Psychotherapeutic Implications of Self Disorders in Schizophrenia

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The ways terms are defined have a significant impact on psychotherapeutic theory, research, and practice. This paper will provide the definitions of and conceptual distinctions among terms that have emerged from embodied and embedded approaches to the self and its disorders. First, it will offer the distinctions regarding conceptual definitions of disembodiment and hyperreflexivity to differentiate these from other psychopathological configurations and normal conditions. Second, it will present disturbances of the self that arise in the consensual processes of establishing intersubjectivity and manifest themselves in narratives. Third, the paper will present the principles of possible psychotherapeutic interventions for persons with schizophrenia. The conclusion states that both ontological (structural) as well as ontogenetic (autobiographical) aspects should be considered in the hermeneutic process of understanding patients. Content should be a significant element of this latter analysis.

KEYWORDS: phenomenology; schizophrenia; hyperreflexivity; disembodiment; psychotherapy

INTRODUCTION

Given that all knowledge involves the knower in a way that is personal, inseparable from the body, from language and from social history, it is especially interesting to understand our way of "being in the world", and of perceiving reality and ourselves. This gives rise to the questions of what human experience is like and how our particular way of being human, of enacting (or bringing forth) a world is (Varela, 1990).

Research into consciousness has breached the limits of scientific methodology by stressing the way that its subjective nature is an essential and

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inherent aspect—the "what is it like?" element (Nagel, 1974). From a nonrepresentational approach emphasis is placed on the sense-making capacities of individuals interacting with the world: far from being an objective representation of a given reality, the world emerges through a history of interactions (Varela, 1990; Varela, Thompson & Rosch, 1991; Maturana & Varela, 1996).

Psychotherapists are in the privileged position to gain access to the direct experiences of others. Psychotherapy, starting from a subjective view of psychopathology and using diverse practices for self-reflection, promotes a greater level of self-knowledge and self-understanding in the person who requests psychological aid. In the therapeutic encounter an understanding of the individual experience is sought. Gadamer (1995, p. 168) notes: "understanding another is, in reality, a difficult art and, what is more, a human task".

With therapeutic guidance consciousness and reflexion can become tools for overcoming pathogenic behavioural and relational patterns since these must first be made explicit in therapy to be changed. Fuchs (2010a) indicates that a mindful, nonevaluative, noninterventional observation of one's own experience leads eventually to a self-distancing, which enables one to bear the psychopathological state and to change it. As such, the polarity of the explicit and the implicit that results from the personal relationship with oneself brings with it the potential for illness as well as healing. However, one key question remains: How does one drift towards one road or the other?

The ways in which terms are defined have a significant impact on psychotherapeutic theory, research, and practice. This paper provides definitions of and conceptual distinctions among the terms that have emerged from embodied and embedded approaches to the self and its disorders. Conceptual analysis will progress from theoretical psychopathology to the practice of psychotherapy:

First, the paper aims to make distinctions regarding conceptual definitions of disembodiment and hyperreflexivity, ones that might (at least) allow readers to discern these unique manifestations in schizophrenia, to differentiate them from other psychopathological configurations, and to contrast them with normative conditions.

Second, I will present conceptualisations of self-disturbances that arise in the consensual processes of establishing intersubjectivity and manifest themselves in the narratives of persons with schizophrenia. The self-narrative loses the principles of consensual coherence, and thus difficulties arise in dealing with shared communication practices and in understanding

others as a secondary disturbance in the "extendend" dimension of self-experience.

Third, I will provide a conclusion regarding the principles of possible psychotherapeutic interventions for persons with schizophrenia, highlighting the relevance of ontological (structural) as well as ontogenetic (autobiographical) aspects in the hermeneutic process of understanding patients. Special consideration is given to psychotherapeutic approaches that focus upon encouraging patients' self-understanding and the establishment of a common communicative base between patient and therapist.

DISEMBODIMENT

Schizophrenia is conceived as a paradigmatic disturbance of embodiment and intersubjectivity, namely "disembodiment" (Fuchs, 2005, 2010b; Stanghellini, 2009). The primary "intercorporality," which is also the basis of common sense, is disturbed (Fuchs, 2001, 2005). Thus, disturbances in the processes of synchronisation with others (commonly generated meanings) arise and lead to difficulties in dealing with shared communication practices and in understanding others.

It is the tacit dimension (the implicit way in which our body functions) or the pre-reflective embodied self-experience that is alienated in schizophrenia. The two levels of self-experience—the implicit and the explicit—can be distinguished by the way in which the subject undergoes them: the former is pre-reflective, tacit or "proximal," whilst the latter involves the subject paying attention to or observing his self-experience in a reflective, thematic or "distal" way (Polanyi, 1967).

"Disembodiment" does not mean an actual (literal) or ontological split of mind and body, but a phenomenological distance from the central or "zero point" of orientation of embodied self-experience (Parnas & Handest, 2003), resulting in what may be called a "disembodied mind" (Fuchs, 2005; Stanghellini, 2004).

Normally, the body functions as the very centre and medium of subjective experience, it constitutes the central point of orientation in space that permits the perceptual view of the world, whilst it is not perceived of in itself (Fuchs, 2010b). On the contrary, in schizophrenia the body loses its tacit central role and does not serve as a medium of being-in-the-world anymore.

Persons with schizophrenia are vulnerable to disturbances of the mediating processes involved in embodiment. The mediacy of the body is affected as a whole. And rather than being tacit and transparent, the body

takes on layers of opacity. The body loses its familiarity, resulting in various forms of self-fragmentation and alienation: Single bodily sensations, movements, feelings, perceptions or thoughts no longer flow naturally as mediating processes of embodiment but appear as obstacles to awareness with object-like qualities.

In delusions and hallucinations the emotional-affective meaning dimension of self-experience is "disembodied", i.e. the patient regards as an external reality something that is, in fact, part of his own fragmented embodied self-experience. Fuchs (2005, 2007a) suggests that, with the progressive loss of agency, the subjective experience becomes externalised (detached from the first-person perspective) and acquires an inverted intentionality in the psychotic states.

In patients prone to delusions, the experience of vulnerability leads to the anticipation of others as dominant or humiliating (Salvatore et al., 2012a). For example, the pervasive fear experienced by patients with paranoid-type schizophrenia becomes the predominant external threat, which acquires the characteristics of a delusion. These patients have a constant fear of being harmed (or killed) by others; somehow it is the world and "the others" that have become unreliable or threatening.

Sass (2007) distinguishes patients with paranoid type of schizophrenia because affective flattening appears less characteristic, and takes notice of the contradictory qualities of affectivity that are manifested among the schizophrenic spectrum. On occasion, patients may even experience both flattening and a certain exaggeration in affective responses (e.g the "Kretschmerian paradox" [Sass, 2007, p. 351]). Thus patients with schizophrenia are heterogeneous with respect to many aspects of affective experience and expression.

Delusions and hallucinations are not external phenomena, but rather symbolic manifestations of the patient's emotional-affective dimension of self-experience; hence, these phenomena have no understandable sense in a public or broader social context. In psychotic states, one would metaphorically say that there is no "border" between self and others, as would normally be the case. There is a loss of the ability to distinguish between self-created meanings and those created by others, and to realize that inanimate objects cannot actually create meanings or messages (for example, self-referential messages patients discern from what they've heard on the radio, watched on television, or read in the newspapers). It could also be noted that there is a pervasive and unnoticed self-referentiality of experience in these cases.

HYPERREFLEXIVITY

Literature is sprinkled with a wide variety of terms that have become grouped together as synonyms of hyperreflexivity. These include self-consciousness, rumination, metacognition, and even self-focused attention or mindfulness (Pérez-Álvarez, 2008). However, it seems suspicious not only that these conditions accompany different psychopathological phenomena, but also that the same conditions may be beneficial to individuals (e.g. mindfulness). And any excess involves a degree of instability, thus it is clear that being "hyper" does not necessarily indicate a characteristic condition for a specific pathology.

"Hyperreflexivity" has been posited as a structural aspect in the psychopathological configuration of schizophrenia: a disorder of *ipseity* or pre-reflective self awareness (Sass, 1992; Sass & Parnas, 2003; Parnas & Handest, 2003; Parnas & Sass, 2008; Parnas et al., 2005; Raballo, Sæbye, & Parnas, 2009; Fuchs, 2010a). *Ipseity,* which derives from *ipse*, Latin for self or itself, refers to a crucial sense of self-sameness and of existing as a subject of experience that is normally implicit in each act of awareness. The central phenomenom of the schizophrenia spectrum disorders is a disturbance of the very "mineness" or first-person perspective that characterizes any experience (Sass, Parnas & Zahavi, 2011).

Sass, Parnas, and Zahavi (2011) have recently made clear that hyperreflexivity is not, at its core, an intellectual, volitional, or reflective kind of self-consciousness. The authors explain that it occurs in an automatic fashion and has the effect of disrupting awareness and action by means of an automatic "popping up" or "popping out" of phenomena and processes that would normally remain in the background of awareness. Nevertheless, it seems important to provide further distinctions for the term, ones that might (at least) allow us to differentiate them from other psychopathological configurations when compared to a normal process of reflexivity—like that which can occur in psychotherapy—and in contrast to normal forms of observing our own experience.

Reflectivity implies a stance towards one's self within an articulation of the subjective experience (similar to that which takes place in a psychotherapeutic context). In this way, the reflecting subject gets "closer" to his subjective experience. On the contrary, the person with schizophrenia, instead of articulating implicit processes, views his own subjective experience as something concrete and takes an external observational point of view, objectivizing the experience. Self-observation (from the external point of view) makes the individual a mere "spectator", of his experience,

which then loses its first-person mode of presentation that is "from within" (Parnas et al., 2005).

It is possible to argue that no reflectivity takes place in the initial states of perplexity (the realization that "something is going wrong") or confusion about meanings, as often occurs in the preliminary states of psychosis. This self-objectification leads neither to self-regulation nor to self-understanding (as reflectivity would certainly do) but to distress and to anxious feelings of depersonalisation until the psychotic breakdown occurs. This process of objectification finally results in pathological attributions or "explications" of the implicit (Fuchs, 2001).

Brief mention should be made of what is meant by mindfulness to illustrate normal forms of observing our own experience. Traditionally, this mediation process involves two complementary aspects: that of being fully present and focusing attention on direct experience from moment to moment (*shamatha*), and that of being conscious of the constructions of meaning involved in our experience (*vipashyana*) (Trungpa, 1991, 1997). This is a method for self-observation that consists in deliberately fixing the gaze on an external point; as a consequence, the embodied experience that arises in the present moment becomes explicit in one′s mind.

Various psychotherapeutic models based on mindfulness have been developed. These usually consider mindfulness as a component of manualized clinical interventions (Kabat-Zinn, 1982, 1990, 2003; Linehan, 1993; Teasdale et al., 2000; Segal, Williams, & Teasdale, 2002). Outside of the clinical sphere, this practice is broadly regarded as a path for spiritual development, self-knowledge and personal growth as in the so-called "contemplative therapies" (Wegela, 1988; Thich Nhat Hanh, 1990; Guzmán & Hast, 2008). Chögyam Trungpa (1998) notes that the constant practice of paying attention (being fully present) involves acquiring a global, broad awareness: It allows one to gain a meta-perspective or panoramic vision of being in the world.

When a person practises mindfulness he positions himself as an observer of his own direct experience, paying nonevaluative attention, which implies no reflection at all. Normally, when one deliberately observes one's experience, it appears as separated, discrete content or episodes, although it retains a sense of continuity as "being mine". It is just this tacit sense of continuity of experience, (in Husserl's terminology) "implicit synthesis" of inner time consciousness, which is lost in schizophrenia (Fuchs, 2010b, 2010c). Since this implicit synthesis is necessary to form meaningful patterns (or *Gestalten*), the patient's subjective experience will appear not only disintegrated or fragmented, but meaningless as a whole.

Therefore, hyperreflexion relates to a circuit of self-observation that is not reflective, but rather is a process of self-observation (monitoring) and paying attention to one's self in an automatic manner. The subject's experience becomes a pervasive object of attention from an external perspective, losing its first-person mode of presentation. The self-experience becomes explicit with an unfamiliar "object-like" quality. From this viewpoint, hyperreflexivity could be better understood as a "hyper-objectification" or self-objectification.

What in this context has been called disembodiment and hyperreflexivity—in the two forms of conceptualisation mentioned above—might together be defined as a characteristic process of "reification", which culminates in the psychotic episode of schizophrenia (Fuchs, 2006; Hirjak & Fuchs, 2010). The word reification, which stems from the German *Verdinglichung,* means making an idea into a thing or separating something from the original context in which it occurs. Here, it refers to the conversion of an experience that is turned into a thing, treating that which is implicit as something tangible, as if it were a separate object, when it is not the case.

INTERSUBJECTIVITY AND NARRATIVES

It is important to bear in mind that humans experience our world on the basis of meaning-attributions that are derived primarily from individual levels of embodiment. On the intersubjective level, the spontaneous attribution of meanings is not naturally constructed like a theory, but emerges from a dynamic process of interaction and coordination with others. This process of "cocreation" of meaning does not imply perfect synchronisation. On the contrary, as Fuchs and De Jaegher (2009) clearly state, "it is the continuous fluctuation between synchronised, desynchronised and in-between states that drives the process forward" (p. 471). Miscommunications occur when there is a failure to appreciate the meaning of the other's emotional display and, together with the activation of pervasive patterns of disturbed interaction, constitute the conditions for the manifestation of psychopathology.

It is, to a certain extent, possible to understand the intentions of others by means of the "visibility" of intentions-in-action perceived in them. Nonverbal processes of intersubjectivity are necessary but not sufficient to trigger more complex empathic forms, which depend on the congruence of the meaning (or personal interpretation) that each individual assigns to a given situation beyond its common context. Thus in human interaction not only is language involved (with the possibility of the "art of dissimula-

tion"), but also the accessibility to subjective experience and the hermeneutic understanding that incongruence in interaction may require is achieved by means of verbal correlates.

Taking an emotional perspective on the world is natural since we are embedded in it. The world appears through our own emotional and mental states (and meanings) so that it sometimes acquires a dangerous, threatening or desolated quality, and sometimes becomes a calm or beautiful place. The curious thing in the psychotic state of schizophrenia is that the subject views the world through his delusional framework, and also that this viewpoint is irrefutable. There is an inability to enter into an open conversation that takes the other's point of view into account, thereby shutting out the intersubjective dialectic given by the second-person perspective (Fuchs, 2013).

The loss of common sense or natural evidence, regarded as the core characteristic of schizophrenia (Blankenburg, 2001, 2012; Stanghellini, 2011), makes it difficult for the patient to have a natural and spontaneous immersion in daily life. This leads to an alteration in the cocreation of meanings with the others and an artificial, enigmatic and uncanny involvement with the environment (Fuchs, 2001). These difficulties progressively lead to a radical withdrawal from social interaction.

Therefore, self-disturbances arise in the consensual processes of establishing intersubjectivity and manifest themselves in the narratives of persons with schizophrenia. The self-narrative loses the principles of consensual coherence, thus difficulties arise in dealing with shared communication practices and in understanding others. In acute psychosis, the self-narrative manifests itself with a collapse of the temporal dimension of the narrative plot; this leads to a decontextualisation of the patient's self-experience (Holma & Aaltonen, 1995, 2004a). Apart from these manifestations of incoherence, it is important to notice that something is not being explained coherently (or being explained at all), something remains ineffable for the subject.

It is worth highlighting the creative process of the psychotic episode. Self-narrative as a creative resource makes it possible to construct a "fantastic" world, making use of a range of symbolic elements that are consistent with the meanings of the patient's personal world. Nevertheless, they appear strange and incomprehensible to outside observers. From this perspective, the contributions of Sass are interesting in that they highlight the creative potential of persons diagnosed with schizophrenia and provide an alternative to the usual emphasis that characterizes schizophrenia in purely negative terms (Sass, 2000–2001, 2001).

Up to this point the disturbance of self-experience in schizophrenia has been referred not only as the structural phenomena of *ipseity* or pre-reflective self-awareness, but also as to the alteration in the processes of explicit consciousness (the so-called extended, reflective or narrative self [Fuchs, 2010b, 2010c]) as a secondary disturbance in the consensual processes of constituting coherence and establishing intersubjectivity.

PSYCHOTHERAPY

In a psychotherapeutic context, reflectivity generally takes place through the active reconstruction of the affective imbalance on an explicit level of self-understanding. In this context the psychotherapist accompanies the patient, and assumes a second-person perspective, being fully present "here and now" in the interaction. Intercorporality (as the sphere of non-verbal, bodily and atmospheric interaction) is essential in the development of the therapeutic relationship (Fuchs, 2007b).

Moving the focus of therapy towards understanding the patient's self-experience (the implicit) and his continuous interaction with others is the key to clarifying how to improve and recover his psychological wellbeing. Gradually, the patient extends the focus of attention towards diverse areas of his life that seem relevant to expand upon, and he makes his way back to daily life. Gadamer (2001) states that the final aim of psychotherapy would be to obtain not only symptomatic recovery, but also the recovery of the patient's sense of unity with himself when rebuilding his capacity of doing and being.

The task of contextualizing the imbalance in the spatiotemporal dimension of the personal history (life story) allows us to take a step back from the immediate experience through the coconstruction of consensual narratives, which facilitate its understanding from a broader perspective. Understanding the person's relational space and its meanings, his way of life or style of existence, should be oriented to enhance the unity (continuity) of personal identity.

It seems important here to point out that psychotherapies belonging to the nonrepresentationalist paradigm not only support the "primacy of emotion", but also that the analysis of negative emotions is fundamental (Hersh, 2003). This conceptualisation implies that all human experience is meaningful, thus it is organized and interpreted precisely in terms of those meanings. Also, new meanings are being created (or are emerging) permanently through new and ongoing situational, perspectival, and contextualized interactions.

From a narrative perspective, noteworthy is the importance of the

patient being led towards a dialogue, taking into account the story he tells of himself, where his personal experience is explicitly shared on the basis of a common meaning (Holma & Aaltonen, 1997, 2004a, 2004b; Seikkula & Olson, 2003; Seikkula et al., 2006). Interventions for persons with schizophrenia hold that the therapeutic ingredient arises from the effect of an "open dialogue" on the patient's immediate social network, and emphasise immediate attention in the cases of acute psychosis before it becomes chronic (Seikkula & Olson, 2003; Seikkula et al., 2006). In this way, thematic articulation of the clinical forms of psychosis, expressed as narrative creations of the patient's own subjectivity (and meanings), allows for its reappropriation and for the understanding of the psychotic process (Guidano, 1999; Irarrázaval, 2003).

Psychotherapy focused on metacognition promotes a range of activities to develop the capacity for self-reflectivity or "thinking about thinking" (Lysaker et al., 2011a, 2011b, 2011c; Salvatore et al., 2012a; Salvatore et al., 2012b). This orientation has been suggested as a model for the treatment of persons with schizophrenia by assisting them to develop metacognitive capacities (Lysaker et al., 2011a). Patient′s narrativity should improve along different levels of articulation by the recognition of beliefs, the incorporation of emotions, and the reconstruction of different meaningful life events. The therapist should promote the capacity for self-consciousness so that the patient is able to accept feeling uncertain and then to think flexibly about different beliefs that he holds, including delusional beliefs (Salvatore et al., 2012b). However, delusional beliefs constitute the patient's only available form of cognitive and interpersonal organization, so instead of confronting them, the therapist should focus on the difficulty in pragmatically comprehending others and on the experience of vulnerability (Salvatore et al., 2012a).

The second-person perspective, or offering the "I-You" encounter between patient and psychotherapist, has been suggested by Stanghellini and Lysaker (2007) as a crucial step in recovering a sense of subjectivity (first-person perspective) in the patient's relationships with others. The principles of the phenomenological approach to psychotherapy for persons with schizophrenia highlight the dialogic process of cocreation of meaning beyond the mere "normalization" of the patient's experiences and beliefs.

Empathic understanding, the basis for every psychotherapeutic encounter, is certainly fundamental in treating persons with schizophrenia as well. So, taking phenomenology as a framework, other implications that might be considered can be summarized as follows:

1) The main task of psychotherapy is to understand how the patient experiences his world in the sense of the all-embracing framework of meaning in which he is embedded: Who is this person beyond the schizophrenic condition?
2) Reflectivity takes place through the active reconstruction of disturbing interactions to understand how the process of synchronisation with others has been interrupted and to actively create possibilities of restoring it. The patient's experience is explicitly shared on the basis of a common meaning with the psychotherapist through a dialogical process that takes the other's point of view into account (second-person perspective). In this way, the dimension of consensual intersubjectivity can be re-established, bringing back understandability.
3) Diagnosis of schizophrenia can be sometimes recognized in an intuitive way by clinicians, the "praecox-feeling" (Rümke, 1990; Parnas, 2011), based on particular difficulties in establishing contact with the patient (affective attunement with the person as a whole). The therapist must be aware of his own embodied experience not only to recognize his owns "intuitions," but also to help the patient restore reciprocity or affective attunement, which is basic for the development of a sense of one's self and for the synchronization with others.
4) It is important to facilitate the realization of the personal perspectives that the patient is taking, from an external attribution to the embodied self experience, i.e. integrating and articulating narratives from "within". For instance, it would be important to explore in the intersubjective context experiences such as the sense of personal value, experiences of loss, separation or rejection, sense of vulnerability, powerless or lack of protection, uncertainty, lack of control, failure, etc. In addition to helping the patient to integrate emotional aspects of his own experience, the therapist should gradually promote the realisation of the overall interpersonal situation affecting him.
5) The spatiotemporal dimension of the personal history allows understandability from a broader perspective, shaping the "concept of the person" himself against the backdrop of his significant interactions. With especial regard to the psychotic state, the patient's personal history could open up a path for the potential understanding of the symbolic elements in the light of significant interactions. It would

also help the patient to visualize the self/others or self/environment "border", thus reinforcing his sense of autonomy.

6) Taking into account the story the patient tells of himself improves the articulation of self-narrative. It gradually extends towards diverse areas of his life whose elaboration appears important for him to make his way back to daily life. It is important to articulate the present on the basis of self-experience that takes place in the actual interpersonal context and from there to articulate the future as a horizon of possibilities.

CONCLUSION

Human experience emerges from a series of complex interpersonal interactions. These interactions constitute the conditions for the experience to manifest itself: the same is the case for the configuration of schizophrenic symptoms. The disturbance of the natural interrelation between the dialectical processes of the implicit and the explicit manifests itself as a loss of self-coherence or common sense in different domains of intersubjectivity. Thus, disturbances in schizophrenia concern both levels of the self:

1) a disorder of the *ipseity* or pre-reflective self awareness (core or basic self), a primary interruption in the continuity of the natural flow of the first-person givenness of experience, and
2) a disorder of the extended, reflective or narrative self, a secondary disturbance in the consensual processes of constituting coherence and establishing intersubjectivity.

Therefore, both ontological (structural) as well as ontogenetic (autobiographical) aspects should be considered in the hermeneutic process of understanding patients. Content should be a significant element of this latter analysis.

Major disturbances in the processes of synchronisation with others, interactional perspectives, and difficulties in dealing with consensual principles of understandability, would appear to be important variables to consider in the sympomatological description of schizophrenic spectrum disorders. The functionality or secondary gain associated with the symptoms is not clear: this might be revealed by means of a comprehensive analysis of the patient's personal history. Rather than carrying out decontextualised interpretations of the symptomatology, it is more important to specify the conditions of the interpersonal context that are the basis of the symptomatological manifestations, i.e. to contextualise the experience in the interpersonal scenario in which it manifests itself.

Conceptualisations established in isolation from direct experience and made on a theoretical level can give rise to confusion. Psychopathological descriptions on this theoretical level are more consistent with the "literary plot" of a patient's "supposed" experience than with what actually the patient subjectively experiences. This is why it is important for researchers in this field to incorporate the patients' first person accounts as valid sources of knowledge: It is the closest we can come to understanding the anomalous self-experience, and from there we may begin to theorise about it.

If we claim that an essential aspect in schizophrenia is the problem with intersubjectivity, then accounting for the patient's life history seems fundamental. Additionally, an autobiographical approach comes from the interest in recovering the concept of the "person". If there is agreement in considering that the main subject of psychiatry and clinical psychology is the person in its entirety (Mezzich, 2007), and that he or she is the bearer of a history and the creator of the plot of a particular existence, then the importance of life stories in approaching psychological phenomena is well-founded.

Special consideration should be given to psychotherapeutic approaches that focus upon encouraging patients' self-understanding and the establishment of a common communicative base between patient and therapist. What is more, if the loss of common sense is regarded as the core ontological characteristic of schizophrenia, then it is sensible to state that recovering understandability would be a key aspect in overcoming alienation. The world is an enigma for persons with schizophrenia, much as those with schizophrenia remain an enigma for psychiatry: This is certainly a great challenge for a possible "fusion of horizons" (Gadamer, 2003) in the field of phenomenological psychotherapy.

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