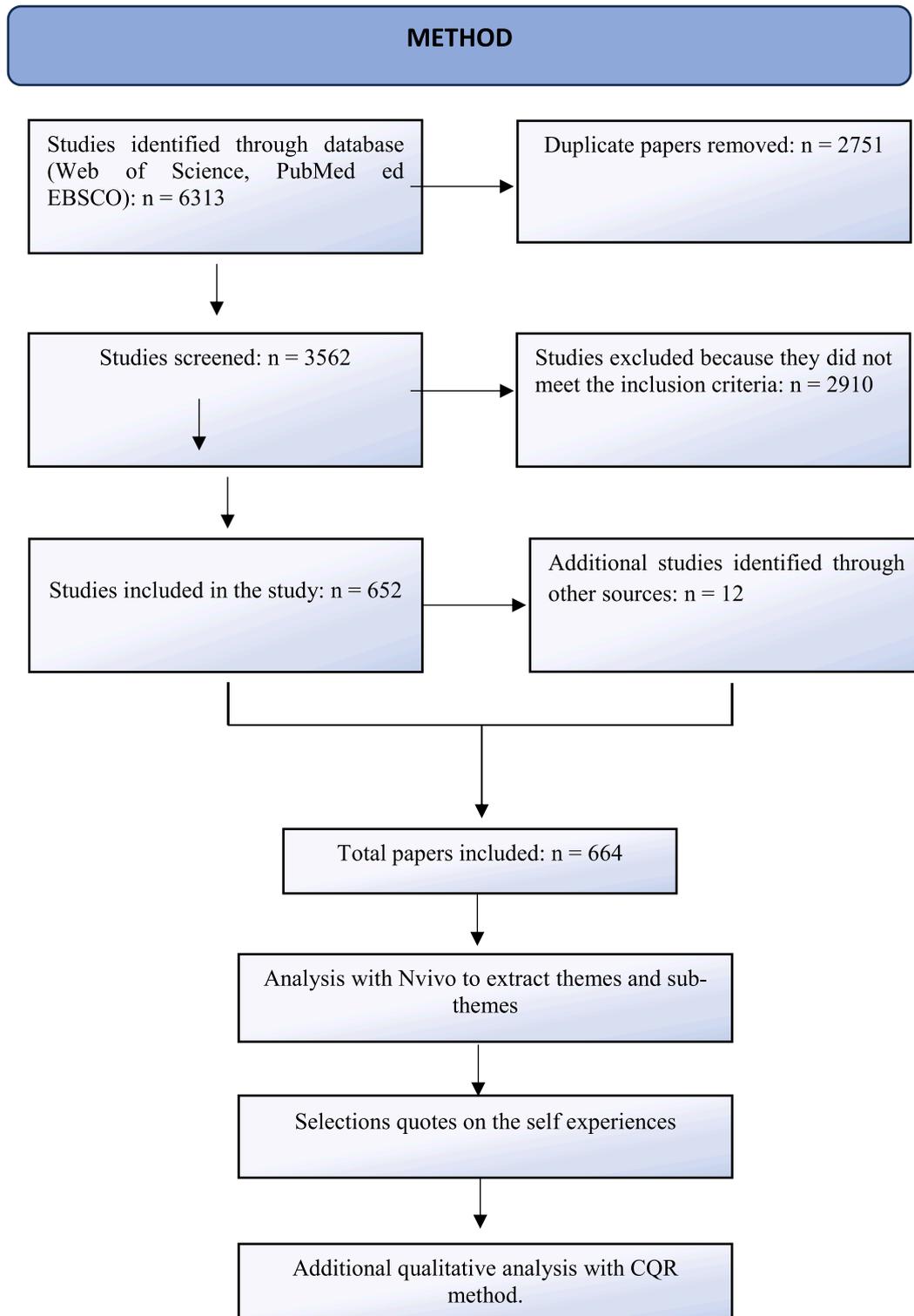


Fig. 1. Diagram of search strategy.

other hand, the concept of self-stigma has recently assumed greater importance, i.e. the internalization of those same social prejudices, which make it more difficult for the subjects to accept their own symptoms, their own diagnosis and the necessary therapeutic interventions (Du et al., 2023). The stigma also leads to diagnostic delay, because people prefer to hide their discomfort rather than being labeled depressed, to a lower investment in therapeutic interventions with poor compliance and a high dropout rate, and in general to a worsening of feelings of loneliness and inadequacy (Lanfredi et al., 2013; Johnco and Rapee, 2018).

Despite the recognized importance of the social experience to the onset and the maintenance of depressive symptoms, few studies have so far qualitatively analyzed the experience of depression in terms of how patients themselves feel perceived from by other people. That is, how depressed subjects feel seen, recognized or rejected within their social context, and how these perceptions influence their experience of illness. Perception is therefore not meant here only as a cognitive construct but is affected by bodily, emotional, and identity factors that strongly influence the lived experience of subjects. The aim of this study is therefore to qualitatively analyze the lived experience of subjects with depression in reference to the social perception of their condition.

2. Methods

This qualitative analysis builds on a previous study by our research group, addressing the lived experience of patients suffering from depression (Fusar-Poli et al., 2023, accepted). During that meta-analysis, a search was conducted on major search databases (WebScience, PubMed, EBSCO), including papers until August 17, 2022. The purpose was to identify articles that included first-person accounts of depressed people. Inclusion criteria were: 1) diagnosis of depression according to ICD/DSM criteria, 2) adulthood, 3) report of first-person accounts. Fig. 1 reports the screening process in more detail. The quotes thus collected were reused for this study, starting from scratch for a new qualitative data analysis.

The qualitative analysis used was the consensual quality research (CQR), a consolidated method for qualitative research, which assumes that consensus among judges improves the quality of the decisions. According with the procedure proposed by Hill e colleagues (Hill et al., 1997, 2005; Hill, 2012), two researchers (a psychiatrist and a senior psychologist) have shared their perspectives on clinical data, reaching consensus. First of all, all researchers involved in the data analysis discussed our personal point of view, including prejudices and expectations, not to superimpose them to the data analysis. Following Hill's procedure (Hill et al., 2005; Hill, 2012), we then create rotating teams of two researchers to examine the data.

In the so-called cross-analysis phase, the two teams analyzed the experiences independently, adopting a single blind procedure. The aim was to identify the 'core experience' that encapsulates the typical characteristics of the phenomenon analyzed. Finally, the external auditors (a psychologist and a psychiatrist) were asked to comment on the results, to ensure the clearness and the sensibility of the cross-analysis. The auditor provided his comments individually to the core team, which discussed them and, if necessary, made the appropriate changes.

In this article, our intention was to explore in detail the qualitative analysis of one of the proposed organizers starting from the first-person accounts of depressed people, which is stigma and perceived social apprehension of depression.

3. Results

Through CQR analysis of qualitative data it was possible to recognize four main categories, which were eventually divided into specific subdomains (as shown in Table 1). The categories identified were: (1) feeling guilty about not meeting others' expectations, (2) feeling socially misunderstood (stereotypes about depression), (3) bringing to light

Table 1
Summary of qualitative categories about social apprehension of depression.

Feeling guilty about not meeting others' expectations	guilty feeling of not having the strength to care for others	"At the worst period of my illness, I hoped my partner would die and free me from the responsibility of pretending to feel any emotion towards her."
Feeling socially misunderstood		
Depression as weakness	social stereotype that considers depression a kind of weakness	"Other people always tend to think that they [depressed people] are weak."
Depression as madness	social stereotype that considers depression as madness	"Everybody who is depressed is regarded as mad."
Bringing to light an inconvenient truth that others do not want to see	feeling like of being showing people an inconvenient truth they'd rather ignore	"People really don't want to know, put their blinkers on."
Hiding from exposure to the judgement of others		
Avoiding others out of fear	feeling afraid of social interaction and prefer to hide	"I didn't want anyone to even see me. I wanted to hide in a hole."
Wearing a social mask	pretending not to be depressed in order to protect oneself	"It's like there's two different yous... what, what you think people expect to see for ya even though you're, might be dyin' inside."

what others do not want to see, and (4) hiding from exposure to the judgement of others. We will proceed to in-depth exploration of these categories separately.

3.1. Feeling guilty about not meeting others' expectations

Depressed people feel that they should be more proactive in order to meet the expectations of the others. This experience can be described as feeling of guilty about not having the strength to care for others. This is particularly experienced in family context, where your relatives (partner, children, parents) ask you to be there for them and to do what you did before, or in the workplace. "I cannot love anyone. My husband expects me to express my love for him, but I do not know where I can find this love" (Asadollahi et al., 2021). Depressed people feel they don't have the strength to please other people but feel guilty about their worthlessness. "The other big thing for me is time with my kids. When I have just this unrelenting exhaustion, it's really hard to be as involved in their lives as I want to be, and I feel guilty about it" (Baune et al., 2021).

3.2. Feeling socially misunderstood (stereotypes about depression)

When depressed people address the others, they often feel socially misunderstood. People who never experienced depression often underestimate, banalize or even overestimate the disease. The result is to worsen the sense of loneliness and isolation of depressed people who realize that others cannot understand what they are feeling. This category about social stereotypes about depression has been divided into three subdomains: (2.1) depression as weakness, and (2.2) depression as madness.

3.2.1. Depression as weakness

One of the most widespread stereotypes about depression is to see depressed people as weak. In the face of life's difficulties that we all have to face depressed people are considered as those who do not have the strength to resist. "Other people always tend to think that they [depressed people] are weak, that they cannot function well, like the rest

of society" (Vargas et al., 2015).

In fact, a common social stereotype is to consider depression as 'weakness of will'. When addressing people suffering from depression, people often behave as if depression is not an illness but something they can have control over. "Everyone says like 'can't you just choose to be happy? You're just choosing to be sad'" (Hussain, 2020). If depressed people don't succeed in controlling their depression, they are thought to be too lazy to engage in normal social interaction. "They think my depression is fake, and they mistakenly think I can control my depression" (Asadollahi et al., 2021).

3.2.2. Depression as madness

An opposite reaction to depression can be to overestimate it and to consider depressed people as mad. "Everybody who is depressed is regarded as mad" (Hedelin and Strandmark, 2001). This position can worsen the isolation and even induce fear of depressed people as if they were dangerous to others. "My husband says I am crazy because I suffer from depression" (Vargas et al., 2015).

3.3. Bringing to light an inconvenient truth that others do not want to see

This experience can be described as the feeling that they are showing people an inconvenient truth they would rather ignore. Depression is generally something that people do not want to see. "People really don't want to know, put their blinkers on" (Brijnath and Antoniadis, 2018). When depressed people talk about their illness or their emotions, they often feel rejected by others who react in an embarrassed way. "I could use the word 'depression'... and you can see it in their face... it's the same sort of response... they're automatically sorry they've asked the question" (Barney et al., 2009).

3.4. Hiding from exposure to the judgement of others

Not to expose themselves to trivialization, misunderstandings and social rejection, depressed people often prefer to hide their suffering. They can do this by avoiding other people or by pretending not to be depressed. This experience has therefore been divided into two sub-domains: (4.1) avoiding others out of fear, and (4.2) wearing a social mask.

3.4.1. Avoiding others out of fear

When depressed people feel they cannot manage social interactions, an option often chosen is isolation. "I didn't want anyone to even see me. I wanted to hide in a hole" (Allan and Dixon, 2009). In this case, other people are avoided not because of lack of interest but out of fear of their reactions. "I would think sometimes em, they don't like me, they hate me, they wish I wasn't here" (Rice et al., 2011). Knowing that social misunderstandings could worsen their sadness, depressed people can choose to preventively isolate themselves. "Sometimes it's easier to dive into a shop door" (Rice et al., 2011).

3.4.2. Wearing a social mask

Another way to protect themselves from social interference or rejection is to behave as if depression doesn't exist. Depressed people can pretend not to be depressed, trying hard to appear as normal as cheerful as possible. "It's like there's two different yous... what, what you think people expect to see for ya even though you're, might be dyin' inside" (Rice et al., 2011). However, this is extremely tiring and can exhaust the already scarce strength of people suffering from depression. Moreover, this worsens the sense of isolation and of not being accepted experienced by depressed people: "I shut myself away, I censor myself" (Rice et al., 2011).

4. Discussion

In depression, feelings of inadequacy and self-devaluation, as well as

guilt towards the expectations of others, are very common. The qualitative analysis of lived experiences of depressed persons with respect to the social perception of their disease has allowed us to highlight some fundamental aspects. As we consider perception as a way of relating to the world in which cognitive, emotional and social factors participate, we must not forget how this is influenced not only by the environment in which the subjects find themselves, but also by their way of relating to it. In depression, subjects are faced with an experience of detuning which influences both the emotional situation (*Befindlichkeit*) and the affectivity (*Stimmung*) in which they are immersed (Fernandez, 2014). The encounter with other people is characterized, for the depressed subject, by experiences of exposure, incomprehension, and awe.

First of all, depressed people feel exposed to the gaze of others who are perceived as judgmental, unavailable, falsely interested (Brijnath and Antoniadis, 2018). Depression is interpreted as an inconvenient truth one would prefer to ignore, and affected individuals are living reminders of a condition one would never want to deal with. For this reason, depressed people often feel that they are bringing an inconvenient secret to the surface to which others react in an inhibited or embarrassed way (Barney et al., 2009). It is as if depression has no place in a society devoted above all to performance and depressed people therefore constantly find themselves being treated as plague-stricken, as if their condition could contaminate those who come in touch with them (Han, 2016).

To protect themselves people often adopt stereotypes that are meant to separate them from the depressed and remove themselves from the possibility of depression (Cox et al., 2012). Through the words of patients, we have recognized two main social stereotypes: the conception of depression as weakness, and as madness. The first subcategory corresponds to a devaluation of the depressive experience which resonate with the subjective experiences of inadequacy and guilt that depressed people are struggling with (Vargas et al., 2015; Asadollahi et al., 2021). People feel judged, as if their depression is indicative of a weak will, as if it is only laziness. The last category instead corresponds to an over-estimation of the depressive experience, which is considered similar to other forms of madness stigmatized as socially dangerous (Hedelin and Strandmark, 2001). For depressed subjects, it is always a question of perspectives that deny them the ownership of the depressive experience, inserting it within schemes of meaning that do not belong to the person. These simplifications do not allow us to see how depression affects the suffering persons' individual experience, their history, and their experience of the world.

Social prejudices can permeate individual experience to the point of invalidating the existential position-taking of the person towards the disease. With existential position-taking we mean the persons' effort at dealing with their own existential vulnerability when confronted with threatening life situations (Stanghellini et al., 2022). Following Husserl thought, by "position-taking" (*Stellungnahme*) we mean those intentional acts which entail not only a passive but also an active orientation toward the object, driven by implicit interpretational schema of our consciousness (Husserl, 1962; Belt, 2019). Clinically, it is a matter of considering not only the phenomenal nature of symptoms that patients experience and their meaning within the life history, but also the existential position that subjects assume in relation to their illness. This hermeneutic gaze is influenced by multi-level dynamics, which include the characteristics of the subject, his history, his interaction with the world and with others, the development of his psychopathological condition (Stanghellini, 2019; Stanghellini et al., 2022). Feeling alone and misunderstood increases the isolation tendency already typical of the depressive situation, worsening the perception of oneself (Paskaleva-Yankova, 2022).

Exposure to the gaze of others does not necessarily come from feeling judged by other people, depressed people often blame themselves for their shortcomings. This happens in conditions in which their illness does not allow them to fulfill the expectations of others, both in the workplace and in the family (Baune et al., 2021). It is interesting to note,

even if further studies would obviously be necessary to investigate this issue, that it is mainly female patients who feel the crushing weight of family demands (Rice et al., 2011). This may be due to inculcated cultural norms and value systems which expect women to be more willing to care for others, but also to the individual drive to care for others, which fails with the decrease in energy due to depression.

Misconceptions reinforce depressed patients in their experience of not being recognized and further distance them from a shared world-view and resonance with others. Not only do depressed subjects feel desynchronized from the world, emotionally detached from sharing with others, but this experience is reinforced by social circumstances (Fuchs, 2001). In fact, the more the encounter with others brings with it feelings of guilt, inadequacy and being not up to par, the more thoughts of not being able to communicate the illness will take over. Loneliness and isolation are the inevitable implications: depressed subjects can choose solitude tout court or maintain a social semblance of normality, not allowing others to access their authentic experiences (Allan and Dixon, 2009; Rice et al., 2011). It is evidently an attempt to protect oneself from those experiences of discomfort, misunderstanding and judgement that we have listed above. The already drained resources are spent not to get out of the depressive abyss, but to hide it from the world. As an alternative to isolation, therefore, there is the image of a social mask, which maintains expectations and standards that were its own before the onset of the disease. It is an exhausting effort, as well as a vicious trap that perpetuates the experience of not being recognized as a person (Rice et al., 2011).

Considering depression as linked to the difficulty of integrating otherness, we cannot fail to underline how the lack of recognition from the outside reinforces the traits of alienation with respect to one's own experience (Stanghellini et al., 2017). Isolation or the adoption of a social mask are attempts to defend oneself from the experience of confrontation with the others, which according to the depressed person can only end with the confirmation of one's own inadequacy, guilt and uselessness (Paskaleva-Yankova, 2022).

The we-experience is eroded and people suffering from depression crystallize in a static vision of reality, incapable of integrating otherness and getting involved in an authentic encounter with the other (Osler, 2021, 2022). Despite the different perspectives, the experience of detuning, whether on a structural or modal basis, is one of the characteristics most shared by the different phenomenological views on depression. As we have seen, the experience of detuning can be characterized as the hyper-sensitivity to the others' judgment, as happens when depressed subjects feel too exposed to the emotional reactions of the world around them, or as the inability to resonate with the others. The categories we have described highlight the difficulty of being with the others on a level of emotional sharing, as well as the presence of a gap between one's own way of experiencing the world and that of others.

5. Conclusion

In conclusion, depression is a clinical condition which, by its very nature, exposes one to a very complex relationship with others, radicalizing the experience of dependence of others, leading to the painful feeling of being misunderstood, inducing feelings of inadequacy and guilt, and implying a temporal and affective desynchronization (Fuchs, 2001; Stanghellini et al., 2017). The importance of the gaze of others in psychopathological conditions is not surprising (Mancini and Esposito, 2021): it is often perceived as a devaluing, judging, even persecutory gaze. Indeed, feeling devalued and criticized by others may take on a frankly persecutory character ('Poor me'), e.g. in paranoid or schizophrenic persons, or instead characterized by feeling deserving of punishment ('Bad me'), often associated with depressive symptoms (Esposito et al., 2021; Chadwick et al., 2005). Generally, schizophrenic paranoia is characterized by less insight and therefore by a greater prevalence of "poor me" paranoia, while depressive conditions, even

when delusional, touch more on themes of guilt and punishment (Chadwick et al., 2005). Our claim, already supported in previous papers (Esposito and Stanghellini, 2020), is that the gaze of others may be a profound driving force behind the genesis and maintenance of psychopathological condition, and in this case of depressive symptoms.

The present qualitative study, analyzing how depressed patients feel perceived by others, covers a gap with respect to the first-person experience of the social consequences of depression. In fact, the stigma and the misunderstandings are aspects that affect the authenticity of the relationship of depressed subjects with others, worsening their sense of detachment from the world. The importance that the role of the others plays in clinical depression must be considered above all in the light of the potential psychotherapeutic implications. In fact, meeting, sharing and dialogue mediate an experience of recognition and retuning which become one of the basic aspects of treatment (Stanghellini et al., 2017; Fuchs et al., 2019).

The limitations of the present work are inherent in the fact that it is a reworking of data already published, even if for the purpose of illustrating and characterizing different phenomena. Specific empirical research on the topic, which specifically addresses the lived experience of others in depressed individuals, is currently lacking and should be conducted to confirm these findings.

Role of the founding source

none.

CRedit authorship contribution statement

Cecilia Maria Esposito: Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Milena Mancini:** Writing – review & editing, Methodology, Data curation, Conceptualization. **Andrés Estradé:** Data curation. **René Rosfort:** Data curation. **Paolo Fusar-Poli:** Supervision, Conceptualization. **Giovanni Stanghellini:** Writing – review & editing, Supervision, Conceptualization.

Declaration of competing interest

The authors declare no conflict of interest.

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