

Psychotherapy of the Lived Space: A Phenomenological and Ecological Concept

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Using phenomenological and ecological psychology as a base, the author develops the concept of lived space as the totality of an individual's spatial and social relationships, including his "horizon of possibilities". The lived space may also be regarded as the individual's ecological niche, which is continuously shaped by his exchange with the environment. Mental illness may then be conceived as a limitation or deformation of the patient's lived space, inhibiting his responsivity and exchange with the environment. Unconscious dysfunctional patterns of feeling and behaving act as "blind spots" or "curvatures" in lived space and 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 reopen his horizon of possibilities. The main agent for this purpose is the interactive field of psychotherapy, which may be regarded as a "fusion of horizons" of the patient's and the therapist's worlds.

INTRODUCTION

At first sight, phenomenology seems to be a rather contemplative, philosophical method, unhelpful to the psychotherapist who is eager to promote patient change. For this purpose, the therapist 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 indispensable if we want to gain a genuine, unprejudiced understanding of the patient's experience. Moreover, phenomenology offers a view that localises the patient's disorder neither in the hidden convolutions of his

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brain nor in the hidden corners of his psyche, but in the actual world of his 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 world. Phenomenology is not an approach mainly based on introspection and inner states, as an old prejudice suggests.¹ On the contrary, it overcomes the dichotomy of internal and 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”, nor “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 instead focus on his *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 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. Of special importance will be 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 may help him to reshape his relationships with others as well.

1. THE PERSON’S WORLD AND LIVED SPACE

My starting point is 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 objective fact. Namely, this is the special *way of being* of what is experienced and *the structure of the experience itself*, which may be uncovered by phenomenology. The central technique used for this pur-

¹Such a view has been explicitly denied by Husserl (1952, p. 38). On this, see also Zahavi 2005, p. 12ff.

pose, 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 that exist independently of the mind or the subject are real—that is 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 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 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 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 the schizophrenic, the obsessive, or the suicidal patient?

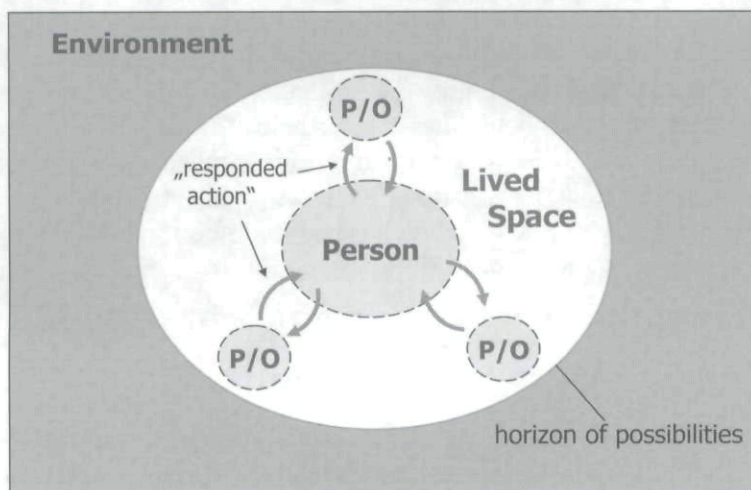
"World", of course, does not mean something outside as opposed to inside, the external world against the internal or mental world. It is rather the totality of life in the sense of an all-embracing framework of meaning in which a person's experience, thinking and acting are embedded. In the same sense,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

In the following, I focus on the phenomenological concept of the *lived space*, though other categories, such as 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 it 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—meaning, 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, "field forces" or vectors, such as attraction and repulsion, elasticity and resistance, etc., permeate the lived space. 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. In analogy to 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 point, 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 lived space, only encountered his 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). In analogy to 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 nonliving 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

Figure 1
PERSON, LIVED SPACE AND ENVIRONMENT
p/o = persons or objects in the lived space



and the responses of the environment may be termed the person's "responded activity" (cf. Willi, 1999). It is assumed that the person seeks and shapes an environment that responds to his actions and offers the valences for his potentialities. The capacity of a person to respond adequately to the stimuli and requirements of his environment, especially to the demands of others, may be called his "responsivity".

The most intense and stimulating responses arise in family or partner relationships. Generally, the individual tries to establish a mutual responsiveness or "co-responsivity" with his 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 the courses of their lives and direct their developments by shaping and acting on their environments, which in turn react on 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 subject and 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 "existence": 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 to others. We do not see the vicinity or distance that things or other persons have for him, nor do we sense the free spaces or perspectives that attract, the barriers that frighten him, or the psychological forces that determine his ways like magnetic field-lines. Nevertheless, in order to understand another person, we have to get to know his familiar surroundings, his sphere of influence and his various relations to his environment. In this way, the major goal of phenomenological psychotherapy is "to enter and to share the world of the other" (Margulies 1984).

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 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 egocentrism and reduce his 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; Kronmüller, 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).

To take another, 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 flung to and fro (Fuchs, 2007). 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" theories of the unconscious are well known; they describe it as a level *below the ground* where all kinds of sinister entities are stored. Such a concept is based on a Cartesian model of the mind as a kind of inner container holding distinct ideas, memories, and representations of external reality that 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 phenomenologists (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. In any case, the latter cannot be conceived as a place or room that contains atomistic, reified mental entities. Not things, fixed objects or memories may be regarded as 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 is behaving and living, and in the ways he is *not* living and behaving. Here phenomenology converges with recent memory research that emphasises *implicit or procedural learning* as underlying our habitual ways of behaving, acting, and also *avoiding* possible actions, without explicit, or only with marginal awareness (Schacter, 1999; Fuchs, 2004).

Merleau-Ponty, with a similar intent, has already analysed the unconscious aftereffect of the psychological trauma. According to him, the repressed resembles the phantom limb in patients who have undergone an amputation in that it constitutes an "empty space" of subjectivity (1962,

p. 86). The repressed unconscious may be regarded as the negative picture of a past experience that the subject could not cope with—a negative that overlays each novel situation without notice, thus fixing the traumatised individual on his 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.*

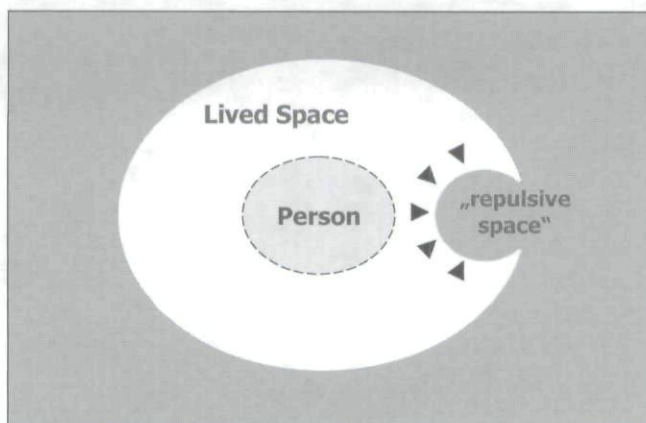
(Merleau-Ponty 1962, p 83; italics by the author, T. F.).

The implicit, or bodily memory, includes all hidden “behind our gaze”, only living on in a general manner or “style” of existence, not revealing itself as an explicit memory; this also applies to certain traumatic experiences. Thus, unconscious fixations resemble distortions or restrictions in a person’s space of possibilities; they are caused by a past that continues to be implicitly present and refuses to give way to the progress of life. The past’s traces, however, are not hidden in some inner world of the psyche. They 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 the individual refuses to take, in the life he does not dare to live, etc.² Like the figure–ground relation of Gestalt psychology, such traces become noticeable as a negative, i.e. as the inhibitions or omissions typical for a person. On the other hand, these traces may 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 our field. It is “unconscious” by not being *object* but by being that through which

²Sartre 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 “willful 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, that means, one looks beside it both with and without intention. On this, cf. Holzhey-Kunz (2002, p. 173ff.) and Bühler (2003).

Figure 2
UNCONSCIOUS "REPULSIVE SPACES"



objects are possible, it is the constellation from which our future may be read.³

(Merleau-Ponty 1964, p. 234)

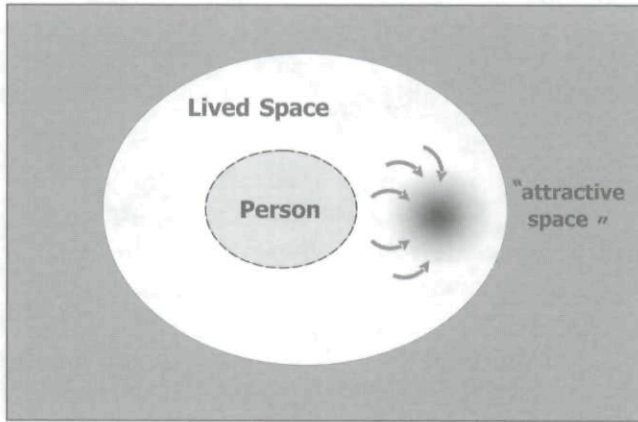
Following this line, I will give a short phenomenological restatement of two central psychodynamic concepts, that of *defence or resistance* and of *repetition compulsion*.

DEFENCE AND REPETITION COMPULSION

(1) The effect of emotional trauma on the individual may be regarded as a specific deformation of his 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"). 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 curved negatively 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

³"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).

Figure 3
UNCONSCIOUS "ATTRACTIVE SPACES"



without conscious awareness because it is 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, which is 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 may try to avoid this by all means. The lived space is curved positively around such areas, and they have become "attracting spaces" (fig. 3). If, for example, a woman's early life experiences were dominated by abusive and violent relationships, her scope of possible relationships will be quite limited. The modes of abuse will vary, but the theme will influence her way to arrange her relationships to the exclusion of others. Her implicit behaviours will have the effect of 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 is enmeshed in her way of living, even in her bodily behaviour.

We could approach other psychodynamic concepts in a similar way, 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 an unconscious that is

not hidden 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.⁴ This leads us further to the phenomenology of the therapeutic interaction.

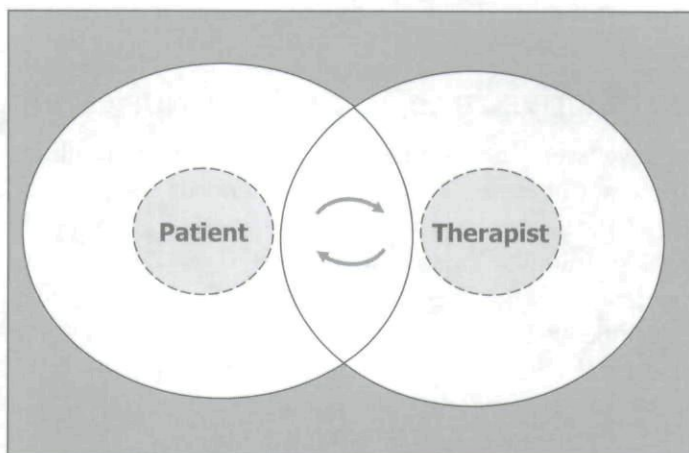
3. THE INTERACTIVE FIELD AS THE AGENT OF CHANGE

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 it is viewed as a restriction of his horizon of possibilities. The aim of treatment, therefore, would be to expand the patient's horizon and to increase his degrees of freedom. From a phenomenological perspective, the main agent for this purpose is the interactive field opened up by the encounter between patient and therapist.

According to older models of psychotherapeutic action, change is produced *in the patient alone*, through a restructuring of his internal world, as a result of cognitive or interpretive interventions by the therapist that lead to insight and, accordingly, to more appropriate responses of the patient to his 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 patient and 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 nonverbal, bodily and atmospheric interaction plays an important role here. Though remaining in the background, it is an essential carrier of the therapeutic relationship.

⁴"(. . .) the latency of psychoanalysis is an unconscious that is *beneath* conscious life and *within* the individual, an *intrapsychic* reality that 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).

Figure 4
"FUSION OF HORIZONS" IN PSYCHOTHERAPY



However, the traditional concept of transference and countertransference does not grasp this interactive, dyadic quality of the therapeutic relationship. 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). What the patient sees in the therapist was regarded only as a distorted image derived from the past. Moreover, transference and countertransference did not meet to form something new. Though projected onto the respective other, they did not actually attain him, 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 only as a projection screen would be in danger of missing the dimension of genuine encounter where he is met as a real, embodied person.

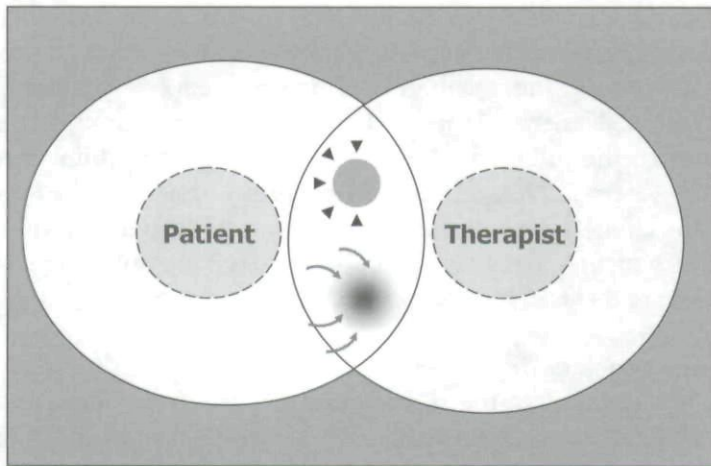
A glance at developmental psychology may be helpful here. Mother-infant research shows that it is not isolated images or "objects" that are stored in memory, but rather interactive experiences, schemes of dyadic interaction that are learnt and acquired in the sensory, motor and emo-

tional mode (Beebe, et al., 1997; Stern, 1998a). From early childhood on, these schemes become 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 that organise 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 therefore are of special importance for the therapeutic process.

We may conclude from these results that it is not the explicit past, which is in the focus of the therapeutic process, but rather the implicit past, which unconsciously organises and structures the patient's *procedural field* of relating to others. To be sure, it is a phenomenological unconscious, i.e., a prereflective, nonthematic, basic structure of experience, that we are dealing with, still different from Freud's dynamic unconscious of repression. However, implicit relational patterns have become increasingly important for psychoanalytic theory, 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 these be replaced by corrective experiences, in special moments of empathic correspondence between patient and therapist ([*moments of meeting*] PCSG, 1998).

Here, the phenomenological stance may be particularly helpful. The corrective emotional experience of psychotherapy is a function of the extent to which the therapist can "put his world and theory in brackets" when encountering the patient. Husserl's *epoché*, i.e. the suspension of judgement and the abstention from preconceived ideas, may help clear the space required for an authentic encounter between patient and therapist without the interference of complex metapsychologies from various therapeutic schools (Margulies, 1984; Varghese, 1988). Phenomenologically oriented therapists refrain from attaching any presumed idea to the patient's experience. They will try to understand as much as possible of "what it is like to be him", to walk in the patient's experiential footprints, to recreate his world view in their own experiences, and to convey this

Figure 5
 "REPULSIVE" AND "ATTRACTIVE SPACES" IN THE THERAPEUTIC
 RELATIONSHIP



experience to the patient in verbal and nonverbal ways. This mutual mirroring may help the patient to deepen his 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 of which he is a part. Otherwise he 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, for example, tends to leave decisions to others in order to avoid responsibility, it would certainly be wrong to become entrapped in this attracting space and tell him what to do. If a patient avoids a shameful experience or a shameful view of himself, it would not be very helpful to share unwittingly his anxiety and carefully move around this delicate zone. Rather, the therapist should 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.

CONCLUSION

To conclude, the considerations on the psychotherapy of the lived space outlined above will be summarised in four main points:

- 1) Phenomenology is the science of subjectivity, in the sense that every subject is a *world*. Subjective experiences are not to be found inside the psyche, even less in 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 exchange with the environment, that is, by his responsivity and responded activity. This exchange is also crucial for his personal development.
- 2) Mental illness is not a state in the head either. Rather, it may be conceived as a limitation or deformation of the patient's lived space or as an inhibition of his 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 to explore and understand the patient's lived space in order to reopen his 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 worlds. 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 viewpoint, the process of psychotherapy is experiential rather than cognitive, insight oriented or "archaeological". The patient's habitual or implicit ways of relating to others are reenacted 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.

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