

# THE PHENOMENOLOGY OF BODY, SPACE AND TIME IN DEPRESSION

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## I. LIVED AND CORPOREAL BODY

My starting-point is the polarity of the lived and the corporeal body as conceptualized by the phenomenologic tradition, especially by Merleau-Ponty (1996). The *lived body* means the body as the medium of all our experience, our embodied being-in-the-world. I act through my body, perceive and exist through it, without explicitly reflecting on it. Hence lived bodiliness means my relation to the world as mediated and lived by the body. The *corporeal body*, on the other hand, is the material, anatomical object of physiology and medicine which can be observed and grasped. It appears whenever the lived-body loses its “taken for granted” mediating role and becomes obstinate or fragile, as e.g. in the experience of heaviness, fatigue, clumsiness, injury, or illness. The lived-body turns into an objective or corporeal body whenever we become aware of it in an embarrassing way. Lived bodiliness is a constant outward movement, embedded in the environment and participating in the world. Corporeality appears whenever this movement is somehow disturbed or disrupted (Fuchs, 2002). Then the lived-body is thrown back on itself, materialized or, as I put it, “corporealized”. Having been a living bodily being before, I now realize that I have a material (impeding, clumsy, vulnerable, finite, etc.) body. In the tradition of body phenomenology, this has been expressed like this: *The lived body is the body that I am, the corporeal body is the body that I have* (Plessner, 1975).

## II. CORPOREALISATION: THE BODY IN MELANCHOLIC DEPRESSION

On this basis we may first describe melancholia in phenomenological terms as a restriction, inhibition or rigidity of the lived-body which I call *corporealisation* (Fuchs, 2000b, p. 99). The restriction may focus on single areas of the body (e.g. feeling of an armour or tyre around the chest, of a lump in the throat, pressure in the head) or also manifest itself in a diffuse anxiety, an overall bodily rigidity (“anxiety” is derived from the Latin “*angustiae*” which means “narrows”, “restriction”). Local or general oppression condenses the fluid and mobile lived-body to the solid and heavy corporeal body which puts up resistance to all expansive impulses. The patient’s gaze becomes tired and blunt, the voice dull, the gestures weak; even breathing, normally a subliminal muscular action, may become a task to be carried out against the load felt on the chest. Thus the materiality of the body, otherwise unnoticed in everyday performance, now emerges and is felt painfully. The faculties of perception and movement are weakened and finally immured by the rigidity which is clearly visible in the gaze, the face or the gestures of the patient. His capacity to participate in the world by his senses and expressions is disturbed, resulting in alienation or even depersonalisation (Kraus, 2002).

Corporealisation thus means that the body does not give access to the world any more, but stands in the way as an obstacle. The exchange of body and environment is inhibited, drive and impulse are exhausted. In addition, a loss of vitality in many systems of the organism comes about; processes of shrinking and dying prevail. The excretions cease; appetite and libido are reduced or lost. The patients look older than they are, their complexion becomes pale, the hair dull. In the worst cases the weight loss may progress to the point of cachexia, and the regulation of the blood circulation gets disturbed. All this literally means a corporealisation, namely in the sense of coming nearer to the corpse, the dead body. The fluidity, mobility and vitality of the body give way to a more or less marked retardation or “stasis”. In serious cases the rigidity culminates in depressive stupor.

## III. RESTRICTION OF THE SENSORIMOTOR SPACE

The restriction I have described so far continues in the sensorimotor space, in the area of perception and movement. The depressive’s per-

ception is characterised by a loss of alertness and sympathetic sensation. Patients may describe a loss of taste, a dullness of colours or muffled sounds as if heard from afar. Their senses are not able to vividly participate in the environment, their gaze gets tired and empty, their interest and attention weakens. They can only passively receive what comes from outside.

Movement, on the other hand, is marked by psychomotor inhibition: gestures, speech and actions are reduced, only mechanically produced, and lack normal energy. A bowed posture, a lowered head, a leaden heaviness of arms and legs show the dominance of forces pressing downwards, as is also pointed out by the word “depression”. The weight of the physical body, otherwise unfelt in the casual performance, now comes to the fore. Step by step does the patient move his body and carries it – so to speak – to the required spot. In order to act, he has to overcome the inhibition and to push himself to even minor tasks, compensating by a high effort of will what the body does not by itself any more.

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

#### IV. LOSS OF BODY RESONANCE

So far I have described depression as a disturbance of body feelings, perception, movement, space and time. However, there is still another dimension of body and space which is not part of our everyday understanding of these terms: it is the dimension of felt atmospheric qualities, of emotional expressions and impressions, of our affective engagement

and participation in the world. Normally we regard these as inner, psychic or “subjective” phenomena which are neither visible nor touchable and therefore not part of the common world. This introjection of feelings into an inner chamber of the so-called “psyche” is still a heritage of the Cartesian split of the world into thinking substance and extended substance. In fact, we do not live in a merely physical world; the space around us is always charged with affective qualities. The objects and persons have their expressive and emotional characters, they attract or repel us. We feel something “in the air”, or we sense an interpersonal “climate”, e.g. a serene, a solemn or a threatening atmosphere. Now this emotional space is essentially felt by the medium of the body which widens, tightens, weakens, trembles, shakes etc. in correspondence to the feelings and atmospheres we experience. There is no emotion without bodily sensation. The body is a “resonance body”, a most sensitive sounding-board in which interpersonal and other “vibrations” constantly reverberate (Fuchs, 1996 and 2000a).

Now in depression the corporealized body loses its capacity of emotional resonance. In milder form this becomes manifest in loss of interest, pleasure and desire. But the deeper the depression, the more the attractive qualities of the environment faint. The patients are no more capable to be moved, addressed and affected by things or persons. Finally the ability to sense feelings and atmospheres is totally lost. This loss of resonance, i.e. the inability to feel emotions, expressions or values is painfully experienced by the patients, for it is not caused by mere apathy or indifference (such as in frontal brain injury) but by the tormenting bodily restriction and rigidity. Kurt Schneider wrote that the vital disturbances of feeling are so intense that psychic (i.e. “higher”) feelings can not appear any more (Schneider, 1920). Patients speak of a “feeling of not feeling” and complain of not being able to sympathize with their relatives any more. We can sense this ourselves when we stay with a depressed patient, notice his scarce expressions of affects and feel the invisible wall that surrounds him. He is not attuned to the environment any more; he has lost the sympathetic participation in the common emotional world.

Thus the bodily restriction in depression results not only in felt oppression, anxiety, heaviness and inhibition, but more subtly, in a loss of sympathetic resonance. The patient does not feel sadness, mourning or grief; he feels rather empty, dull, rigid or dead. Even the ability to shed tears is lost. This culminates in the stony, empty expression of the psychotic melancholic patient, whose depth of pain we may not even empathically feel any more. The patients themselves notice this freezing of

their expressivity and try in vain to substitute the missing bodily communication by repeating their complaints mechanically again and again. Often it is only after the solution of the inhibition that they can tell what despair they have been going through. Typically the recovery starts with a gradual solution of the inhibition and an increase in motor activity, whereas the more subtle affectability of the body necessary for emotional resonance is only reached again at the end of the healing process. The regained ability to shed tears may be an important sign for the solution of the rigidity.

## V. DEREALISATION AND DEPERSONALISATION

Since the vital, sympathetic contact to the environment is essential for our sense of being-in-the-world, a loss of body resonance always results in a certain degree of derealisation and depersonalisation: loss of feeling means at least a partial loss of self. However, there is a special kind of melancholic depression in which depersonalisation is the prominent symptom; in German psychopathology it is called "*Entfremdungsdepression*" (depersonalized depression; Petrilowitsch, 1956). Here the emotional quality of perceptions is totally lost. The patients do not sense the atmosphere of a sunny morning; a red surface is no more red in the sense of "warm", "bright", "attractive", but only "red". The sensual perceptions remain abstract and cannot be felt. At the same time, space becomes empty and, as it were, hollowed out. In the words of a patient of Victor von Gebattel (1954, p. 25): «There is only emptiness around me; it fills the space between me and my husband; instead of conducting it keeps me away. I am kept away from the whole world; there is an abyss in between». The patient feels like an isolated stone in a world of relationless objects. There is only a "known" or abstract space around her, not a lived, embodied space any more. Perception only shows the naked framework of objects, not their connectedness or their "flesh".

The depersonalisation in severe depression culminates in the so-called nihilistic delusions or the Cotard-Syndrom, formerly aptly called "*melancholia anaesthetica*" (Schaefer, 1880). The patients do not sense their body any more; taste, smell, even the sense of warmth or pain are gone, everything seems dead. Persons and objects seem hollow and unreal, the whole world is empty or does not exist any more. This makes the patients conclude that they have already died and ought to be buried. They may even deny their own existence or the existence of the world.

A 65-year-old patient of mine maintained that her body, her stomach and bowels had been contracted so that there was no hollow space left. The whole body, she said, was dried out, nothing did move any more; she sensed neither heat nor cold. At the same time she was convinced that all her relatives had died, that she were alone in the world and had to live on for ever.

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

*«Someone who resembled my wife, was walking beside me, and my friends visited me [...] Everything was as it would be normally. The figure representing my wife constantly reminded me of what I had failed to do for her [...] What looks like normal life is not. I found myself on the other side. And now I realized what the cause of death had been [...] I had died, but God had removed this event from my consciousness [...] A harsher punishment could hardly be imagined. Without being aware of having died, you are in a hell that resembles in all details the world you had lived in, and thus God lets you see and feel that you have made nothing of your life» (Kuiper, 1991, p. 136).*

For a person in this state of utter depersonalisation there is no criterion to convince himself of the reality of what he is seeing, even of his existence itself. Descartes' "cogito ergo sum" here proves to be insufficient. A person who only thinks without having bodily feelings, who has lost the elementary self-affection of life, does not "exist" any more, in the sense of the living existence that is fundamental for all thinking. Being dead alive seems the description of such a state that suggests itself.

## VI. TEMPORALITY AND DESYNCHRONISATION

Let us consider in a bit more detail the temporal aspect of the nihilistic delusion. For the patient, the state of having died is literally an eternal one. Like the Eternal Jew he is doomed to be dead alive forever. He cannot even imagine to be in another state some time in the future. As I pointed out before, there is a narrow connection between the lived body, space and temporality. In the last analysis, the possibility of bodily movement, the accessibility and openness of space, and the move-

ment of life towards the future are one and the same thing. But the accessibility of space depends not only on our motor faculties, but also on our body resonance, on our emotional participation in the world around us. So if the body is completely isolated by restriction and all its resonance is lost, then the space will appear to be inaccessible, unreachable and detached from the potentiality of our body. But what is more, the temporal movement of life will also cease and come to a standstill. The present state will become eternal, and there will be no possibility of change any more.

However, an inhibition or standstill of lived time is not only a phenomenon of delusional depression, but the hallmark of depression in general, as the Straus, von Gebattel and Tellenbach have pointed out. Following Straus, in melancholia the “ego-time” of the movement of life gets stuck, whereas the “world-time” goes on and passes by. The inhibition of inner time does not allow the patient to progress towards the future, nor is he able to close and leave behind his past experiences. «The more the inhibition increases and the speed of inner time slows down, the more the determining power of the past is experienced» (Straus, 1928). What has happened remains conscious as a fault or failure, as ever-growing guilt. Tellenbach (1980), for his part, coined the term “remanence”, which means falling short of rigid demands on oneself concerning duty and orderliness. According to Tellenbach, remanence is the risk inherent in the personality structure of the “Melancholic Type”.

Such analyses are still fundamental for a psychopathology of temporality. However, they consider lived time as primarily monadic, without reference to intersubjective or social time. Thus the depressive pathology of time seems to be comprehensible as a merely individual disturbance. Modifying this approach, I will consider the melancholic pathology of time not as an individual inhibition but as a disturbance of a synchronized relation, or a *desynchronisation*. Melancholia then means an uncoupling in the temporal relation of organism and environment, as well as of individual and society.

Of course, the concept of synchronisation is derived from chronobiology, referring to the order of rhythms such as the sleep-wake-cycle or the diurnal period of hormone levels. In order to introduce this term into phenomenological psychiatry, we must extend its meaning over different levels. On the *biological* level, there is a continuous attunement between endogenous and exogenous rhythms or timekeepers, a synchronisation of organismic with cosmic rhythms, such as daily, lunar and solar periods. Thus e.g. the sleep-wake-rhythm of 24 hours is

known to be the result of a synchronisation between endogenous and exogenous time-keepers or oscillators.

But if we turn to the *social* level, we find many forms of synchronisation as well. Since birth, the rhythms of the organism (eating, sleeping, excretion times etc.) are shaped by socialisation. More subtly, the everyday contact with others implies a continuous fine tuning of emotional and bodily communication, a “resonance”. These microdynamics of everyday interaction bring about a basic feeling of being in accord with the time of the others, and to live with them in the same, intersubjective time. Moreover, the social synchronisation is conspicuous in the manifold ways of “timing”, of day- and week-time regulation, date scheduling, as well as in all mutual commitments and agreements that are kept up by self-constraint and standardisation. This coupling of individual times has been increasingly institutionalized and internalized in modern age, leading to the nearly perfect synchronisation of all members and sequences in the present society, without which it would, for all its complexity, fall into a functional chaos.

All these biological and social synchronisations, however, are not at all constant. The homoeostasis of the organism in relation to its environment is only preserved through recurring deviations or *desynchronisations*. And on the social level, too, we periodically experience asynchronies, i.e. situations which require us to re-adapt to external changes, to compensate for disturbances and backlogs. Uncompleted tasks, unresolved conflicts, strain and distress accumulate, thus inhibiting our progress toward the future. And in serious experiences of trauma, in guilt, loss or separation the person temporarily loses the lived synchrony with others.

Such discrepancies and deviations from the present require specific processes of coping and *resynchronisation*. Different biological and psychic processes serve to re-establish the present and to bring the individual “up to date”. Among them are the periodicity of the vital functions, the compensation for shortage by satisfaction of needs, and the psychological processes of coping with the unfinished, e.g. by forgetting, remorse, grief, readjustment of values and demands, or by overcoming major life crises (Fuchs, 2001).

## VII. MELANCHOLIA AS A DESYNCHRONISATION

A lasting desynchronisation between the individual and the environment is characteristic of melancholic depression. It ensues when the



person's coping with major changes fails, i.e. resynchronisation mechanisms do not succeed and break down. The typical constellation triggering melancholia has been characterized by Tellenbach as a situation of *remanence* concerning social demands and tasks, and we may well understand "remanence" in the temporal sense: the melancholic does not feel equal to the speed of external changes or to necessary self-developments. Often he gives up in the face of painful processes of detachment or grief, or he refrains from necessary role changes.

This corresponds to the premorbid striving of the Melancholic Type to avoid discrepancies in relation to his environment at any rate. The "hypernomia" which Alfred Kraus (1987) has worked out as the hallmark of the melancholic's social identity, is a "hypersynchrony" as well. Down to the microdynamics of everyday behaviour the melancholic seeks continuous resonance by compliance and friendliness, social attunement, punctuality and timely completion of his tasks. This inability to cope with desynchronisations inhibits his personal development and renders him all the more vulnerable to inevitable biographical breaks or role changes.

The capitulation before an inescapable task of coping or development now leads exactly to what the melancholic fears most of all: to the break-down of coherence with his environment in depressive illness. Depressive psychopathology may thus be viewed as the result of a general desynchronisation, as a psychophysical slackening or stasis. On the physiological level, their manifestations are well-known: the disturbances of neuro-endocrine and temperature periods, of the sleep-wake-rhythm, of the female cycle; the loss of drive, appetite or sexuality. Finally one may think of the seasonal depressions as desynchronisations in relation to the annual period. The uncoupling of organism and environment also manifests itself in the experience of *corporealisation* which I described before. The lived-body loses its embedding in, and resonance with the environment and turns into an obstacle that falls short of its tasks.

Let us now consider the desynchronisation concerning intersubjective time. Depressed patients avoid the environment with its social or physical timekeepers. They do not get up in time, withdraw from social obligations, their tasks are taken over by others, important family decisions are made without them. Futile attempts to keep pace with events and to catch up on tasks increase the feeling of remanence. Moreover, the depressive patient suffers from the loss of sympathetic resonance. The affective attunement with others fails. Painfully, the patient experiences his rigidity in contrast to the movement of life going on in his

environment. The desynchronisation also becomes manifest in a failure to achieve forgetting and elimination of the past. «Everything goes through my head again and again, and I always have to wonder if I did things right». It is the torture of not being able to forget, of being constantly forced to remember and therefore not arriving at the present any more.

With increasing inhibition the basic movement of life comes to a standstill, as anthropological psychopathology has described it. The depressive has fallen out of common time and has become, as it were, a living anachronism. He literally lives in another, sluggish time, and the external, intersubjective time passes him by – as an empty time that he cannot fill or shape any more, like a continuous call: «Gone! Over!» These phenomenological analyses of time disturbance can be experimentally verified, as Mundt and colleagues have shown again recently (Mundt *et al.*, 1998). Depressive persons experience a time dilation, i.e. they estimate given time intervals to be longer than the actual, objectively measured time.

With the uncoupling from the external time the future is blocked, which means that *the past is fixed once and for all*; it may no more be changed or compensated by future living. Now all past guilt and all omissions are actualized, as Kuiper writes: «What has happened can never be undone again. Not only the things go by, but also possibilities pass by unused. If one does not accomplish something in time, it is never done any more [...] The real essence of time is indelible guilt» (Kuiper, p. 58). Thus in melancholia time is continuously transformed, as it were, into guilt which can not be discharged any more. Not the intensity, but the principal irrevocability is the characteristic sign of melancholic guilt. The confessions of the patient are not at all directed toward resynchronisation with others through remorse or compensation, for its prerequisite, the common dimension of time, does not exist any more. His guilt is irreparable *as such*.

Complete desynchronisation is marked by the transition to melancholic delusion. Now the return to a common intersubjective time has become unimaginable, the determination by the past total. In nihilistic delusion the asynchrony reaches the extreme of a loss of reality, a separation of two worlds. To quote Kuiper once more: «Someone who resembled my wife, was walking beside me, and my friends visited me [...] Everything was as it would be normally. But what looks like normal life is it not. I found myself on the other side» (*ivi*, p. 136). – This is the characteristic of depressive delusion in general: a state of self outside the present one is unimaginable. The patient is forced to

identify with his present state of bodily stasis and decay, with his state of feeling guilty as such, or, in nihilistic delusion, with his state of not feeling alive any more. He is no more able to keep his situation in perspective, and to relativize his convictions. It has always been like this, and it will stay the same for ever – all reminiscence or hope different from that is deception.

Now if for the patient there is no state of self outside the present one, he loses the capacity to change his perspective and to transcend his present experience towards an intersubjective view. Depressive delusion is therefore rooted in the total restriction of self-experience and its separation from the others: *the capability of taking the perspective of others depends on a common intercorporeal space and interpersonal time which for the depressed patient do not exist any more*. Corporealisation and desynchronisation, i.e. bodily and temporal separation from the world prevent him from taking the perspective of others. He loses the freedom of self-distancing, of considering other possibilities of self-being. Nihilistic, hypochondriacal delusions, delusions of guilt or impoverishment are all just different expressions of the same state of the self: a state of total objectivation or “reification” that cannot be transcended any more.

#### VIII. A RESYNCHRONISING THERAPY

I have described melancholic depression by two main alterations which are closely interconnected: *corporealisation* and *desynchronisation*:

1) In melancholia, the body is corporealized: it becomes, heavy, clumsy, immobile. The inhibition of drive results in a general paralysis and restriction. The corporealized body does not give access to the world any more, but stands in the way as an obstacle. Moreover, instead of participating in the world by his senses and feelings, the patient experiences a loss of body resonance, an alienation and even depersonalisation.

2) Persons with a predisposition to melancholia have a limited capacity for resynchronisations. They feel a necessity not to allow discrepancies to grow, not to deviate or fall back from the standardized course of life. If this happens all the same, the complete desynchronisation or temporal uncoupling of melancholic depression may ensue, implying a biological as well as an intersubjective desynchronisation.

The loss of goal-oriented capacities of the body, of drive, appetite and desire are equivalent to a slowing-down and finally a standstill of lived time. Thus the past, the guilt, the losses and failures gain dominance over the future and its possibilities. Melancholic delusion is the utter manifestation of this uncoupling from common time.

From this point of view, the treatment of depression should have the aim to restore and support the missing processes of synchronisation. On the *biological* level, well-known instruments for this are e.g. pharmacological or electroconvulsive therapy, sleep deprivation or light exposure. A psychotherapeutic “*resynchronising therapy*” should take into account the following guidelines:

1) The first requirement would be a spatial and temporal frame creating a definite and legitimate recovery period for the patient, a “time-out” so-to-speak, during which he can gradually readapt to the common social course of time with as few pressures as possible. In this phase of treatment the aim is to loosen the rigidity of bodily restriction and anxiety, which is mainly achieved by psychotropic medication, but also by the relief of everyday duties and tasks that overburden the patient’s capacities.

2) Secondly, it is important to give rhythm to everyday life, i.e. to emphasize repetition and regularity in the structure of the day and week. This helps the patient to gain a stand against fleeting time and to further the resynchronisation of internal and external rhythms.

3) Then a careful activation therapy may support the patient’s orientation toward future goals, however modest. This may be stressful at first, since the patient’s own, appetitive motivation is still missing and each action is in immediate danger of not satisfying his high demands on achievement. It is therefore important to explain to the patient that the intentional arc alone, that he draws in plan and execution, is enough to extend his sensorimotor space again and to re-establish his anticipation towards the future.

4) From this follows the principle of “optimal resynchronisation”: the patient should experience a degree of activation and stimulation appropriate to his present state, so that the idle time is filled again, without however causing a relapse into uncoupled time by forced rehabilitation. The image of a gear-change suggests itself here, where different levels of synchronisation are chosen according to the present speed.

5) After the remission of acute depression, it becomes important to further the psychological and social resynchronisations whose failure

has contributed to the onset of illness, above all, processes of grief and role change.

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

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

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