The Phenomenology of Body and Space in Depression

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Abstract

The lecture describes depression in phenomenological terms, i.e. on the basis of the distinction of 'lived' and 'corporeal' body. While the body is normally embedded into the world and extended into space, depression interrupts this lived contact to the world and to others. Local or general oppression condenses the fluid, mobile lived-body to the solid, heavy corporeal body which puts up resistance to all remaining expansive impulses. The depressed person is thus restricted to a 'corporealized body' which does not give access to the world any more, but stands in the way as an obstacle. The patient's capacity to participate in the world by his senses and feelings is thwarted by alienation and even depersonalisation. The lecture interprets the typical clinical symptoms of depression on the background of this concept and arrives at some therapeutical conclusions.

I.The Dialectics of Lived and Corporeal Body

In one of My starting-point is the polarity the lived and the corporeal body as conceptualized by the phenomenologic tradition, expecially by Merleau-Ponty (1962). The *lived body* means not only the felt body, the subjective space of bodily sensations, but comprises my prereflective experience as a whole, insofar as it is mediated by the body, by its senses and limbs. I act through my body, perceive and exist through it, without explicitly reflecting on it. Hence lived bodiliness means my relation to the world as mediated and lived by the body, or my embodied being-in-the-world. The *corporeal body*, on the other hand, is the anatomical object of physiology and medicine which can be observed, grasped and even manipulated - an object, however, which through its peculiarity of being owned by a person enters a complex relation to the.subjective 'lived-body'. *In short: the body that I am, and the body that I have.*

In fact, the corporeal body may well be experienced, even though in a certain negativity. It appears

(1) in the experience of heaviness, fatigue, injury, or illness; i.e. whenever the lived-body loses its 'taken for granted' carrying role and becomes obstinate or fragile - the body which I have;

(2) in all kinds of clumsiness, e.g. when we try to perform or train a certain movement that we have not mastered yet, the body is no longer medium but, as it were, a difficult tool to be handled;

(3) in situations of exposure to the view of others when the body becomes an object for them, a 'body-for-others' (*corps pour autrui*, Sartre 1956). Thus is the case e.g. in shame, when we suddenly become aware of our blushing body in an embarrassing way; in our conscious appearance, e.g. in clothing, make-up, deliberate gesture or facial expression, etc; or else in the physical examination by the doctor who objectifies and turns the lived into the corporeal body.

If we take all this together, the corporeal body appears whenever the primary performance of the lived-body is interrupted; when the body loses its automatic coherence with the surrounding world; when our spontaneous bodily expressions are disturbed, blocked, or objectified by others, and our attention turns back upon ourselves. The corporeal body is the obstinate or heavy body; the body as shown or exposed to others; the body that I have, to which I am bound, or that I reflect upon. Primordial or lived bodiliness is a constant outward movement, embedded into the environment and participating in the world. Corporeality appears whenever this movement is paralysed or disrupted, when the lived-body is thrown back on itself, reified or 'corporealized'.

Bodiliness and corporeality are therefore dialectically intertwined. The body oscillates in the polarity of being unnoticed or conspicuous, of automatic performance or interfering resistance, of being subject or object, being lived or being had. The body, as Merleau-Ponty (1962) put it, reveals the fundamental 'ambiguity' of human existence.

II. The Body in Melancholic Depression

I will now describe melancholia in phenomenological terms as a *corporealization of the lived-body*. First I should justify why talk about the body in depression at all; depression is commonly regarded as an affective or mood disorder. However, not all patients show affective symptoms. We know that there exists something called masked depression where somatic complaints are prominent and the patients are not aware of depressive emotions. Transcultural studies have also shown that in traditional societies the equivalent to western depression is often a state of fatigue, somatic complaints and social withdrawal which lacks the feelings of sadness, guilt or anxiety typical for our notion of depression. This could be explained by a bodily basis of melancholic depression that is the fundament for the emotional experience of guilt, sorrow or despair. Kurt Schneider coined the term „vital symptoms' which in German psychopathology is essential for the diagnosis of melancholic depression.

From a phenomenological point of view, melancholia may be regarded as a a freezing or rigidity of the lived-body; I call it *bodily restriction*. This may focus on single areas of the body (e.g. feeling of an armour or tyre round the chest, of a lump in the throat, pressure in the head) or else manifest itself as a diffuse anxiety, an overall bodily rigidity ('anxious' as well as *'Angst'* are derived from the latin *'angustiae'* which means 'narrows', 'restriction'). We know the characteristic complaints: I feel the anxiety pressing my chest like a vice; I feel like being immured. In depression I felt like being crammed together, now I notice it is widening again around me, and I can breathe more freely.

Local or general oppression condenses the fluid and mobile lived-body to the solid and heavy corporeal body which puts up resistance to all remaining expansive impulses. The patient's gaze becomes tired and blunt, the voice dull, the gestures weak; even breathing, normally a subliminal muscular action, may become a task to be carried out against the load felt on the chest. Thus the bare materiality and corporeality of the body, otherwise unnoticed in everyday performance, now emerges and is felt as an obstacle. The faculties

of perception and movement are weakened and finally immured by the rigidity which is clearly visible in the gaze, the face or the gestures of the patient. His capacity to participate in the world by his senses and feelings is replaced by alienation and depersonalisation.

Corporealization thus means that the body does not give access to the world any more, but stands in the way as an obstacle. The exchange of body and environment is inhibited, drive and impulse are exhausted.

In addition, a loss of vitality in many systems of the organism comes about; processes of shrinking and dying prevail. The excretions cease; appetite and libido are reduced or lost. The patients look older than they are, their complexion becomes pale, the hair dull. In the worst cases the weight loss may progress to the point of cachexia, and the regulation of the blood circulation gets disturbed. All this litterally means a corporealisation, namely in the sense of coming nearer to the corpse, the dead body. The fluidity, mobility and vitality of the body give way to a more or less marked retardation or stasis. In serious cases the rigidity culminates in depressive stupor. A literal freezing and reification of the body ensues which is no longer capable of resonance with its environment. From an ethological perspective, it may be interpreted as a 'freeze'- or 'play dead'-reaction (Eibl-Eibesfeld 1969).

III.Sensorimotor Space

The restriction I have described so far continues in the sensorimotor space, in the realm of perception and movement. The depressive's perception is characterised by a loss of alertness and sympathetic sensation. Patients may describe a loss of taste, a dullness of colours or muffled sounds as if heard from afar. Their senses are not able to vividly participate in the environment, their gaze gets tired and empty, their interest and attention weakens.They may only passively receive what intrudes from outside.

Movement, on the other hand, is marked by psychomotor inhibition: Movements, gestures and speech are reduced, only mechanically produced, and lack normal energy. A bowed posture, a lowered

head, a leaden heaviness of arms and legs show the dominance of forces drawing or pressing downwards, as is also pointed out by the word depression. The weight of the physical body, otherwise unfelt in the casual performance, now comes to the fore. Step by step does the patient move his body and carries it, so to speak, to the required spot. In order to act, he has to overcome the inhibition and to push himself to even minor tasks, compensating by an effort of will what the body does not by itself any more. The wind in the sails is missing and can only insufficiently be substituted by rowing.

Consequently, the external aims and objects withdraw from the patient, as it were; they are not at the disposal of his body as a matter of course. Using Heideggers terms, they are not at hand any more, but only there (zuhanden- vorhanden). All this means that the body's space shrinks to the nearest environment. Phenomenologically speaking, the depressed person cannot be outside of his body – which is what we normally are when we are looking at and desiring things, potentially reaching for them, and potentially walking towards our goals, in one word: anticipating the immediate future. Time and space, as we can see, are interconnected: Anticipation of what is possible or what is to come, and the extension of space around me are one and the same thing. For the depressed person, however, space is not embodied as it normally is; there is a gap between the body and its surroundings. This in turn reinforces the bodily restriction and enclosure I mentioned before.

One may also recall here Gibson's concept of perception: Our environment is structured by „affordances' which means it provides clues for certain purposes – some things provide fun, others shelter, others food, others adventure, and so on. For the depressed person, however, the environment loses this profile; it does not invite him, it does not speak to him any more, or if it does at all, then only in a negative, reproachful way: This should have been done; that slipped me again; this is out of reach for me; that was attractive in times before but is not any more. Affordances are replaced by rejections or reproaches.

IV. Loss of Body Resonance

So far I have described depression as a disturbance of body feelings, perception, movement, space and time. However, there is still another dimension of body and space which is not part of our everyday understanding of these terms: It is the dimension of felt atmospheric qualities, of expression and impression, of our affective engagement and participation in the world. Normally we regard these as inner, psychic or „subjective' phenomena which are neither visible nor touchable and therefore not part of the common, spatial world. This introjection of feelings into an inner chamber of the so-called psyche is still a heritage of the Cartesian split of the world into thinking substance and extended substance. In fact,we do not live in a merely physical world; the space around us is always emotionally charged. The objects and persons have their expressive and affective qualities, they attract or repell us; we feel something in the air, or we sense an interpersonal climate, e.g. a serene, a solemn or threatening atmosphere. This emotional space is felt by the medium of the body which widens, tightens, weakens, trembles, shakes etc. in correspondance to the feelings and atmospheres we experience. No emotion without bodily The body is a resonance body, a most sensitive sounding-board in which interpersonal and other vibrations may reverberate.

Now in depression the corporealized body loses its capacity of emotional resonance. Patients speak of a 'feeling of not feeling' ('Gefühl der Gefühllosigkeit') and complain of not being able to sympathize with their relatives any more. We can sense this ourselves when we stay with a depressed patient, look at his rigid face, notice his scarce expressions of affects and feel the invisible wall that surrounds him. He is not attuned to the environment any more; he has lost the sympathetic participation in the common emotional world. Even the ability to shed tears is lost. The patients themselves notice this freezing of their expressivity and try in vain to substitute the missing bodily communication by repeating their complaints mechanically again and again. This culminates in the stony, empty expression of the psychotic melancholic patient, whose depth of pain may not be empathically felt by others any

more. A severely inhibited, nearly motionless patient can often tell only after the solution of the inhibition what degree of despair he has been going through.

The loss of resonance may be interpreted as a more subtle result of the general bodily restriction and rigidity. The patient is no more capable to be moved, addressed and affected by things or persons. In milder form this becomes manifest in loss of interest, pleasure and desire. The deeper the depression, the more the attractive qualities of the environment faint. Finally the ability to sense feelings and atmospheres at all is lost. This loss of resonance and the inability to feel values or emotions is painfully experienced by the patients, for it is not caused by mere apathy or indifference (such as in frontal brain injury) but by the tormenting bodily restriction. Pain, anxiety and also guilt are the feelings that remain even under the condition of severe bodily oppression, whereas other emotions require a more subtle and mobile body resonance.

The depressed patient does not feel sadness, mourning or grief; he feels rather empty, dull, stony or dead. The affective side of the disorder is characterized by the *inability to sense feelings* such as sadness, joy or pleasure. Kurt Schneider wrote that the vital disturbances of feeling are so intense that psychic (i.e. higher) feelings can not appear any more. Thus the bodily restriction in depression results not only in felt oppression, anxiety, heaviness and inhibition, but more subtly, in a loss of sympathetic resonance. Therefore the recovery typically starts with a gradual solution of the inhibition and an increase in motoric activity, whereas the subtle mobility of the body necessary for emotional resonance is only reached again at the end of the recovery. Often the regained ability to shed tears is an important sign for the solution of depressive rigidity.

V. Derealisation and Depersonalization

Since the vital, sympathetic contact to the environment is essential for our sense of being-in-the-world, a loss of body resonance always means a certain degree of derealisation and depersonalisation: Loss of feeling means at least a partial loss of self. However, there is

a special kind of melancholic depression where depersonalisation is the prominent symptom; in German psychopathology it is called *Entfremdungsdepression* (depersonalized depression). Here the emotional quality of perceptions is totally lost. The patients do not sense the atmosphere of a sunny morning, of a summer evening; a red surface is no more red in the sense of warm, bright, attractive, but only red. The sensual perceptions remain abstract and cannot be felt. At the same time, space becomes empty and, as it were, hollowed out.

There is only emptiness around me; it fills the space between me and my husband; instead of conducting it keeps me away. I am kept away from the whole world; there is an abyss in between (v.Gebsattel). Another patient sees everything flat, „in one row, there are no differences of depth any more. All seems to be a fixed surface, like on a screen (Tellenbach). Thus the structuring of the environment into near and far, into more or less reachable for the body is abolished. There is only a cognitive, a known or abstract space, not a lived, embodied space any more. Perception shows only the naked framework of objects, not their connectedness, their flesh, so-to-speak. The patients themselves feel like an isolated stone in a world of relationless objects.

The depersonalisation in severe depression culminates in the so-called nihilistic delusions or the Cotard-Syndrom, formerly aptly called *„melancholia anaesthetica'*. The patients do not sense their body any more; taste, smell, even the sense of warmth or pain are gone, everything seems dead. This makes them conclude that they have already died and ought to be buried. They may even deny their own existence or the existence of the world.

A 65-year-old patient of mine maintained that her body, her stomach and bowels had been contracted so that there was no hollow space left. The whole body, she said, was dried out, nothing did move any more; she sensed neither heat nor cold. She could not even die, for everything was already dry and dead. She also could not imagine anything, neither her husband nor relatives or any external object. Persons and objects seem hollow and unreal, the whole world is

empty or does not exist any more. Ths derealisation may be associated with the Capgras-delusion: The patients are convinced that relatives have been substituted by dummys or actors. This phenomenon may be explained by the complete loss of the emotional quality of perceptions: Only a cognitive recognition of the person is possible, but it is contradicted by the missing emotionaly familiarity, and this contradiction can only be explained by the delusion of a substitution. We can only recognize others when they appeal to our own bodily resonance and elicit a feeling of connectedness, an interpersonal atmosphere. That is why Merleau-Ponty spoke of the *intercorporëité*, the intercorporal sphere of prereflective connection and pairing of human bodies.

The complete loss of resonance, however, lets others appear to be fakes and actors who present an infernal theater to the patient. The dutch psychiatrist Piet Kuiper who fell ill from psychotic depression, reported his experience:

> 'Someone who resembled my wife, was walking beside me, and my friends visited me ... Everything was as it would be normally. The figure representing my wife constantly reminded me of what I had failed to do for her ... What looks like normal life is not. I found myself on the other side. And now I realized what the cause of death had been ... I had died, but God had removed this event from my consciousness ... A harsher punishment could hardly be imagined. Without being aware of having died, you are in a hell that resembles in all details the world you had lived in, and thus God lets you see and feel that you have made nothing of your life' (Kuiper 1991).

For a person in this state of utter depersonalisation there is no criterion to convince him of the reality of what he is seeing, even of his existence itself. Descartes' „cogito ergo sum' here proofs to be insufficient. A person who only thinks without having bodily feelings exists no more, in the sense of the living existence that is fundamental for all thinking. Having died is the description of such a state that suggests itself.

VI. Depressive Delusion

Let us consider in a bit more detail the temporal aspect of the nihilistic delusion. For the patient, the state of having died is litterally an eternal one. Like the Eternal Jew he is doomed to be dead alive forever. He cannot even imagine to be in another state some time in the future. As we saw before, there is a narrow connection of the lived body, space and temporality. The possibility of bodily movement, the accessibility and openness of space and the anticipation of the future are one and the same thing. Now the accessibility of space depends on our emotional resonance, on our participation in the world around us. So if the body is completely isolated by restriction and all its resonance is lost, then the space will be inaccessible, unreachable and detached from the potentiality of our body. But what is more, the course of time will also cease and come to a standstill. The present state will become eternal, and there won't be even a possibility of change.

This is the hallmark of depressive delusion in general: A state of self besides the present one is unimaginable. The patient is totally identified with his experience, and this means extreme separation from others, being thrown back on himself, lost and decayed. He is no more able to keep his situation in perspective, and to relativize his opinions. It has always been like this, and it will stay the same for ever – all reminiscence or hope different from that is deception. Even the remembrance of a former recovery from a depressive episode remains abstract and does not change the hopelessness of the present episode. Now if for the patient there is no state of self outside the present one, then the certainty of his statements on it cannot be less than the certainty of his existence itself. Nihilistic, hypochondriacal delusions, delusions of guilt or impoverishment are all just different expressions of the same state of the self: a state of total objectivation or „reification' that cannot be transcended any more. Depressive delusion is therefore rooted in the total restriction of self-experience and its separation from the others: *The capability of taking the perspective of others depends on a common interpersonal and intercorporeal space which for the depressed patient does not exist any more.*

I want to illustrate this in two kinds of depressive delusion, i.e. delusions hypochondriasis and of guilt. – In accordance with the bodily restriction, hypochondriacal delusions mainly refer to a blockage of body passages, a shrinking and overloading of the body's inner space. The exchange processes seem disturbed by constriction or interrupted by constipation. The patients complain of not being able to eat or breathe any more, of an inner putrefication or decay. They are sure to die soon, and they may also report signs of cancer or another lethal disease.

These supposed signs are of course not more than ordinary bodily sensations in most cases. But as I said before, depressive delusions are not delusions of explanation or inference; they are rather „exclamations', immediate expressions of the state of self the patient experiences. The language of delusion is not a descriptive or indicating language, but similar to utterances like „ow!' or „help!' So if the depressed patient declares e.g. I have cancer, this sentence does not denote a medical diagnosis, i.e. an intersubjectively constituted fact; it is rather the immediate expression of his existential state, characterized by the experience of decay and dying. It means not a part of the body or a certain disease but existence as such. Some patients express it by saying that the whole body is decayed, ruined or spoilt. The patient does not retain a position besides his state and his body; he is totally identified with his present experience, and this is an experience of a paralysis of all vital processes, of imminent death.

Turning now to delusions of guilt, we can recognize two conditions on which they are based.

(1) First we have seen that the patient's total identifikation with his present state means a loss of anticipated future. The bodily experience of „I can', of capability and possibility is missing; lived time comes to a standstill. *With this, however, the past is fixed once and for all*; it may no more be changed, evened out or abolished by future living. Objective time, the hours and days keep on counting and passing by, as a constant call gone!, over!. In melancholia, time continuously turns into guilt which can no more be discharged.

> What has happened can never be undone again. Not only the things go by, but also possibilities pass by unused. If one does not accomplish something in time, it is never done any more ... The real essence of time is indelible guilt. (Kuiper 1991)

(2) The second condition is the bodily restriction and loss of bodily resonance which means a disconnection of all bondings. For the melancholic patient or the 'Typus Melancholicus' the emotional bonds to his fellowmen are of utmost and vital importance. Therefore the radical separation from the world and the others implies not only a severe loss, but also recalls experiences of elementary guilt, of being 'deserted' or 'expelled'.

> It comes from below, from the belly, like a terrible oppression mounting up to the chest; then a pressure arises like a crime that I have committed; I feel it like a wound here on my chest, that is my tortured conscience ... then it sucks forth my memories, and I have to think again of all that I have missed or done wrong ... (Kuiper 1991).

Such descriptions point to the possibility that the depressive guilt feelings may be rooted in bodily experience itself: Guilt reminiscences turn up, when the person is in a bodily and emotional state corresponding to their first appearance. In melancholic depression the patient experiences utter bodily rigidity as a overwhelming experience of guilt which reactivates an archaic, punishing conscience. It is not the perhaps objectively given occasions for guilt or remorse in the patient's biography, but often vain or banal contents which then become issues for his self-reproaches. Neither do such guilt feelings lead to a mature coping process, to insight, acceptance, or remorse for the (assumed or actual) mistakes. Melancholic guilt is not embedded in a personal relation which could make this possible: It results precisely from the interruption of all relations. It remains basically autistic. The wronged persons named by the patient are only pseudo-authorities toward whom there is no actual remorse, even less a reconciliation. The melancholic is so identified with his guilt that he is guilty as such; this corresponds to

an archaic, undifferentiated self-perception. He feels as being the center of a 'guilt-world', in which everything becomes a sign of his omission. There is no forgiveness, no remorse or reparation in the future; being guilty comprises his total being.

As we can see, the bodily restriction and separation from the world prevent the melancholic patient from taking the perspective of others. He loses the freedom of self-distancing, of considering other possibilities of self-being. So he is forced to identify with a distorted picture of himself, a picture into which he is deluded to believe by his actual bodily state. This distortion corresponds to the radical separation which for the essentially social human being is equivalent to experiences of guilt, punishment, decay and death.

VII. Conclusion

To conclude, we may say that in depression the specific, dialectical relation of lived and corporeal body loses its balance. The body is corporealized: it becomes, as it were, physical, i.e. heavy, clumsy, immobile. The inhibition of drive results in a general paralysis and restriction. The loss of goal-oriented capacities of the body, of drive, appetite and desire are equivalent to a slowing-down and finally a standstill of lived time. Thus the past, the losses and failures gain dominance over the future and its possibilities.

The 'corporealized body' does not give access to the world any more, but stands in the way as an obstacle. Moreover, instead of participating in the world by his senses and feelings, the patient experiences a loss of body resonance, an alienation and even depersonalisation. This radical separation from the world and from the others means not only a severe loss; it also reactivates basic and early experiences of separation, shame, guilt and punishment – experiences that implied a corporealization as well. These elementary feelings of guilt call forth corresponding autobiographic material, i.e. the failures and mistakes of a life time. The standstill of time leaves no possibility to discharge this guilt any more.

The separation from the others and the exclusion from the common interpersonal space culminates in depressive delusions.

Now the patient is no more able to change perspective and to transcend his present experience towards an intersubjective view. On the contrary, he is forced to identify with his present state of bodily stasis and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of not feeling alive any more.

If we look back on this account, what may we say about the anthropological basis of melancholic depression? The corporealisation of the lived body is apparently a specific tendency of human life since it is not only subject to processes of aging and dying, but lends much of its energy to consciousness and reflection. Reflexion also corporealizes the lived body by interrupting its primary performance and impulses. The anthropological basis of depression may therefore be found in the fundamental irritability of human instinctual life which is characterized by an uncoupling of drives and their objects, by inhibition, reflection and ambivalence. This renders vital processes susceptible to disturbances and blockades, inhibiting the primary direction of the body towards the environment. It is no coincidence that the typical period of first manifestation of depression lies after midlife, when the vital processes of growth, development and reproduction come to a standstill, and reflection gains dominance over the primary, future-oriented direction of life. Then the body may finally fall into a general stasis, as is the case in severe depression.

VIII. Therapeutic Consequences

In the first phase of treatment the aim is to loosen the rigidity of bodily restriction and anxiety, which is mainly achieved by psychotropic medication. An important supplement is also the relief of everyday duties and tasks that overburden the patient's capacities. Thus a spatial and temporal frame is required creating a legitimate recovery period for the patient, a 'time-out' so-to-speak, during which he can gradually readjust with as few pressure as possible.

Then a careful activation therapy may further the patient's orientation toward future goals, however modest. This may be stressful at first,

since the patient's own, appetitive motivation is still missing and each action is in immediate danger of not satisfying his high demands on quality. It is therefore important to explain to the patient that the intentional arc alone, that he draws in plan and execution, is enough to extend his sensorimotor space again und to to re-establish his anticipation towards the future.

Therapeutic approaches that refer to the body should have the aim to relax, widen and mobilise the rigid body. This applies of course to relaxation and movement techniques, to physical training or swimming, since the rhythmic swelling and expansion breaks through the bodily restriction. Other therapies may elicit the more subtle resonance and affectivity of the body, such as music therapy – our music therapist uses to lay patients on large kettledrums to make them feel the vibrations, with good success! – or also training of sensuality and pleasure; the aim is to further the sensual and emotional participation in the environment. The self-expression in art therapy, rhythmic painting or clay modelling is another way of regaining a feeling for the environment.

Then there is the possibility of therapeutic touch mainly in the way of massage – we know from clinical experience how many depressed patients ask for this kind of treatment. Meanwhile some studies have shown a significant effect on general well-being. From a phenomenological viewpoint it helps to overcome the isolation the patient feels within his body. – We should not forget, however, that each therapeutic conversation implies a bodily level as well; it opens an intercorporal sphere of prereflective body communication that stimulates resonance and at least for the moment reduces the restriction the patient feels.

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