PSYCHOTHERAPY OF THE LIVED SPACE: A PHENOMENOLOGICAL AND ECOLOGICAL CONCEPT[1]

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Abstract

Based on phenomenological and ecological psychology, the paper develops the concept of lived space as the totality of an individual's spatial and social relationships including the «horizon of possibilities». The lived space may also be regarded as the individual's ecological niche that is continuously shaped by his\her exchange with the environment. Mental illness may then be conceived as a limitation or deformation of the patient's lived space inhibiting his/her responsivity and exchange with the environment. Unconscious dysfunctional patterns of feeling and behaving act as «blind spots» or «curvatures» in lived space that lead to typical distortions, thereby further restricting the patient's potentialities and development. Accordingly, the task of psychotherapy is to explore and understand the patient's lived space in order to re-open his/her horizon of possibilities. The main agent for this purpose is the interactive field of psychotherapy that may be regarded as a «fusion of horizons» of the patient's and the therapist's world.

Keywords: Lived space, phenomenology, ecology, responsivity, horizon of possibilities.

Introduction

At first sight, phenomenology seems to be rather a contemplative philosophical method, unhelpful to a psychotherapist who is eager to promote the patient's change. For this purpose he/she will usually rely on well-known psychodynamic or behavioural explanations and techniques. Phenomenology offers neither causal explanations nor therapeutic techniques; so it seems that therapists might as well do without it. In this paper I will try to show the opposite. In my view, a phenomenological stance is not only indispensable if we want to gain a genuine, unprejudiced understanding of the patient's experience. Moreover, phenomenology offers a view that localises his/her disorder neither in the hidden convolutions of the brain nor in the hidden corners of his/her psyche, but in the

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actual world of his/her life with others, the *lifeworld* (*Lebenswelt*) – and this is, after all, the only world in which psychotherapy is effective.

Instead of searching for explanations behind the phenomena, phenomenology may help the therapist to perceive better and understand 'what it is like' to be the patient and to live in his/her world. For phenomenology is not an approach that is mainly based on introspection and inner states, as an old prejudice suggests.[3] On the contrary, it overcomes the dichotomy of the internal and the external by emphasising embodiment and being-in-the-world as the fundamental modes of existence. Subjective experiences are not to be found 'in the psyche' or 'in the brain' but extend over the body, space and world of a person. As a consequence, psychotherapists inspired by phenomenology will move away from trying to change the inner states of the patient and focus instead on his/her *'lived space'*, i. e. his prereflective or implicit way of living with others. And they will in particular use the therapeutic relationship as a field for extending the patient's lived space and for changing his/her implicit relationship patterns.

In the following sections, I will first outline the phenomenological concept of a person's world and lived space. Then, I will move to psychopathology and characterise mental disorders as various kinds of constrictions or deformations of the patient's lived space. It is of a special importance to gain a different approach to the problem of the unconscious which I regard not as an inner compartment of the psyche in the traditional psychoanalytic sense, but as a certain way of living without full awareness – a blind spot in lived space, so to speak. In the final part, I will describe the interactive field of psychotherapy as a partial fusion of the horizons of the patient's and the therapist's worlds. This fusion expands the patient's lived space and, by this, may help him/her to reshape his/her relationships with others as well.

1. The Person's World and Lived Space

My starting point will be a short outline of the phenomenological method as developed by Husserl (1950/1931). – The fundamental presupposition guiding the phenomenologist is that more is implied in every experience than merely an objective fact, namely the special *way of being* of what is experienced, and *the structure of our experience itself* which may be uncovered by phenomenology. The central technique used for this purpose, also termed *epoché* (abstinence) by Husserl, implies a «bracketing» of our commonplace assumptions about reality. Above all it is essential to restrain from believing that only those things which exist independent of the mind or the subject are real – the «world outside» or the «objective world». We are requested to put in abeyance what we believe we «should» think or find, especially any explanation that derives the phenomena from underlying causes (mechanisms, substrates) not to be found in themselves. Instead, the phenomenologist

[3] Such a view has been explicitly denied by Husserl (1952, p. 38). On this, see also Zahavi (2005, p. 12 ff).

analyses the way in which the subject conceives the world and how the relationship between the subject and the world has to be described. This process of the so-called 'transcendental reduction' leads to a disclosure of the originary underpinnings of our experience. It traces the constitution of the self and the world back to the basic structures of corporality, spatiality, temporality, and intersubjectivity.

If the psychiatrist undertakes this process, he/she arrives at the prereflective dimension of experience which is affected in mental disorders: It comprises everything that is normally not consciously thought about or aimed at, but implicitly lived, inherent in our habitual ways of dealing with the world and with others. Central aspects are the lived body, lived space, lived time and lived ways of relating to others. Phenomenology thus helps to explore altered worlds of experience that cannot be elucidated by accumulating data from the 3rd person perspective, e. g. data on brain functions. How does the patient perceive the world? What is it like to be depressive? How do lived time and lived space change for the manic person? What is the world like for a schizophrenic, an obsessive, a suicidal patient?

«World», of course, does not mean something outside as opposed to inside, the external world as against the internal or mental world. It is rather the totality of life in the sense of an all-embracing framework of meaning in which person's experience, thinking and acting are embedded. In the same sense we also speak of the world of an infant, the world of a farmer, the world of a man in the modern age, etc. Though, even if different worlds overlap and intersect in every individual, it is still a peculiar and unique world in which the individual thinks, feels and acts. In order to understand him/her, one has to enter his/her world and envision his/her *horizon,* in which all that he/she does has its meaning – even if this meaning deviates from the normal as in mental illness.

In the following I will focus on the phenomenological concept of the *lived space*, even though other categories like temporality and intersubjectivity are certainly of equal importance for psychopathology and psychotherapy. The concept of lived space traces back to Kurt Lewin's «topological» or «field psychology» (Lewin 1936) and was later revived by ecological psychology and psychotherapy (Barker 1968; Gibson 1986; Graumann 1978; Willi 1999). Lived space may be regarded as the totality of the space that a person prereflectively 'lives' and experiences, with its situations, conditions, movements, effects and its horizon of possibilities – that means, the environment and sphere of action of a bodily subject. This space is not homogeneous, but centred on the person and his body, characterised by qualities such as vicinity or distance, wideness or narrowness, connection or separation, attainability or unattainability, and structured by physical or symbolic boundaries that put up a rigid or elastic resistance to movement. This results in more or less distinct domains such as one's own territory, property, home, sphere of influence, zones of prohibition or taboo, etc. Moreover, the lived space is permeated by «field forces» or vectors such as attraction and repulsion, elasticity and resistance, etc. Competing attractive or aversive forces

lead to typical conflicts which may be regarded as opposing directions of possibility that the person faces. Thus, the lived space offers different 'valences', 'relevances' or 'affordances' – to use Gibson's term – in accordance to the motives and potentialities of a person. By analogy with physical fields, there are effects of 'gravitation' and 'radiation', caused for example by the influence of a significant other or by a dominant social group, and there are 'curvatures of space' that impede straight or spontaneous movements, for example around zones of taboo for the obsessive person or around areas of avoidance for the phobic person.

By this, it has already become obvious that the concept of lived space should not be conceived as static, but as dynamically connected with movement and development, i.e. with the course and temporality of life. Moreover, it is manifest that the lived space as the spatiality of the *Lebenswelt* is particularly shaped by social relations and meanings. In order to clarify this dimension and also to avoid the risk of subjectivism – as if the subject, in his/her lived space, only encountered his/her own representations and projections – we may borrow a term from biological ecology and characterise the lived space of persons in their environment as their «ecological niche» (cf. Willi 1999). By analogy with the biological niche or habitat, it signifies the section of the physical and social environment that corresponds to the dispositions of perceiving and acting, to the motivations and intentions of a person. The personal niche, thus, comprises all living or non-living objects a person is in active exchange with and has influence on – family, neighbours, colleagues, home, work place, products of work, etc. (fig. 1). The ongoing feedback circle of a person's actions and the responses of the environment may be termed as the person's «responded activity» (cf. Willi 1999). It is assumed that the person basically seeks and shapes an environment that responds to his/her actions and offers the valences for his potentialities. The capacity of a person to respond adequately to the stimuli and requirements of his/her environment, especially to the demands of others may be called his/her 'responsivity'.

The most intense and stimulating responses arise in a family or partner relationships. Generally, the individual tries to establish a mutual responsivity or «co-respondancy» with his/her partners (Willi 1999). By this choice of a certain environment or niche, persons also become the indirect producers of their own developments (Lerner 1981). Human beings influence their courses of life und direct their developments by shaping and affecting their environments that in turn re-affect them. The course of life develops as a circular process, guided by one's own activity and the responses from the environment.

To summarise, the concept of the lived space and the personal niche expresses the idea that the subject and the world do not exist separately but constitute each other. It implies an 'existential topology', i. e. a personal matrix of meanings and relationships creating the existential time-space with its curvatures, gradients, barriers, etc. According to this concept, subjectivity is spread into space and 'ek-sistence': The question *«Who am I?»* is inseparable from the question *«What is the world like*

in which I live?» This world is of an essentially social nature: Responsivity and correspondency shape the interpersonal structure of the lived space. Of course, the space inhabited by an individual in this sense is invisible for others. We do not see the vicinity or distance that things or other persons have for them, or the free spaces or perspectives that attract or the barriers that frighten them, or the psychological forces that determine their ways like magnetic field-lines. Nevertheless, in order to understand another person, we have to get to know his/her familiar surroundings, his/her sphere of influence and his/her various relations to his/he environment. In this way, the major goal of phenomenological psychotherapy is *«to enter and to share the world of the other»* (Margulies 1984).

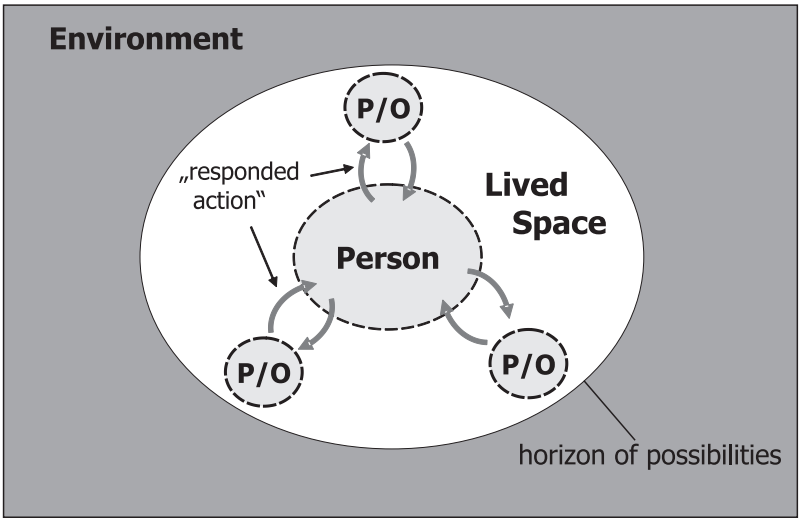

Figure 1: Person, lived space and environment
(P/O = Persons or Objects in the Lived Space)

2. Psychopathology as Constriction of Lived Space

On this basis, psychopathology may be regarded as a *narrowing or deformation of an individual's lived space*, as a constriction of his/her horizon of possibilities, including those of perception, action, imagination, emotional and interpersonal experience. Psychiatric disorders of various kinds are often the result of a disruption in the circle of responded activity, be it by a separation from significant others, a loss of one's occupational tasks, or, in general, by a mismatch of one's potentialities and the valences of the environment. Once manifested, these disorders in turn inhibit the responded activity of the patient, increase his/her egocentrism and reduce his/her responsivity towards others. The ecological niche becomes constricted, fragmented or otherwise unfitting.

Thus, to give an example, Melancholic Type personalities, i.e. persons prone to develop severe depression, have been shown to be rather

restricted in their lived space. They are over-identified with the spatial boundaries of their homes, their social roles, their responsibilities at work and their private relationships (Tellenbach 1980; Kraus 1987; Kronmueller et al. 2002). They live under a constant pressure of normalisation, as it were. A major deviation from these rigid demands and constraints may result in depressive illness. Thus, their horizon of possibilities is limited even before their first illness. In depression itself, the restriction of the lived body (inhibition, anxiety, loss of drive) and the loss of emotional resonance lead to a severe disturbance of the patient's responsivity and exchange with the environment (Fuchs 2001, 2005).

Let's take another, a rather contrary example: Patients with Borderline Personality Disorder are severely restricted in their capacity to establish stable and reliable attachments and role identities. They are not able to build up a continuous ecological niche of responded activity. Instead, their lived space is crisscrossed by intensive emotional impulses, i.e. by attractive and even more repulsive vectors by which they are constantly torn to and fro (Fuchs 2006). This leads to an instability and fragmentation of lived space, with numerous disrupted relationships, projects and careers. Borderline patients are, so to speak, tossed about in their lived space, unable to find a supporting ground and a reliable centre of their existence. – In a similar way, other psychopathological conditions may be regarded as disturbances of lived space (Fuchs 2000).

Phenomenology of the Unconscious

Based on the concept of the lived space, we may also gain a phenomenological understanding of the unconscious which is of special importance for psychotherapy. The difficulties inherent in the traditional psychodynamic 'cellar' theory of the unconscious are well-known – describing it as a level 'below the ground' where all kinds of sinister entities are stored. Such a concept is finally based on a Cartesian model of the mind as a kind of inner container holding distinct ideas, memories and representations of external reality which have been introjected, internalised as 'object representations' or 'images', i. e. as reified, immutable entities which populate the brighter or darker realms of the psyche. These realms are reified as well, receiving names such as consciousness, the unconscious, the super-ego, and so on.

All this has been vehemently criticised by phenomenologist (e. g. Binswanger 1963; May 1964; Ricoeur 1969; Hersch 2003). However, as a primary science of consciousness, phenomenology has had problems in developing an alternative theory of the unconscious until today. In any case, it cannot be conceived as a place or room that contains atomistic, thing-like mental entities. Not things, fixed objects or memories are unconscious, but rather potentialities, dispositions or tendencies in the person's life. Thus, a phenomenological approach will look for the unconscious in the implicit ways in which the patient behaves and lives, and in the ways he/she does *not*. Here phenomenology converges with recent memory research that emphasises *implicit or procedural learning*

as underlying our habitual ways of behaving, acting, but also *avoiding* possible actions, without explicit, or only with marginal awareness (Schacter 1999; Fuchs 2004).

With a similar intent, Merleau-Ponty has already analysed the unconscious aftereffect of the psychological trauma. According to him, the repressed resembles the phantom limb in amputated patients, in that it constitutes an «empty space» of subjectivity (Merleau-Ponty 1962, p. 86). It may be regarded as the negative of a past experience that the subject could not cope with – the negative that overlays each novel situation without notice, thus fixing the traumatised individual on his/her still present past:

> «Of course this fixation does not merge into memory; it even excludes memory in so far as the latter spreads out in front of us, like a picture, a former experience, whereas this past which remains our true present does not leave us but remains constantly hidden behind our gaze instead of being displayed before it. The traumatic experience does not survive as a representation in the mode of objective consciousness and as a 'dated' moment; *it is of its essence to survive only as a manner of being and with a certain degree of generality*» (l. c., p 83; italics by the author – *T. F.*).

The implicit or bodily memory includes all that is covered «behind our gaze» and only lives on in a general manner or a «style» of existence without revealing itself as an explicit memory; and this applies also to certain traumatic experiences. Thus, unconscious fixations resemble distortions or restrictions in a person's space of possibilities, caused by the past that continues to be implicitly present and refuses to give way to the progress of life. Its traces, however, are not hidden in some inner world of the psyche but manifest themselves in the 'blind spots', gaps or curvatures of lived space: in the patterns of behaviour that entrap a person time and again, in the actions he/she refuses to take, in the life he/she does not dare to live, etc.[4] Like in the figure-ground relation of gestalt psychology, such traces become noticeable rather as a 'negative', i. e. as the inhibitions or omissions that are typical for a person. On the other hand, they may still be actualized symbolically or bodily, in the way of somatic symptoms. Instead of a determinist view of the unconscious, however, the phenomenological view will emphasize its potential, future-directed character. Unconscious in the psychodynamic sense are «the potentialities for action and awareness which the person cannot or will not want to actualize» (May 1964, p. 182):

> «This unconscious is to be sought not at the bottom of ourselves, behind the back of our 'consciousness', but in front of us, as articulations in

[4] Sartre has shown, using the term of «bad faith» (*mauvaise foi*), that there is an essential component of *self-deception* inherent in this distortion (Sartre 1943, p. 86). The subject adopts an insincere and ambiguous stance towards itself, slipping into a «wilful nonattention». One does not know something *and* does not want to know it. One does not see something and does not want to look at it, which means one looks beside it both with and without intention. On this, cf. Holzhey-Kunz (2002, p. 173 ff.) and Bühler (2003).

our field. It is 'unconscious' by not being *object* but by being that through which objects are possible, it is the constellation from which our future may be read».[5]

Following this line, I will give a short phenomenological restatement of two central psychodynamic concepts, that of *defence or resistance* and of *repetition compulsion*.

Defence and Repetition Compulsion

(1) The effect of emotional trauma on the individual may be regarded as a specific deformation of his/her lived space, which becomes manifest in an avoiding stance towards certain frightening regions or *'repulsive spaces'* (fig. 2). The best analogy is the 'relieving posture' adopted automatically when a limb has been hurt: Instinctively one avoids exposing it to threatening objects and holds it back («a burnt child dreads the fire»).

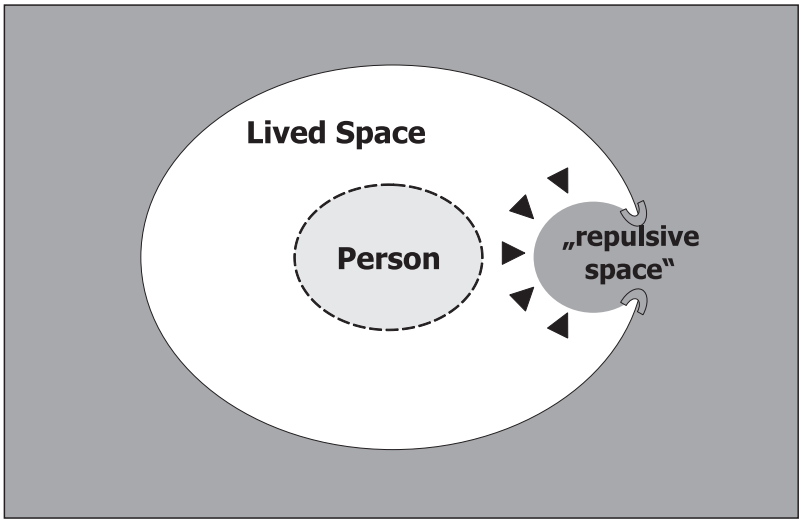

Figure 2: Unconscious «repulsive spaces»

The fact that this happens unconsciously is not due to a repression of the injury, but simply to a bodily learning process that occurs without explicit awareness. Similarly, the psychological trauma causes zones of avoidance and, thus inhibits the free development of one's potentialities. The lived space is negatively curved around these areas, and they have come to be gaps or 'blind spots'. Here the intentionality of the unconscious becomes obvious: An imminent contact with a danger zone is anticipated and prevented without conscious awareness, because it is

[5] «Cet inconscient à chercher, non pas au fond de nous, derrière le dos de notre 'conscience', mais devant nous, comme articulations de notre champ. Il est 'inconscient' par ce qu'il n'est pas *objet*, mais il est ce par quoi des objets sont possibles, c'est la constellation où se lit notre avenir» (Merleau-Ponty 1964, p. 234).

more economic not to reactivate the stress and anxiety of the traumatic experience again and again. The resistance or defence of psychodynamic theory is often nothing else but this relieving or avoidance posture manifested in the context of psychotherapy.

(2) The opposite pattern may be found in the psychodynamic concept of the 'repetition compulsion': Here, the individual is entrapped time and again in the same dysfunctional patterns of behaviour and relationships, even though he/she may try to avoid this by all means. The lived space is positively curved around such areas, and they have become 'attracting spaces' (fig. 3). If, for example, a woman's early life experiences have been dominated by abusive and violent relationships, her scope of possible relationships will be quite limited. The modes of abuse will vary, but this theme will influence her way to constellate her relationships to the exclusion of others. Her implicit ways of behaviour will act as self-fulfilling her expectancies, and she will continuously encounter the same kind of situations Thus, the unconscious is not a hidden realm of her psyche but enmeshed in her way of living, even in her bodily behaviour.

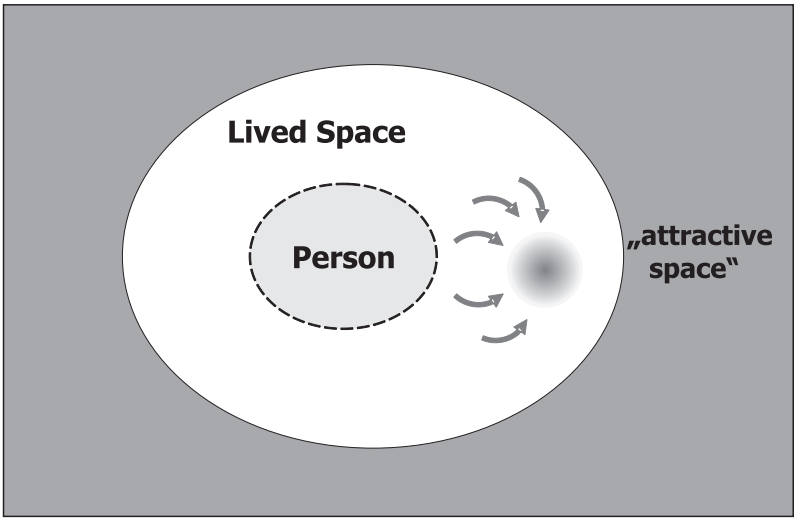

Figure 3: Unconscious «attractive spaces»

In a similar way, we could approach other psychodynamic concepts, but these examples shall be sufficient. From a phenomenological point of view, as we have seen, the unconscious is not an intrapsychic reality, located in some depth 'below consciousness', but it surrounds and permeates conscious life in a way similar to a picture puzzle in which the blinded out figure permeates the foreground. It is the unconscious that is hidden not in the *vertical* dimension of the psyche but rather in the *horizontal* dimension of the lived space and in the 'intercorporality' of our social contact with others.[6] – This leads us further to the phenomenology of the therapeutic interaction.

[6] «…the latency of psychoanalysis is an unconscious that is beneath conscious life and *within* the individual, an *intrapsychic* reality that

3. The Interactive Field as the Agent of Change

As we have seen, phenomenology regards «mental illness» not as something mental or inside, but as an alteration of the patient's being-in-the-world, in particular as a restriction of his/her horizon of possibilities. The aim of treatment, therefore, would be to expand the patient's horizon and to increase his/her degrees of freedom. From a phenomenological perspective, the main agent for this purpose is the interactive field opened up by the encounter between a patient and a therapist.

According to older models of psychotherapeutic action, change is produced *in the patient alone*, through a restructuring of his/her internal world, as a result of cognitive or interpretive interventions by the therapist, which leads to insight and, accordingly, to more appropriate responses of the patient to his/her current life situations. But psychotherapy is an interpersonal process based on circular interactions that cannot be grasped from an individual perspective. It implies a mutual creation of meaning which is not a 'state in the head' but arises from the 'between' or the system of a patient and a therapist. On the basis of the concept of the lived space and using a crucial term of Gadamer's hermeneutic philosophy, we may regard the interactive process as a «fusion of horizons» of the patient and the therapist (Gadamer 1995; cf. fig. 4). Their pre-existing phenomenal worlds interact, even merge in part, resulting in a new, emergent and dyadic world that is harboured by the 'therapeutic niche' and creates a new horizon of possibilities. At the same time, the blind spots or gaps in the patient's lived space may become visible by the illumination of the interactive field. This new and wider space may relieve or even overcome the constriction of his horizon. Intercorporality as the sphere of non-verbal, bodily as well as atmospheric interaction plays an important role here. Though remaining in the background, it is an essential carrier of the therapeutic relationship.

However, this interactive, dyadic quality of the therapeutic relationship is not grasped in the traditional concept of transference and counter-transference. This concept was still seriously flawed by the subject-object-split. Feelings were conceived as happening inside the patient in a quite atomistic and mechanistic way (Hersch 2003, p. 228). They seemed to be isolated entities, endowed with certain amounts of energy, capable of being stored, moved hither and thither, disconnected from their object and projected on another person. Thus, transference was conceived as an anachronism:

> «Impulses, feelings and defences pertaining to a person in the past have been shifted onto a person in the present» (Greenson 1967, p. 152).

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leads to a psychology of depth in the *vertical* dimension. …The latency of phenomenology is an unconscious which *surrounds* conscious life, an unconsciousness in the world, *between us*, an *ontological* theme that leads to a psychology of depth in the *lateral* dimension» (Romanyshyn 1977). – On the unconscious in existential analysis, see also Bühler (2004); on «intercorporality» see Merleau-Ponty (1967, p. 213).

What the patient sees in the therapist was regarded only as a distorted image derived from the past. Moreover, transference and counter-transference did not meet to form something new. Though projected onto the respective other, they did not actually attain him/her, but remained inside the person experiencing them. This reification and materialisation of feelings surely does not fit to the interactive and emergent nature of the phenomena. A therapist who in this way regards himself/herself only as a projection screen would be in danger of missing the dimension of genuine encounter where he/she is meant as a real, embodied person.

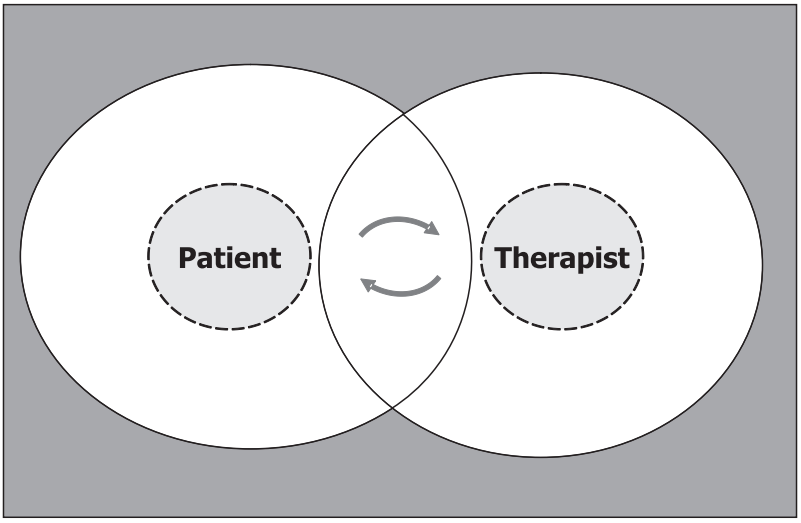

Figure 4: «Fusion of horizons» in psychotherapy

A glance at development psychology may be helpful here. Mother-infant research has shown that it is not isolated images or 'objects' that are stored in memory, but rather interactive experiences, schemes of dyadic interaction that are stored in the sensory, motor as well as emotional mode (Beebe et al. 1997; Stern 1998a). From early childhood on, these schemes become a part of the procedural or implicit memory and create what Lyons-Ruth (1998) has called «implicit relational knowing». It comprises stored patterns of bodily and emotional interaction that are prereflectively activated by subtle situational cues (e. g. facial expressions, gestures, undertones, atmospheres). This knowledge is a temporally organised, 'musical' memory for the rhythms, dynamics and undertones that are present in the interaction with others. Thus, procedural *'schemes-of-being-with'* (Stern 1998) or *implicit relational styles* are acquired, which organises the child's interpersonal behaviour and will later be transferred to other environments. They shape the basic structures of a person's relational space and, thus are of a special importance for the therapeutic process.

So, we may conclude from these results that it is not the explicit past that is in the focus of the therapeutic process but rather the im-

plicit past which unconsciously organises and structures the patient's *'procedural field'* of relating to others. To be sure, it is a phenomenological unconscious that we are dealing with, i. e., a prereflective, nonthematic, basic structure of experience, still different from Freud's dynamic unconscious of repression. However, implicit relational patterns have become increasingly important for psychoanalytic theory as well, stimulating new models of therapeutic change on the basis of a *«moment-to-moment process»* (Stern 2004). It is the present interactive field of psychotherapy through which relational patterns are made visible like iron filings in a magnetic field. Alteration of implicit patterns presupposes their activation as 'enactments' in the therapeutic process. Only then can they be replaced by corrective experiences, above all in special moments of empathic correspondence between a patient and a therapist *(«moments of meeting»*, PCSG 1998).

Here, the phenomenological stance may be particularly helpful. For the corrective emotional experience of psychotherapy is a function of the extent to which the therapist can 'put his/her world and theory in brackets' in encountering the patient. Husserl's *'epoche'*, i.e. the suspension of judgement and the abstention from preconceived ideas, may help to clear the space which is required for an authentic encounter between a patient and a therapist, without the interference of complex metapsychologies of various therapeutic schools (Margulies 1984; Varghese 1988). Phenomenologically oriented therapists will refrain from attaching any presumed idea to the patient's experience. They will rather try to understand as much as possible of 'what it is like to be him/her', to walk in his/her experiential footprints, to re-create his/her world view in their own experiences and to convey this experience to the patient in verbal and non-verbal ways. This mutual mirroring may help him/her to deepen self-experience and self-understanding as a starting point for any therapeutic change.

Certainly, empathic understanding of the patient is not all that is needed here. To avoid the pitfalls of the patient's relational patterns, the therapist should be well aware of the interpersonal process that is going on and that he/she is also a part of it. Otherwise he/she will risk stumbling right into the patient's 'attracting spaces' or, on the other hand, unwillingly take part in his or her avoidances (Merten & Krause 2003; cf. fig. 5). If a patient e. g. tends to leave decisions to others in order to avoid responsibility, it would certainly be wrong to get entrapped in this attracting space and tell him/her what to do. Or if a patient avoids a shameful experience or a shameful view of himself/herself, it would not be very helpful to unwittingly share his/her anxiety and carefully move around this delicate zone. The therapist should rather develop an intuitive sense of the 'curved zones' in the relational field, in order to make them visible and to neutralise them as far as possible by corrective experiences in the secure space of therapy. By this, the patient's lived space may be cleared and expanded in general.

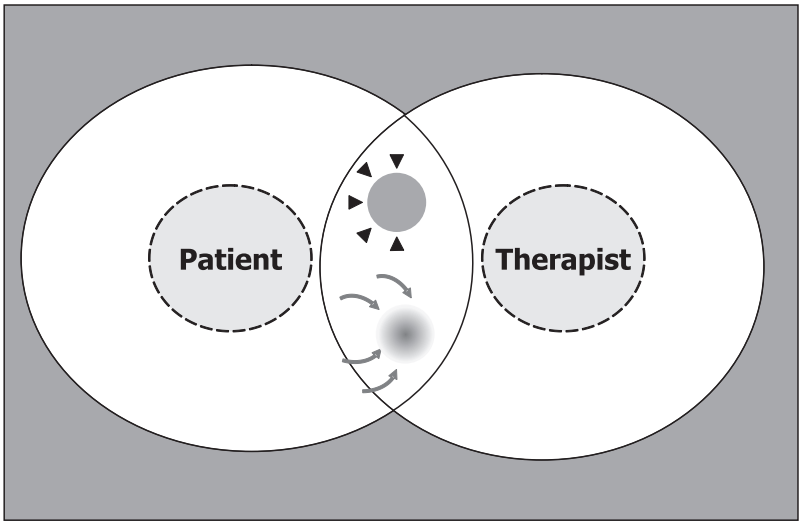

Figure 5: «Repulsive» and «attractive spaces» in the therapeutic relationship

Conclusion

The considerations on the psychotherapy of the lived space outlined above can be summarised in four main points:

1) Phenomenology is the science of subjectivity, but every subject is a world. Subjective experiences are not to be found inside the psyche or the brain, but extend over the person's lived body and space. The lived space may also be regarded as the person's ecological niche that is continuously shaped by his/her exchange with the environment, that is, by his/her responsivity and responded activity. This exchange is also crucial for his/her personal development.

2) Mental illness is not a state in the head either. It may rather be conceived as a limitation or deformation of the patient's lived space, as an inhibition of his/her responsivity and exchange with the environment. Unconscious dysfunctional patterns of feeling and behaving act as 'blind spots' or 'curvatures' in lived space that lead to typical distortions, thereby inhibiting the patient's potentialities and development.

3) The task of psychotherapy is first to explore and understand the patient's lived space in order to re-open his/her horizon of possibilities. The main agent for this purpose is the interactive field which may be regarded as a 'fusion of horizons' of the patient's and the therapist's world. It provides a new, dyadic experiential space that is capable of illuminating the blind spots or curvatures in the patient's lived space. Hence, from a phenomenological point of view the process of psychotherapy is rather experiential than cognitive, insight-oriented or 'archaeological'. The patient's habitual or implicit ways of relating to others are re-enacted in the 'here and now' of the therapeutic relationship.

4) Phenomenology may serve as a framework for conceptualising these processes in terms of embodiment, spatiality, temporality and intersubjectivity. It offers a language for the varieties of subjective experiences which is not imported from any theoretical paradigm but is mainly derived from hermeneutics. Thus, there is no «phenomenological psychotherapy» which could be regarded as yet another therapeutic school. Phenomenology rather offers the foundations for an experiential and unprejudiced attitude which any therapist should seek to gain.

References

Barker R.G. (1968) *Ecological psychology. Concepts and methods for studying the environment of human behaviour*, Stanford Univ. Press

Beebe B., Lachman F., Jaffe J. (1997) Mother-infant interaction structures and presymbolic self- and object representations, *Journal of Relational Perspectives*, 7, pp. 133–182.

Binswanger L. (1963) Freud's conception of man in the light of anthropology. In: L. Binswanger *Being-in-the-world.* Selected papers of Ludwig Binswanger translated and with a critical introduction to his existential psychoanalysis by Jacob Needleman, New York: Basic Books, pp. 149–181.

Bühler K.-E. (2004) Existential analysis and psychoanalysis: Specific differences and personal relationship between Ludwig Binswanger and Sigmund Freud, *American Journal of Psychotherapy*, 58, pp. 34–50.

Fuchs T. (2000) *Psychopathologie von Leib und Raum [Phenomenology of lived body and space]*, Darmstadt: Steinkopff.

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

Fuchs T. (2004) Neurobiology and psychotherapy: an emerging dialogue, *Current Opinions in Psychiatry*, 17, pp. 479–485.

Fuchs T. (2005) Corporealized and disembodied minds. A phenomenological view of the body in melancholia and schizophrenia, *Philosophy, Psychiatry & Psychology*, 12, pp. 95–107.

Fuchs T. (2006) Fragmented selves: temporality and identity in Borderline Personality Disorder, *Psychopathology* (in press).

Gadamer H.G. (1995 [1960]) *Truth and method*. 2nd revised ed. (trans. J. Weinsheimer, D.G. Marshall), New York: Continuum.

Gibson J.J. (1986) *The ecological approach to visual perception*, Lawrence Erlbaum Associates.

Graumann C.F. (1978) (ed.) *Oekologische Perspektiven in der Psychologie (Ecological perspectives in psychology)*, Bern: Huber.

Greenson R. (1967) *The technique and practice of psychoanalysis*, New York: International Universities Press.

Hersch E.L. (2003) *From philosophy to psychotherapy. A phenomenological model for psychology, psychiatry and psychoanalysis*, Toronto: University of Toronto Press.

Holzhey-Kunz, A. (2001) Psychopathologie auf philosophischem Grund: Ludwig Binswanger und Jean-Paul Sartre, *Schweizer Archiv für Neurologie und Psychiatrie*, 152, pp. 104–113.

Husserl E. (1950) *Ideen zu einer reinen Phänomenologie und phänomenologischen Philosophie. I. Allgemeine Einführung in die reine Phänomenologie*. Husserliana III. Den Haag: Nijhoff. – Engl. Trans. W.R. Boyce Gibson (1931) *Ideas: An introduction to pure phenomenology*, New York: Macmillan.

Husserl E. (1952) *Ideen zu einer reinen Phänomenologie und phänomenologischen Philosophie. III. Die Phänomenologie und die Fundamente der Wissenschaften*. Husserliana V. Den Haag: Nijhoff.

Kraus A. (1987) Rollendynamische Aspekte bei Manisch-Depressiven [Role dynamics in manic-depressive persons]. In: K.P. Kisker et al. (eds.) *Psychiatrie der Gegenwart*, Vol. 5, Berlin Heidelberg New York: Springer, pp. 403–423.
Kronmueller, K., Backenstrass, M., Kocherscheidt, K. et al. (2002) Typus melancholicus Personality Type and the Five-Factor Model of Personality, *Psychopathology*, 35, pp. 327–334.
Kruse L., Graumann, C.F. (1978) Sozialpsychologie des Raumes und der Bewegung. In: K. Hammerich, M. Klein (Hrsg.) *Materialien zu einer Soziologie des Alltags*, Opladen: Westdeutscher Verlag, pp. 176–219.
Lerner R.M., Bush-Rossnagel, N.A. (1981) (eds.) *Individuals as producers of their own development. A life-span perspective.* New York: Academic Books.
Lewin K. (1936) *Principles of topological psychology* (trans. by F. Heider, G. Heider). New York: McGraw Hill.
Lyons-Ruth K. (1998) Implicit relational knowing: Its role in development and psychoanalytic treatment, *Infant Mental Health Journal*, 19, pp. 282–289.
Margulies A. (1984) Toward empathy: The uses of wonder, *American Journal of Psychiatry*, 141, pp. 1025–1033.
May R. (1964) On the phenomenological basis of psychotherapy. In: E.W. Straus (ed.) *Phenomenology: Pure an applied. The First Lexington Conference*, Pittsburgh: Duquesne University Press, p. 166–184.
Merleau-Ponty M. (1962 [1945]) *Phenomenology of perception* (trans. by C. Smith). London: Routledge and Kegan Paul.
Merleau-Ponty M. (1964) *Le visible et l'invisible*. Paris: Gallimard.
Merleau-Ponty M. (1967) *Signes.* Paris: Gallimard.
Merten J., Krause R. (2003) What makes good therapists fail? In: P. Philippot, E.J. Coats, R.S. Feldman (eds.) *Nonverbal behavior in clinical settings*, Oxford University Press, Oxford.
PCSG (Process of Change Study Group) (1998) Non-interpretative mechanisms in psychoanalytic therapy: The ‚something more' than interpretation. *International Journal of Psychoanalysis,* 79, pp. 903–921.
Ricœur P. (1969) *Freud and philosophy: an essay on interpretation*, New Haven: Yale University Press.
Romanyshyn, R. D. (1977) Phenomenology and Psychoanalysis, *Psychoanalytic Review*, 64, pp. 211–223.
Sartre J.-P. (1966 [1943]) *Being and nothingness* (trans. H.E. Barnes), New York: Philosophical library.
Schacter D. L. (1996) *Searching for memory*, New York: Basic Books.
Stern D. (1998) *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*, New York: Basic Books.
Stern D. (2004) *The present moment in psychotherapy and everyday life*, New York, London: Norton&Comp.
Tellenbach H. (1980) *Melancholy. History of the problem, endogeneity, typology, pathogenesis, clinical considerations*, Pittsburgh: Duquesne University Press.
Varghese F.T. (1988) The phenomenology of psychotherapy, *American Journal of Psychotherapy*, 42, pp. 389–403.
Willi J. (1999) *Ecological Psychotherapy. Developing by Shaping the Personal Niche*, Cambridge/MA, Toronto, Goettingen: Hogrefe&Huber.
Zahavi D. (2005) Being Someone, *Psyche*, 11(5) [Electronic resource] Mode of access: http://psyche.cs.monash.edu.au/