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Article

Which Kind of Body in "Mental" Pathologies? Phenomenological Insights on the Nature of the Disrupted Self

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Guided by a phenomenological perspective, this paper aims to account for the existence of a corporeal consciousness—something that clinicians should take into account, not merely in the case of physical pathologies but especially in the case of mental disorders. Firstly, I will highlight three cases: schizophrenia, depression, and autism spectrum disorder. Then, I will show how these cases correspond to three different kinds of bodily existence: disembodiment (in the case of schizophrenia), chrematization (in melancholic depression), and dyssynchrony (in the autism spectrum disorder). Finally, I will argue for the importance of an "expressive common environment" between the patient and the clinician, who are two distinct, embodied conscious subjects resonating with one another. In this view, the primary goal of the therapeutic process seems to develop a shared understanding of the patient's life-world, which finds its main expression through the disrupted body.

KEYWORDS: *disembodiment, dyssynchrony, hyperembodiment, mental pathology, therapeutic relationship*

> You gave this divine soul to me and then
> imprisoned it in a weak and fragile body,
> how sad it is to live in it.
> —Michelangelo Buonarroti

I. DISRUPTED BODIES, DISRUPTED CONSCIOUSNESS

> The union of soul and body is not sealed by arbitrary decree between two mutually external terms, object and subject. In every moment it is accomplished in the movement of existence.
> —Merleau-Ponty, *Phenomenology of Perception,* 1945

Merleau-Ponty's phenomenology can be considered the first description of psychophysical subjectivity, a description that today is well-known thanks to a tendency called "the embodied turn."[1] Because of numerous neuroscientific discoveries, and not least of the advancement of qualitative analyses in psychopathology (Parnas et al., 2005; Sass et al., 2017), we can no longer deny the inextricable entanglement between the mind and the body. In this re-orientation, phenomenology has played a key role: in both classical (like Husserl, 1952; Merleau-Ponty, 1945) and contemporary authors (Zaner, 1964; Fuchs and Schlimme, 2009; Fuchs, 2015; etc.), we can find a view of the subject not only as a body, but as a body that is affectively and kinesthetically linked to the others and the world.[2] If I am primarily an intentional, bodily consciousness that is able to live in the world by virtue of my practical

possibilities of movement and affective affordances, it seems clear that, in the experience of illness, "I find myself to be that person who is bound to this particular embodiment and who is irrevocably bound to suffer whatever this particular body suffers" (Toombs, 1992, 60).

Considering psychopathology exclusively in a biological sense is, therefore, a reductive and incomplete approach to the problem. Alternative epistemological medical approaches instead allow[3] the sick person to be considered with regard to both her "pure" biological dimension *and* her existential, psychological features. Both dimensions have been reevaluated as constitutive for the experience of the illness. From such a perspective, the patient's body can no longer be conceived as a mere biological organism (*Körper*), but needs to be considered as a sensing and feeling body (*Leib*)[4] crucially influenced by anthropological, cultural, and social factors that give it a specific history and shape.

On a theoretical level, the body of the patient has begun to be examined as a "bio-psycho-social whole," and consequently, the clinical approach began studying the body in a Gestaltic and holistic manner. In other words, considering the subject as a psychophysical whole involves the shift from the *disease* – a vision of the pathology as something that affects the biological organism which medicine should rigorously and *objectively* study in detail, in its unlimited fragmentation which paradoxically makes the body "invisible"—to the *illness:* a pathology considered as a *lived experience* which changes the subject both somatically and psychically.

The vision of the patient's body changes from a body as object of medical therapy to a body as subject of the clinical relationship, or, as Sacks (1985) put it, there is a shift from a mere "medical vision" to a "human vision" where the meaning of the illness is grounded in lived experience and does not represent an "abstraction" from it.[5] The necessity to enlarge the horizon of medicine, and to consider illness as a complex personal experience, involves several issues, both of ethical (the patient is a subject with her own autonomy) and of clinical efficacy (the patient has to supervise her own illness from a first-person perspective). In this view, a phenomenological approach seems to be useful: considering the subject a *Leib* challenges Cartesian dualism by understanding the patient in her entirety, as a *lived body*. The experience of the illness involves the transformation of the body from "silent ally" to "cumbersome presence," to the point of limiting the horizon of the individual's possibilities: the life of the subject undergoes a slow and progressive modification, the causes of which are closely linked to the changing ways the body is experienced.

Phenomenology shows that a sick body is not only an organism that does not function on the basis of pathophysiological processes but also represents a way through which the existence of the individual manifests itself, influencing the very course of pathology. It is clear that, in its bio-psycho-social meaning, the disease is first of all an *existential experience.*

Consequently, only by considering the body as *Leib*, as lived body, is it possible to understand how much the state of illness is primarily the experience of a body-subject that lives through the alienating situation of perceiving itself divided between a mind that tries to explain the changes that have occurred and a body that becomes the object of continuous questioning.

Merleau-Ponty claimed that in the experience of the sick body it is as if two different kinds of knowledge coexist: on the one hand, the habitual way the subject is related to the world (her way of being and her abilities before the onset of the disease); on the other hand, the individual's current way of relating to the context, as imposed by the restrictions of the disease, of which one is not fully aware. The appropriate way to treat the subject is, therefore, neither to reduce her body to a malfunctioning physiological object nor to consider the disease exclusively through a disembodied first-person perspective. Rather, it is necessary to treat the patient as an *embodied consciousness* present in every kind of manifestation.

Therefore, for an extensive analysis of the disease, there should be a shift from the body as object to the body as subject. While this process is relatively easy for what concerns biological diseases (if I have a headache, it would be easy for my clinician to figure out that also my affordances and my attitude towards the life-world will change, favoring a Gestaltic approach to my pain and my illness), this is not necessarily the case for the realm of *mental* illness. On the one hand, we can find a biological perspective that tends to objectify the mental disorder and reduce it to a brain or cognitive dysfunction; on the other hand, the very fact of it being mental seems to justify a sort of "disembodied" approach towards the causes and the effects of being psychopathologically ill. Against this background, a number of recent studies and monographs (Ratcliffe, 2008; Matthews, 2004; MacLachlan, 2004; Stanghellini,

2006; Fuchs, 2005; Glannon, 2009) consider embodiment as the major paradigm for psychopathology, especially if we conceive of the body as an enactive and ecological organism circularly connected with the environment and social interactions (Fuchs, 2018). In other words, "mental" illness is never "purely" mental, since our self is intertwined with a living body which equally expresses and manifests the arising disorder. Especially in this case, it is important to emphasize the dual ontology of the self: an embodied mind (or a mindful body) which, in the case of mental illness more than in corporeal disease, is disrupted in a way that compromises the subject's affordances—her being in the world and, above all, her relations with the other. How can the clinician (the psychiatrist or the psychotherapist) cope with this kind of disorder? And how can we conceive of the clinical relationship in the case of mental illness?

In what follows, I will take into account three different mental disorders (schizophrenia, melancholic depression, and autism) that involve different kinds of embodiment but yield the same consequence: a detachment from the intersubjective (and intercorporeal) domain.

In fact, being a *lived body* allows not only for self-consciousness, but also for the experience of the alterity. Firstly, because others are implied in my perceptual horizon before a concrete face-to-face encounter: *perception is never exhausted in the short term, but is an original reference structure for potential and anonymous co-perceivers.* Since this implicit co-perceiver is characterized by perception capabilities, she is necessarily embodied. Furthermore, through the *Leib*, otherness is constituted as a new form of reality recognized as *analogous* thanks to the similarities between my body and that of others. Being embodied is essential: only through the *Leib* can I, in fact, enter into the field of perception of the other which, in turn, recognizes me as *Leibanalogon*, a corporeality which finds its expression in an individuality (see also Bizzari, 2018a, 2018b). The consequence is that, if the embodied being of a subject is compromised, her self-consciousness and her capability of attunement with the other and the world will be lost or disrupted.

Therefore, it will be necessary to address the therapeutic relationship accordingly. I will claim that this particular kind of therapeutic relationship should be characterized by an *"expressive common environment"* grounded on the intercorporeal, temporal, and spatial exchange between the subjects involved. By "expressive common environment," I explicitly refer to Schütz's (1962) "communicative common environment." I believe that, in order to account for the specific interaction between clinician and patient, Schütz's thought is important because, while analyzing the interactive field, he recognizes that there must be "some kind of social interaction which, though it is an indispensable condition of all possible communication, does not enter the communicative process and is not capable of being grasped by it" (1951, 90). Schütz argues that this very basic layer, which is a sort of atmospheric ground where we grasp the other as on other and we are open to her, is the necessary condition for higher-level connections to develop. Like Schütz, I claim that in order to have an intersubjective exchange (in this case, the therapist-patient one) is important to establish a common environment provided with shared and pre-linguistic features that elicit higher kinds of engagement. Nonetheless, I prefer to describe it as "expressive"[6] since in mental disorders communication is often compromised. As I will argue, this does not mean that the patient is not willing to relate to (and communicate with) the other. On the contrary, communication is what is compromised together with corporeality, and it is the basis on which the therapist should build the healing path.

I believe what is important and, in case of certain disorders, needs to be restored, is indeed *the expressive and bodily engagement* that usually allows the individual's mutual tuning-in with others. After this first intercorporeal and interaffective exchange (see also Fuchs, 2017) the subjects involved will manage to focus on more complex and shared goals.

In other words, if psychopathologies involve core disruptions at the lived bodily and intersubjective levels, it would be important for clinicians to take them and their different manifestations into account. This will allow a better understanding of patient's expressiveness and narratives.

II. SCHIZOPHRENIA AS DISEMBODIMENT

> For years, I'd seen my body as the place that I lived, and the real me was in my mind; the body was just the carrying case, and not a very dependable one - kind of dirty,

animal-like, unreliable.
—Saks, *The Center Cannot Hold*, 2007

Psychopathologies often involve the disappearance of the lived body as the center of the being: suddenly, it becomes reified and alien. In the dialectical relationship that usually links the body-that-I-am and the body-that-I-have, we can observe a prevailing rigidity of the body-object, to such an extent that there is an alienating feeling of strangeness towards it. On the other hand, the body may no longer be able to recognize its own borders and distinguish itself from the surrounding environment. This is what happens in schizophrenia, where the living body (*Leib*) is reified and the subject can also identify herself with an external object, through the process of depersonalization.

As noted by Stanghellini (2006) and Fuchs and Röhricht (2017), in schizophrenia we have to deal with the process of *disembodiment* that seems to be the core of this pathology, and usually involves:

- a weakening of the basic sense of self,
- a disruption of implicit bodily functioning,
- a disconnection from the intercorporeality with others.

In terms of *perception*, the ability to recognize familiar patterns of objects could be impaired, and the subject may register a disintegration of habits or automatic practices. In other words, in the schizophrenic subject, the *praktognosia* (speaking in the Merleau-Pontian sense), that is, our tacit and enactive knowledge, is lost. "To have a body is to possess a universal setting, a schema of all types of perceptual unfolding and of all those inter-sensory correspondences which lie beyond the segment of the world which we are actually perceiving" (Merleau-Ponty, 1945, 326). People with schizophrenia may lose these sets of possibilities or *affordances*.

The alterations in the domain of the lived world are intertwined with alterations in the experience of the lived body; in fact, it is the lived body that conveys the practical knowledge of how to interact with others—how to understand their expressions and actions on the background of the common situation. Thus, we are involved in a sphere of primary "intercorporeality": "a tacit or enacted knowledge that is also the basis of 'common sense' and provides a fluid, automatic and context-sensitive pre-understanding of everyday situations, connecting self and world through a basic habituality and familiarity" (Fuchs, 2015, 199). This practical immersion of the self in the world normally mediated by the body is impaired or lost, while the subject experiences abnormal bodily experiences, that is,

> …subjective 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 abnormalities in bodily demarcation, vitality, coherence, identity, and activity. 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. (Doerr-Zegers and Stanghellini, 2013, 2)

It is very interesting to notice that the loss of the spontaneous attunement with the world, usually mediated by the body, can appear before the onset of acute psychosis. The disembodiment of the self—the loss of the primordial, bodily openness towards the others and the lifeworld, which is usually prior to any kind of objectual experience and knowledge—is linked with an atmospheric feeling of disconcern, a suggestive delusional mood, and a state of "uncanny particularity" (Sass, 1994), a feeling of confronting a world that is fragmented, meaningless, or unreal, but often perceived as threatening.

Therefore, the lived body seems to be the subjective structure that is the main determinant of all other types of experience: in addition to the disembodiment of the self and intersubjectivity, it is possible to record numerous anomalies in the perception of space and time. The schizophrenic often reports distorted and disjointed temporal experiences which can be described as an incessant succession of decontextualized moments. It is as if the subject lived in a constant present. In the same way, the disruption of the lived body involves a disruption in perception: space loses the properties given by a perspectival vision and is perceived as a shapeless mass of decontextualized objects.

III. MELANCHOLIC DEPRESSION AS HYPEREMBODIMENT OR CHREMATIZATION

> Today my soul is sad to the very marrow of its bones. My whole self hurts: memory, my eyes, my arms.
> —F. Pessoa, *The Book of Disquiet,* 1991

Usually, depression is described as a severe condition whose core is constituted by a disturbance of mood and affect, typically connected to negative cognitions, self-evaluations, and emotions such as anxiety, shame, and guilt. According to the DSM III, melancholia is the by-product or sub-species of a Major Depressive Episode and it is classified as an episode with melancholic features. In fact, from DSM III on, all depressive disorders have been included in the major depressive group, leading to diagnostic confusion. Nevertheless, melancholic depression is qualitatively different from other kinds of depression, and it can also lead to suicide. In this pathology, we can observe a body that loses its fluidity, becoming heavy and solid and inhibiting the realization of the subject's intentions. The subject is no longer able to transcend herself and empathize with others, and she remains confined to her present bodily state. She cannot perceive her potential to act in the world (her *affordances*); space is limited to the surrounding environment. For these reasons, we can define melancholic depression as an "hyperembodiment" (Fuchs, 2005) or a "chrematization" (Doerr-Zegers, 1995) of the body, which becomes so heavy that it can also block its own functions. With this in mind, *chrema*[7] is the inanimate nature of the body which loses its contact with the world. Furthermore, the patient loses her emotional resonance and falls into an "anaesthetic melancholy." She feels as if she were dead, as if she were a mere material body, sometimes even a corpse[8].

The intertwinement between the mental and the bodily pain is strong, as the following first-person reports testify: "Why do they call it a 'mental' illness? The pain isn't just in my head; it's everywhere, but mainly at my throat and in my heart. Perhaps my heart is broken. Is this what this is? My whole chest feels like it's being crushed. It's hard to breathe" (Brampton, 2008, 34). And: "Now, sitting in my pine-paneled room, I felt myself hurtling once more into the abyss. The mental pain was physical, as if the marrow of my bones were being ground into dust" (Thompson, 1995, 246).[9]

Accordingly, even the other structures of subjectivity become impaired. The subject perceives a temporal becoming which is not projected into the future, but rather it is crystallized into the present situation, constantly facing what has happened in the past (*post festum),* while space is perceived as too distant. Furthermore (where the schizophrenic bewailed a diminished self-consciousness), the depressed person registers an excessive identification with a fixed role, a reified self (Kraus, 1991). The subject loses her eccentricity, and there is a shift to an existential orientation dangerously "centric" or egodystonic.

As in schizophrenia, we can affirm that the disturbances of embodiment we can register in melancholic depression comprise different but intertwined dimensions (Doerr-Zehers et al., 2017):

1) *The embodied self,* that is to say, the alteration of the subject's relationship with her own body;
2) *The embodied intentionality:* the alteration of the relationship of the subject with the world. Bleuer (1978) has defined this disruption as "the alteration of the centrifugal functions", those functions that connect us with the environment. This disturbance can also appear as a missing of the patient's bodily resonance in the context of an intercorporeal and interaffective dialogue during the diagnostic process;
3) *The embodied time:* the alteration of biological (and existential) rhythms.

We can, therefore, define melancholic depression as a form of alienation from the interpersonal and intercorporeal world. The lived body loses its emotional and practical directionality, and its unchanged, constant, and static presence becomes an impediment for the development of the vital essence, of the *praktognosia* (our practical and world-directed knowledge) typical of a *Leib* that is usually intersubjective and dynamically connected to the world. All this results, on a phenomenal level, in a subjectivity ontologically folded on itself, blocked by a corporeality that prevents it from relating to the world and to the other, from distinguishing between itself and a material objectivity. Even in this pathology, the subjective bodily awareness is weak and the subject can be described rather as a "chrematized" body disconnected from its surrounding context.[10]

IV. AUTISM AS A DYSSYNCHRONY[11]

> A person can feel that there is something missing when relating to someone who is autistic
> – it is as if one is in the presence of a changeling, someone from a different world
> – but this escapes the net of scientific methods.
> —Hobson, *The Cradle of Thought,* 2002

Autism is usually described as a disorder which involves problems in social interactions, communication, and social imagination. Furthermore, we can register abnormalities in perception along with sensorial and motor deficits. The contemporary literature about autism oscillates between neural (Plaisted et al., 1999; Spencer et al., 2000; Pellicano and Burr, 2012), behavioral (Goldman, 2006), and cognitive explanations (Happé and Frith, 1996; Happé, 1999).

Nonetheless, it seems that the core problem of communicative and social disruptions is indeed a problem of (inter)corporeality,[12] in the spontaneous engagement that, by means of corporeal gestures and expressions, reciprocally connects the self with the other. We can notice, for instance, that autistic movements are not always influenced by external stimuli, to such an extent that we can describe their body as a "quasi-autonomous" one (Grohmann, 2017). We register not only problems in sensorial processes such as proprioceptive awareness and sensory regulation, which hinder the subject from easily coping with external stimuli, but the autistic body also falls out of the "intercorporeal, intersubjective dance" because it is not able to "synchronize" itself with others and the environment. In other words, the core problem of autism seems to be a problem of *dyssynchrony*.

In the development of sociality, synchrony is the means by which reciprocity and interpersonal alignment arise. For this reason, synchrony can be considered a predictor of various interpersonal outcome variables, for instance the quality of relationships (Ramseyer and Tschacher, 2011). In fact, social interactions require movements of the body that become synchronized over time and both intentional and spontaneous synchrony have been found to be a fundamental part of human interaction (Fizpatrick et al., 2016).

There is evidence of synchrony impairments in autism, linking this deficit to a deficit in cognitive empathy (Koehne et al., 2016). First-person reports describe social interactions in terms of "being flooded," an "inability to keep up," and not knowing "when and how" to respond to what others do (Schilbach et al., 2013, 411). *Dyssynchrony* characterizes both low and high-functioning autism, where it has been shown that individuals seem immune to interpersonal motor alignment—which usually changes the perception of the environment—in spite of competent explicit social cognitive capacities (Schilbach et al., 2012, 159).

Significantly, an autistic subject claims:

> I think my movement disorder is most apparent in the fact that I am unable to respond to someone or something, when my intelligence would tell me to respond in an appropriate manner. For instance, when I should be smiling, sometimes I know that I am not smiling but maybe even frowning. This causes me a great deal of pain and makes me look as though I am not comprehending when, in fact, I am trying to respond in an appropriate manner. (Hale and Hale, 1999, 32)

We can register, therefore, several experiences of profound *dyssynchrony* in which the different sensory aspects of a situation fail to match up coherently. The experience of time is characterized by circularity (repetition) and discontinuity (fragmentation), hindering the arising of a synchronic attunement with others and the world. This has effects on the emotional world as well. Timing our actions in accordance with the actions of others is important to our experience of emotion, and the success or failure of mutual timing can profoundly influence our relationships with and feelings about others. Accordingly, affective capacities will suffer disruptions as well, both in dyadic experiences (such as face-to-face empathy, imitation, and in general, all face-to-face interactions) and collective ones (such as shared and group-based emotions, emotional contagion etc.).

In other words, we can claim that autistic people show a loss of bodily resonance (intercorporeality) and emotional resonance (interaffectivity), elements that are linked to one another and that can be considered the very core of this condition. In contrast to Baron-Cohen's notion of "mind-blindness" (Baron-Cohen, 1995), we can claim that autistic people suffer from intersubjective "body-blindness."

V. THE CLINICAL ENCOUNTER: AN "EXPRESSIVE, COMMON ENVIRONMENT"

> It was like two melodies being played simultaneously, although these two melodies are as dissonant as can be, a certain balance becomes established between the notes of one and the other and lets us penetrate a little further into our patient's psyche
>
> —Minkowski, *Lived Time,* 1970

The subjective, bodily disorders that I have described share a common, dramatic consequence: a deep detachment from others and the world. If the body is not able to be in tune with others' bodies, the clinical encounter, which is an intercorporeal encounter as well, will be very difficult to handle for both the therapist, who will have to adjust her lived body in order to synchronize herself with the other, and the patient, who usually fails to resonate with others.

The centrality of intersubjective resonance in the clinical encounter appears initially in the diagnostic phase. Clinicians often make the diagnosis of mental disorders within the first five minutes of interviewing a patient, which shows the significance of the clinician's intuition. We have not only the "praecox feeling" in schizophrenia (Rümke, 1942) but in the 1980s, Otto Doerr Zegers and Tellenbach described the "melancholy feeling" in depression (Doerr Zegers and Tellenbach, 1980). Concerning autism, Hobson (2002) describes very well what it means to be in the presence of an autistic person: a feeling of unfamiliarity, of being in the presence of a changeling.

The clinician's primary goal will be therefore the attempt to restore a shared environment which will allow for the full understanding of the *meaning* behind the lived experience of the patient, which goes beyond the causal origin of the illness. In this view, the therapeutic relationship itself is a dialogical, intercorporeal space, whose primary components are pre-reflective, interaffective elements which converge into a participatory "we-subject." The final aim will be the creation of an "expressive, common environment" where the patient would be helped to express herself and re-synchronize her body into a common, meaningful life-world.

According to Schütz, the world of everyday life is, from the outset, an intersubjective world: each individual is always located within a context and takes for granted "...the bodily existence of other men, their conscious life, the possibility of intercommunication, and the historical givenness of social organization and culture" (1962, 313). In particular, he claims the necessity of a "communicative common environment," which is responsible for the "natural attitude" in which we are all immersed. In the case of psychopathology, I take a step back to declare the need for an "*expressive common environment*," which is necessary for communication. In fact, Schütz himself describes successful communication as something which is "possible only between persons who share a substantially similar system of relevances. The greater the differences between the systems of relevances, the fewer are the chances for successful communication" (1962, 322). While communication presupposes the development of higher forms of intersubjectivity (such as shared language, culture, and values), expressiveness is the basis of all communication, being thus grounded on bodily, affective gestures and the body's capacity to resonate with others. I cannot communicate without being expressive, without being aware of my emotional, intentional, and bodily presence in a shared world. In the preceding descriptions of disorders, the patients are not only detached from the shared cultural and social environment, but also impaired in their intercorporeal, expressive capacity, which hinders any forms of communication. In the meeting with the other, the body is in fact the unthematized mediator which creates the "totality of the space that a person pre-reflectively 'lives' and experiences, with its situations, conditions, movements, effects and its horizon of possibilities" (Fuchs, 2007, 426).

In order to achieve an "expressive, common environment," the clinician should focus on those pre-reflective elements—bodily intentionality, lived temporality, and spatiality—on which subjectivity relies in its exploration of the world. These subjective structures are compromised in illness, and this might hinder the implicit resonance between expressions and corporeal, emotional reactions. We can find this disruption in schizophrenia, in terms of a subject who is detached from her body and devoid of common sense; in depression, where the body does not express the self but rather imprisons it; and in autism, where the core is the inability to synchronize with others' movements, gestures, and affectivity.

Concerning the *lived body*, Minkowski (1970) already claimed that the therapist should first familiarize herself with the concept of *existential stagnation,* manifesting itself in the kinesthetic paralysis of the patient's body.[13] From that, the therapist ought to begin creating a dialogue that gives voice to the patient's painful disconnection from the lifeworld. The clinician should be "embodied aware" of herself (for the notion of "embodied awareness" in the clinical encounter, see Sholokhova, 2019) focusing not on the patient's body or on her own impressions only but on their encounter as embodied persons.[14] In fact, "...as an embodied being, the psychiatrist always and already finds herself in an intercorporeal connection with the other person," and she knows "... how to interpret the bodily presence of the other person and responds in the form of attunement or that of disengagement, for example, to the body of patient" (Sholokhova, 2019, E-92).

The other structures that the clinician should take into account are lived *time* and lived *space*. A disruption of embodiment usually involves a distortion of the lived temporality and spatiality of the patient: in depression, time is stuck in an eternal present and constantly directed to the past; in schizophrenia time is fragmented; in autism we can register the need of repetition in order to compensate for the lack of rhythm and synchrony. Accordingly, the lived space would be characterized by the complete lack of affordances (in the case of melancholic depression), by affordances whose meanings are detached from common sense (in the case of schizophrenia), or by a world where the subject is unable to synchronize herself with others (in the case of autism).

The clinician should adapt herself to the intersubjective situation that she finds, shaping the interpersonal space, and building a new shared space (a "we-space", as Krueger, 2011, called it) from where the patient can start to re-adjust her field of possibilities.[15] But how can the clinician address such a shared space? Again, Schütz's thought seems to be helpful. In fact, in *Making Music Together* (1951) he underlines the importance of time and synchrony for a genuine intersubjective meeting. Following his thought, we can claim that, in the clinical encounter, the clinician should pay attention to the inner time of the other and "re-perform or co-perform the thought of the speaker" (Zaner, 1961, 82). In order to achieve this goal, there should be a mutual tuning-in relation through which "the other's body and its movements can be interpreted as a field of expression of events within his inner life" (Schütz, 1951, 97).

Furthermore, in order to create a common environment, the face-to-face relationship should unify "the fluxes of inner time" and bring about "their synchronization into a living present" (Zaner, 1961, 82). The temporally subjective experiences of the subjects involved should be taken into account – fragmented in the case of the schizophrenic; crystallized in the case of the depressed; discontinuous and circular in the case of the autistic—and the clinician should attempt to restore the temporal dimension.

Another peculiarity of the face-to-face relation that should be considered in the therapeutic context is that the other is encountered as a unique individual, with her own biographically determined situation. In my view, this is even more important in the clinical relationship, which is usually a face-to-face one and that should consist in a meeting where the patient is not seen and "analyzed" in her social role but in her uniqueness as individual, prioritizing the role of her lived experiences over other social and cultural features.

The relationship between the clinician and the patient can be therefore regarded as "a fusion of horizons" (Fuchs, 2007; Gadamer, 2013), a participatory experience in which two embodied subjects resonate with one another, trying to extend "the patient's lived space and change his implicit relationship patterns" (Fuchs, 2007, 424).

VI. CONCLUSION

Consciousness lives through its body. While usually our body is perceived as a "silent ally," when we become ill, we realize its importance and its role in our way to exist and move in the world. This is

dramatically true for conditions such as schizophrenia, melancholic depression, and autism spectrum disorder, where different disturbances of embodiment lead to the same effect: a detachment from the intersubjective domain.

After having described the importance of conceiving of the subject as embodied, I have argued for the necessity of an "expressive common environment" between the clinician and the patient, whose relationship itself is part of the therapeutic process. In fact, even the effects of medical treatment largely depend on the quality of the patient–clinician exchange, to the extent to which they both build a shared understanding of the disorder at stake. To focus on the corporeality of the patient (while being aware of her own corporeality) allows the clinician to elicit this process: corporeality *expresses* many things about the way the subject inhabits the world. Being aware of the "here and now" and taking into account the pre-verbal—primarily bodily and temporal—dimension of the patient-clinician encounter, will be helpful for re-establishing lost connections between feelings and the interpersonal situation. In other words, the *(inter)corporeal openness* is not only a key feature of the self, but it can also be considered a *therapeutic tool* when the self seems to lose its inextricable entanglement with the world.

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NOTES

1 This trend can be found not only in the phenomenological field (e.g., in Gallagher, 2005; Fuchs, 2009), but also within the cognitive sciences, which boast numerous enactive theories and which are increasingly moving towards the so-called 4E cognition (see: Thompson, and Varela, 2001; Thompson, 2005).

2 For the emphasis on the kinesthetic affordances of the subject, see Sheets Johnstone (2009, 2019); Behnke (1988).

3 Medicine, especially Western medicine, has often been associated with a rigorous and aseptic analysis, not an interpretation but a direct perception of the pathology. According to this perspective, the core of the medical practice is the opening of the corpse, in order to better observe the disease. The body is thus conceived as essentially inert and passive matter that should be analyzed and used exclusively for clinical purposes. Accordingly, the patient's narrative is completely superfluous and useless: rather, it is the body (understood as mere matter) that speaks through physical evidences. This dualism is overcome in the 19th century, when different movements (such as Gestalt psychology, integrative medicine, and Caunguilhem's normative approach) start to consider the subject as a body in relation with the world.The role of the incorporated, empirical subject is emphasized, and the medical paradigm undergoes a huge change: from the body-object to the re-evaluation of the body-subject, whose experiential dimension can still have a role in the definition of the diagnosis. Influenced by such a vision of the body, even medicine itself is therefore destined to change, and to free itself from the dream of pure objectivity. This vision is endorsed in particular by the phenomenological approach, thanks to the notion of *Leib*, which allows thinking about the subject as a psychophysical whole (see Leder, 1990; Pellegrino, 2004; Bizzari, 2020).

4 The phenomenological tradition (see in particular Husserl, 1952, sections 35–42) introduced the distinction between *Körper* (the body as object-like thing that occupies a dimensional space, with quantifiable measures, or the body-that-I-have) and *Leib* (the body-as-subject, the psychophysical whole that represents the unity of perception and movement and that also incarnates a horizon of significant symbols and interpersonal meaning).

5 Also Mishler, in 1984, distinguished between "the voice of medicine" (i.e., a naturalistic, scientific attitude towards illness) and "the voice of lifeworld" (i.e., the natural attitude of the everyday life).

6 I do not intend to say that Schütz considered this "communicative common environment" as a non-expressive one: my aim is to emphasize the *pre-reflective and pre-linguistic* nature of this "environment".

7 From the Greek *chrema*, which means thing, object.

8 In this pathology in particular, the role of the body is so important that many scholars argue that it is comparable to a somatic disease and consists of nothing more than a strongly altered body state. According to Ratcliffe et al. (2013) the brain alteration that can be recorded in depression is the same that can be observed in such other somatic diseases as flu.

9 For other insightful first person reports see also Aho (2014), in which the reification of the body experienced in depression is emphasized and it is argued that depression is not a *brain* disorder, but a *self* disorder. He links this bodily, experiential disorder to a *disconnection* from the surrounding world.

10 Where the schizophrenic complains of a fragmented identity, the depressed subject finds herself crystallized in a fixed role. In both cases the disruption of the lived body leads to a detachment from the social realm.

11 The idea of associating autism with a "dyssynchrony" condition came into my mind thanks to a paper where autistic movements are described using this term (Amos, 2013). I am also grateful to Prof. Thomas Fuchs for the several and inspiring talks we had concerning this specific topic.

12 If we conceive of intersubjectivity as an umbrella term to describe our social capacities, intercorporeality—or pre-inferential attunement, openness towards the other— seems to be the necessary condition for intersubjectivity to arise.

13 Especially for what concerns severe schizophrenic patients, it will be certainly difficult to "tune in" with them and grasp their subjectivity through their bodily movements: in this case, in fact, the clinician should also take into account the effects of pharmacological treatment, that usually influence on their bodily movements and expressions (there will be a slow body, an hypo-reactivity in bodily expression etc.). The clinicians should therefore be able to distinguish between these specific side effects and the subjective kinaesthesia.

14 We can find a coherent approach in psychoanalysis, which emphasizes both the relationship between the therapist and the patient and the therapist's feelings (Winnicott, 1994; Hayes, 2004). Nonetheless, psychoanalysis describes the patient-clinician encounter mostly in terms of projections of the one towards the other, and it conceives of corporeality as something that is an expression of our unconscious, while in the phenomenological perspective our body is itself our subjectivity, it is "mediated immediacy" (Plessner, 1981) through which the subject lives in the world.

15 We cannot talk about a phenomenological therapy itself: on the contrary, phenomenology offers conceptual and epistemological tools on which a psychotherapy can be grounded. Examples of therapies that take into account the phenomenological notions of intercorporeality, lived time, and lived space can be: dynamic psychotherapy, re-synchronizing therapies (such as music therapy), or phenomenologically-informed psychotherapy (Stanghellini and Lysaker, 2007). More specifically, movement and music therapies can be really useful for all of the conditions described, in order to elicit the intercorporeal attunement, while, concerning in particular the autism spectrum disorder, a useful therapy can be the DIR model developed by Greenspan and Wieder (1998), a model that takes into account Development, Individual Differences and Relationship-based features, and that can be easily enriched with a special attention to the Embodied dimension as well (Bizzari, 2019).

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