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Phenomenology of corporeality. A paradigmatic case study in schizophrenia

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We discuss the case of a person with schizophrenia who is unable to maintain the upright posture and to stand the other's look and whose subjectivity in not accessible by means of standard methods of interview. To make sense of the patient's otherwise odd and incomprehensible behavior, we analyze by means of the phenomenological method the clinician's subjective experiences during the encounter with him. We also contrast the patient's behaviour with classic essays is phenomenological psychopathology. During the encounter with this patient, a current of forces is produced, not physical but physiognomic. What takes place is a dynamics, involving the lived body of the patient as well as that of the clinician, that jeopardizes the patient's capacity to maintain the upright posture in front of the other and makes the clinician feel that he overwhelms the patient. The look plays a major importance in this dynamics. Human beings in the upright posture distance themselves through sight from the immediate contact with things and other living beings. The look is probably the most prominent phenomenon of the expressive body that allows distance, prevision, decision and reflection, rather than leaving us at the mercy of the other. We speculate that the patient's loss of the upright posture and his incapacity to contrast with his look the objectifying power of the look of the other are the two origins of an embodied, existential chiasm at the heart of the schizophrenic form of life.

Keywords: Abnormal bodily phenomena, Look, Phenomenology, Schizophrenia, Upright posture

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Fenomenología de la corporalidad. Estudio de un caso paradigmático de esquizofrenia

Se presenta el caso de una persona con esquizofrenia incapaz de mantener la postura erecta y de mantenerse en pie frente a la mirada de los otros, cuya subjetividad no es accesible mediante métodos estándar de entrevista. Para dar sentido a la conducta del paciente, de otro modo extraña e incomprensible, se analizan mediante el método fenomenológico las experiencias subjetivas del clínico durante su encuentro con él. También se realiza una comparación de la conducta del paciente con lo descrito en ensayos clásicos de la psicopatología fenomenológica. Durante el encuentro con este paciente, se produjo una corriente de fuerzas, no físicas, sino fisonómicas. Lo que tiene lugar es una dinámica, que implica el cuerpo vivido del paciente, así como el del clínico, que pone en peligro la capacidad del paciente para mantener la postura erguida en frente al otro y hace que el clínico sienta que avasalla al paciente. La mirada tiene una importancia fundamental en esta dinámica. Los seres humanos desde la postura erguida toman distancia del contacto inmediato con las cosas y los demás seres vivos por medio de la mirada. La mirada es probablemente el fenómeno más prominente del cuerpo expresivo que permite la distancia, la previsión, la decisión y la reflexión, en lugar de dejarnos a merced del otro. Se propone que la pérdida del de la postura erguida por parte del paciente y su incapacidad de contrarrestar con su mirada el poder objetivante de la mirada del otro, son los dos orígenes de un quiasma existencial encarnado en el corazón de la forma de vida esquizofrénica.

Palabras clave: Fenómenos corporales anormales, Apariencia, Fenomenología, Esquizofrenia, Postura erguida

INTRODUCTION: THE BODY IN SCHIZOPHRENIA

The signs and symptoms of schizophrenia that have to do with corporeality are quite numerous. On one side, we have abnormal bodily experiences, that is, subjective, experiential anomalies and complaints in one's feelings, sensations, perceptions arising in the domain of one's lived body. The most representative of these symptoms are vulnerability, altered shape or structure, false composition and altered regional sensitivity[1-4]. These abnormal bodily experiences may lead to psychotic symptoms, such as hypochondriac delusions, and typically schizophrenic symptoms, like delusions of somatic control, in which the body is the main theme.

The most striking example of observable sign in schizophrenia is catatonic behaviour, including stereotypical movements, unnatural poses, forced gestures. Kahlbaum[5] recorded dumb-founded expressions, inward-peering gazes, rigid and inflexible arms that may become as malleable as wax. Next to catatonia, we find several other signs like the paranoid's look, mannerisms, extravagant postures, that characteristic walk close to a wall at an oblique angle with the direction in which one is moving, or the impersonal nature acquired by the spaces dwelled in by persons with schizophrenia, whether in their own home or in a hospital ward.

In this paper, we will confine our analyses to observable or behavioural bodily abnormalities. These phenomena are very difficult to analyze in phenomenological terms since in most cases patients simply manifest these behaviours and are unable to explicate their meaning, goal, or function. For this purpose, we will analyse the case study of a man in his thirties that we will call David whose posture and motor behaviour are characterized by his inability to maintain the upright posture (he stands half bent over, glancing over his shoulder), to walk forward, to sustain the gaze of the other, as well as by very extravagant behaviour (e.g., arranging the objects of his house in the most arbitrary way).

As for our method, since David's subjectivity was impossible to grasp with standard interview methods (when David was asked about the reasons of his conduct either answered out of context or he waxed pseudo-philosophical more and more removed from the subject in question), we analysed the clinician's (O.D.) subjective experiences during the encounter with him. We chose to proceed to a phenomenology of the feelings that the patient's posture and movements, and the in-between space, elicited in the clinician, and later in his co-worker (G.S.) by means of free-fantasy variations[6].

LIFE-HISTORY

David's illness began when he was a 22 years old University student. At that time he was diagnosed *schizophrenic paranoid psychotic episode* with delusions about the subject of "magnetism", what he was studying at that moment. He was not able to return to his studies and he only held minor jobs. This first outbreak left him a relatively important defect, but in spite of his residual state the patient was able to keep himself together in a precarious balance when he had his mother's support.

When I (O.D.) met him he was unemployed, divorced and the father of a 8 year old boy. As a result of the serious illness of his mother, he had a second acute psychotic episode. His mother's death coincided with David's admission to the Psychiatric Hospital. He began to show very extravagant behaviour, such as putting cotton batting in his nose and ears, walking backwards, arranging the objects of his house in the most arbitrary way imaginable, neglecting his personal hygiene or failing to change his clothes when bathing, etc. The most alarming phenomenon was his distrust of others and his tendency to remain isolated, already made obvious during the interval between the two psychotic episodes and becoming more and more marked. In spite of his weirdness and the many voices he heard, he somehow managed to take care of his sick mother. However, when it became obvious she would die, he became very agitated and had to be hospitalized urgently.

THE PHENOMENON: LOSS OF THE UPRIGHT POSTURE

The first thing that calls the attention in this patient is his inability to maintain upright posture. He appears before me half bent over, looking very uncomfortable, glancing over his shoulder and walking backwards or sideways, never forward. When I approached him, he immediately made a movement as of retreat and when I extended my hand, he touched only my fingertips and but for a second. When asked to take a seat, he also did so very uncomfortably, resting his left buttock at the back of his chair, or the farthest possible from me. At the same time, he stretched the same (left) leg in a totally meaningless gesture and that only made his position in the chair even more uncomfortable, although he was able to maintain the balance on the floor over the base of support of the right leg.

He was extremely untidy and smelly. His self-neglect went far beyond what one has seen or imagined in *clochards* or other marginal people. From the somatic point of view, no pathological finding besides the loss of weight was found. His language was characteristically lax and full of answers unrelated to the questions, but without neologisms or major language anomalies.

During the interview he avoided looking at me, moreover, he covered his eyes with his left hand, keeping it raised about four inches from his face, at the height of his eyes. Asked about this, he said it bothered him when others look at him, he did not know why, but he could not stand it, although it might be because looks transmit words that got into his head.

In addition, he made a series of strange and disagreeable movements and gestures, such as spitting on his right hand or his own clothes and picking his nose.

David had a peculiar reaction when a young, tall and well built colleague –who was also present at the interview– stood up ready to leave the room, for which he had to pass near the patient: he shrunk even more, adopting almost a foetal position, abruptly moved his chair back. Later, he explained that big bodies terrified him. Apart from the above mentioned clarifications it was not possible to understand more in depth the reasons for the behaviour and experiences of the patient.

An essay by Erwin Straus[7] can shed some light on the meaning of the loss of the upright posture in David. Upright posture characterizes human beings. Nevertheless, it is not taken for granted and we as human beings have to struggle to achieve and maintain it. The natural stance of man is, therefore, resistance. As argued by Straus, expressions like 'standing' or 'to be upright' have a double connotation: one physical, the other psychological or moral. 'To be upright' means to rise, to stand on one's own feet, as well as not to stoop to anything and to stand by one's convictions (p. 137). The same holds for the expression 'to face' that means 'to look at things straight ahead' and 'to withstand their thrust' (p. 162). 'To stand' means to be erected, but also to endure against threat, danger and attack (p. 143). With the upright posture, ambivalence pervades human existence. It expresses 'austerity, inaccessibility, decisiveness, domination, majesty, mercilessness, or unapproachable remoteness' (p. 145). There is a close connection between the upright posture and vision. Man in upright posture does not move in the line of his digestive axis (thus, in the direction of his basic drives) as all animals do; rather, he moves in the direction of his vision. The upright posture distances us from the immediate contact with things and other living beings, thus allowing prevision, decision and reflection, rather than living us at the mercy of our instincts, and at the same time holds us aloof from our fellow-men since 'verticals never meet' (p. 145).[7]

PHENOMENOLOGY OF THE IN-BETWEEN

Now, how to understand what the patient revealed on the outside, that manifested through his dumb corporeality? Since we had no direct access to his subjectivity, that is, to the experiences subtending his behaviour, to make sense of his strange comportment we decided to analyze our own subjectivity, that is the experiences he elicited in ourselves. For that purpose, we will proceed to analyze the encounter with him[8], what occurs in the 'between'[9,10], the 'atmospheric'[11], in that space that extends between the clinician and his patient. We will proceed to a phenomenology of the in-between based on the clinician's feelings[12], impressions, and fantasies elicited by the encounter with David.

My first feeling is as if I unavoidably come up on top of him and push him, without succeeding in containing myself and keeping my position. I soon realize that David's tendency to bend and occupy less and less space is his response to my feeling of surmounting him. My lived body expands and his lived body shrinks.

Without doubt, it is the absence of his look that causes this lack of equilibrium in the encounter[13]. He does not look at me, and this makes our encounter dramatically unbalanced. I have seen and looked at smaller, thinner, or more bent over persons than him without experiencing in any way the feeling of invading or running over them. The fact that he does not look at me implies that his look cannot keep me in right distance. If he looked at me, this would avoid me staring at him in such an invading way. The other's look offers a kind of resistance to the invading power of my own look: but this is not the case with David.

This phenomenon does not resemble what I feel when I contemplate a beautiful landscape. Like David, also the landscape does not 'look' at me, but the effect is very different. Its beauty traps me and makes me feel as if I were losing my identity, to the point of merging with it (as described by Dostoyevsky[14] when he reports the experiences of Prince Myškin in Lucerne Lake). This way of encounter with a sublime landscape is very different from the one taking place between David and me, since in the former I shrink and merge with the landscape, whereas in the latter I become bigger and feel that I invade David (who, perhaps, feels that is invaded by me). Also: I feel that I somehow objectify David.

Also, this phenomenon bears only some general analogies with what occurs in the encounter with the *depressive*. The body of the depressive acquires an inert, passive, non-resonant, and at the same time solid and impenetrable character, that reminds of that of a dead body. The depressive's look, its opacity, reveals the same aspect. The body of the depressive suffers a process of *devitalization*, denominated *'chrematization'* (from 'chrema'=corpse) by me (O. D.) in previous works[15-18].

Nothing of that occurs with David's twisted and diminished body. Unlike the depressive who cannot look because he lacks vitality for it, David does not want to look

at me. He covers his eyes with his hands so that my look does not get to him and he needn't reciprocate with his own.

But his *not wanting to look* plus his *standing bent and walking backwards* does not produce in me that light sensation of nausea and repulsion we have in front of a stuporous depressive[15,16]. Rather, it kindles a sort of fascination in me, feeling impelled to go on looking at him without him reciprocating. As a consequence, I become more invading and he feels more invaded.

TWO FACES OF THE LIVED BODY: THE BODY-AS-SUPPORT AND THE BODY-AS-WILLING

David's way of walking and occupying the least possible space is neither a whim nor a mere mannerism, but the necessary consequence of a deep alteration of his corporeality. Now, which *body* is the one that is altered?

It is certainly not the objective body or soma, the body I can measure and explore with instruments. It is not a somatic problem related to a neurological disorder or a neuroleptic side effect (that a careful examination have excluded). It is the lived body, the *Leib*, what is affected. Both in depression and in schizophrenia there is a deep change of the *body I am*[19], or *intrabody*[20], or *lived body*. The *extra body* is the body of anatomy and of physiology, divorced from all consciousness. This body can be measured, examined with medical devices, operated under anaesthesia and transplanted. It is in the framework of the study of this body which has made possible the great achievements of modern medicine have been possible, that same medicine that ignoring the lived body has not known how to conceptualize let alone treat the so called 'functional' disorders. The *intrabody* is ultimately the lived body, the *body I am*, an important element of the basis of psychiatric anthropology. The lived body is not just an object among objects, but subjectivity incarnate.

The essential, substantive feature of *depression* is a change of finding oneself in one's own body, that is to say, in a *modification of the lived or intra-body* that basically consists in a commitment of "vital feelings", in Max Scheler's[21] sense[15-18,22-26]. The radical alteration has to be found in the world of vitality, of basic needs, drives and emotions; ultimately, of *vital feelings*. 'My body is dead', 'My interiority is lifeless', 'I feel deprived of all sort of sparkle coming from within', 'I cannot feel', 'I cannot be impressed by what's going on around me', 'I don't feel empty, I *am* empty' – these are just a few examples of the lived corporeality of persons with depression. It is a feeling of diminished vitality, freshness, physical and psychical integrity that dominates the existence of depressives.

An important and distinctive feature of embodiment in persons with depression is its being dominated by the structure of overidentification in the sense of Kraus[27,28]. These patients show no distance between the ego-identity and the role-identity, with a lot of consequences, among them the tendency to keep very close to their body. And so, they can feel that they are *nothing but* their body which is experienced as abnormally materialized and reified, heavy and rigid, devoid of emotions, energies, and drives. This loss of bodily elasticity and resonance implies painful sensations of derealization (feelings of detachment from other persons and external reality).

Complaints of loss of emotional resonance (e.g. the incapacity to have empathic feelings with others) are typical in acute episodes of depression. Another distinctive feature is that these experiences have the paradoxical character of a painful lack of feeling, an excruciating incapacity to be affected, the 'feeling of the loss of feelings'[29] – quite the opposite of ataraxia.

But if it is the lived body the one that is altered, where do the differences between the feelings elicited by David and those elicited by the body of a depressive person arise from? Are there different forms of disordered lived corporeality? An excursus on two dimensions of the lived body and its modifications is at place here.

The *body I am* has at least two faces: the body-as-support and the body-as-willing[30] (see Table 1).

The first face, the *tragender Leib* (body-as-support) in Zutt's psychiatric anthropology, corresponds to the vital region called 'affective-vegetative'. It is constituted by the involuntary and pre-reflexive background of our needs (e.g., hunger, thirst, sleepiness, sexual desire) and vital feelings (e.g., courage/ discouragement, vitality/fatigue, pleasure/ nausea, etc.). Needs/vital feelings direct us to the world and to the objects of interest that populate it. The body-as-support is the seat of autonomous processes (moods and drives) that move us/stop us. This dimension of the lived body is characterized for being in greater or lesser measure alien to the will (I cannot decide to be hungry or sleepy or euphoric or tired) and subject to the time of maturation, of becoming, also certainly involuntary. The modification of corporeality, observed by looking at depressives, reflects a disorder of this dimension, as shown by these patients' complaints: discouragement, lack of energy, lack of strength, heaviness of limbs, feeling of cold, nauseas, generalized pains, etc.

Now, there exists another face of the body-I-am or lived body that is somehow diametrically opposed to the affective-vegetative body, to the *body as support of* our action and experiences. It corresponds to the *body of the willing life*, of movement, walking, looking, grasping and shaping. I become

Table 1

Body-as-support

Involuntary body: affective-vegetative (sleep-wake cycle) drives (hunger, sex), moods (boredom, depression, elation), involuntary becoming, *tragender Leib* ('driving' or 'supporting' body).

The seat of autonomous processes (moods and drives) that move us/stop us.

Body-as-willing

Voluntary body: aesthetic/physiognomic, voluntary actions (grasping, walking, watching), attitudes, position-taking, self-manifesting body.

The seat of auto-nomia.

sleepy or hungry (I am passive when this happens to me), and in contrast, I decide to transform a stone into a weapon or to direct my look towards somebody or my steps towards some place. This body of the willing acts is the same that is open to the world, inserted in it, continuously expressing and revealing itself, and above all, advancing. It is the body through which the human being realizes his condition of *itinerant*[31]. To the essence of this body belongs walking, to be always on one's way somewhere.

This dimension of the lived body expresses its essential reference to the world (*welthafter Leib*). Being relative to the world means above all to have a place in the world and to reveal oneself in it as a body that looks and is looked at, listens and is listened to, touches and is touched. At the same time, this body takes distance and sets limits; this is the anthropological basis of *dwelling*. It is not that we dwell because we have dwellings, but on the contrary, we build walls as an extension of our body through its need to take distance and to reside. It belongs to the body-as-willing that it builds frontiers and limits separating him from the strange and unknown and then establishes ranks putting in order his relations with what is known and known persons, and dialogue with the other (*in Erscheinung stehender Leib*). "Dwelling" is an "existential order"[32] (p. 409) related with another fundamental order, the *rank*. There are persons who never pass through the doorway of my house and contact with them occurs at the front door. Others arrive in the living room of my house (acquaintances, condolence visitors, etc.). Fewer still eat with me in the dining room (friends) and very few enter my bedroom (only my wife and children). *Rank* as well as *dwelling* are functions of the body-as-willing as it is revealed to the world; but they are not fixed, they change with time, they are historical.

Also, this dimension of the body is the seat of position-taking (*Stellungsnahme*), that is, of standing, facing, resisting; and of auto-nomia, that is, of the capacity to give a norm (*nomos*) to one's own self (*autos*)[33], that is, to actively shape and give form to one's facticity, i.e., one's own basic needs, drives, personal history and one's position in the world.

The body-as-willing is also where the look is placed and the dynamics of *looking* and *being looked at*. In the encounter with the other's lived body a dynamics of forces is produced. These forces are not physical, but physiognomic: menacing/reassuring, overwhelming/capitulating, fleeing/standing, etc. What takes place here is a dynamics of affecting and being affected, maintaining the posture before the other or being overwhelmed by him. The phenomenon of the look plays a role of major importance in this dynamics.

CONCLUSIONS

Whereas the lived body in persons with depression reflects sinking, loss of support and loss of being carried – all dimensions of the body-as-support - David's body reflects an impairment of the body-as-willing.

Thus the case of David, so incomprehensible from a psychological point of view and unexplainable from a somatological point of view, is shown to us as a consequence of the modification of a *fundamental structure of being human*, which is its condition of lived body in its upright posture, referred to the world, expressive, owner of a particular position, posture or bearing (*Stand*) and always on the way to some place. This structure, that is neither reducible to psychic nor to somatic, is the chiasm between the upright posture and the look, that is, the possibility to distance oneself from the other with the power of one's gaze. David has completely lost this existential posture, as demonstrated by the following phenomena:

Inability to maintain upright position, tending to twist and turn until reaching for moments the fetal position (in absence of either spine distortion or any neurologic disease). Traditional psychiatry would erroneously consider it as a mere mannerism, but here it is the expression of the loss of a secure stand in the world (especially in the social world).It expresses the incapacity to withstand the thrust, to endure against threat, danger and attack.

Inability to stand the look of the other. David's body also reflects the disproportion between looking/being looked at, penetrating/being penetrated, feeling protected/menaced. David has to cover his eyes with his hands. It would be mistaken to see this as a mere mannerism, since the patient explains his behaviour by saying he is unable to

stand it when others look at him. Human beings in the upright posture distance themselves through sight from the immediate contact with things and other living beings. The look is probably the most prominent phenomenon of the expressive body that allows prevision, decision and reflection, rather than living us at the mercy of our instincts and of other people. Perhaps the most catastrophic consequence of David's loss of the upright posture is that he cannot contrast with his look the objectifying power of the look of the other.

Inability of position-taking and the consequent loss of all order or rank. With respect to the former, not only do looks go through him, but he hears voices he has not called and strange thoughts interfere with his own –according to him- through the looks themselves. All these express loss of orientation and also a deterioration of the horizontality position, that is, of position-taking in the context of human relations. One of the most prominent features of David's corporeality is the loss of horizontal position[34], that is, in general a disorder of lived spaced (indwelling in the life-world) characterized by the loss of a stance, of perspective-taking and position-taking among his fellow-men. David's body is incapable of dwelling. Being incapable of taking distance and setting limits, he implodes into himself, twisted like a point of interrogation.

Inability to advance through the way of life. Another characteristic of the expressive body -which is always going towards somewhere- *also appears destroyed.* David finds difficulty with every frontal movement, that is, every step towards the future. He can only move sideways or backwards. David is not only unable to perform work, which always implies a certain degree of planning and progress forwards, but the act of walking itself has lost its natural frontality, showing in corporal and concrete way his incapacity to advance through the way of life.

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