Reopening Selves: Phenomenological Considerations on Psychiatric Spaces and the Therapeutic Stance

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Abstract
Classical and contemporary phenomenological approaches in psychiatry describe schizophrenia as a disorder of common sense and self-affection. Although taking into account intersubjectivity, this conceptualization still puts forward an individualistic view of the disorder, that is, the intersubjective deficit resides within the person. To overcome such individualism, in this article, we first propose that schizophrenic experience might be understood as arising from a dialectic relation between the self’s loss of openness to the world and the world’s loss of openness to the self. To show the relevance of social factors at the onset of schizophrenic experience, we propose a phenomenological analysis of trigger situations. In the second and main part of this article, we then focus on the implications of these phenomenological insights for the clinical practice: we argue that if schizophrenia is understood as a loss of openness between self and social world, psychiatric institutions should be transformed into spaces that enable a reopening of selves. We first describe enclosing phenomena such as coercive treatment to then, in contrast, present particular forms of open psychiatric spaces such as open door approaches and open dialogue. Besides the institutional-structural level, we also highlight aspects of openness at the intersubjective level of the individual agents, thus particularly emphasizing the role of an open therapeutic stance. We thus speak of (re)opening selves as we believe that the reopening of the patients’ self cannot but be related to and fostered by a reopening of the professionals’ self and stance. We thus argue that openness in the therapeutic stance is key to initiating the further process of recovery, which we describe as a readjustment of selves both at the bodily and narrative level. Last but not least, we sketch out possibilities for future phenomenological research on the question of psychiatric space and draw some broader societal implications.

Introduction
One of the main phenomenological concepts of schizophrenia is that of a loss of common sense, that is, the capacity to play the game of everyday social interactions and to pragmatically access the world. This “loss of natural self-evidence” has especially been the focus of Blankenburg [1] together with his patient Anne Rau. Blankenburg [1] shows that this loss does not only refer to the level of

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intentional common sense thinking but also to the intercorporeal dimension of embodied and intuitive interaction of everyday life. The affected persons seem to have difficulties to spontaneously read between the lines of what others say and express [2]. This disturbance of intersubjectivity as described by Blankenburg [1] as well as by other classical phenomenological psychopathologists has been recently described and outlined in detail in the phenomenological interview EAWE (Exploration of Anomalous World Experience) [3]. Even if it has been explored in its own right, this intersubjective dimension has also been shown to be tightly related to a disturbance within the self. Indeed, Sass [4] points out that disturbances in these practical and everyday life processes are rooted in an even deeper disturbance of self-affection, that is, the basic, pre-intentional, and vital sense of self of the subject. Self-affection designates the fact that under normal conditions our experience is always accompanied by a feeling of “mineness”: it is us making an experience, having feelings, or acting on the world. Accordingly, it is this very feeling of mineness that seems diminished in schizophrenia spectrum disorders [5] disabling the constitution of everydayness and common sense interaction with the world. A thorough phenomenological description of the disorder of the minimal self can be found in the phenomenological interview EASE (Examination of Anomalous Self Experience) [6]. Even if these recent phenomenological accounts (EASE and EAWE) have paralleled disturbed self-affection with an analysis of a disturbed world experience and intersubjectivity [3, 7] and have thereby acknowledged the relation between the subjective and intersubjective dimension, they still assume the primacy of an individual disorder.

This conceptualization of schizophrenia entails the risk of reducing it to an essence or structure residing within the individual, that is, to a mere diminishment of the minimal self and of bracketing social factors relevant to the understanding of the emergence of schizophrenic experience (see [8, 9]). Such tendency towards individualism might also lead to conceive of treatment as being ultimately mainly pharmacological and might thus lessen the importance of psycho- and sociotherapeutic approaches.

In contrast, in this article, we underline the centrality of the intersubjective and social dimension in the emergence of schizophrenic experience and thus also for its treatment. Of course, there have been and there are several psychotherapeutic and psychiatric approaches and theories that have emphasized the importance of intersubjective factors in the etiopathogenesis and treatment of schizophrenia (see [10–13]). Yet, when it comes to the phenomenology of schizophrenia, an individualist perspective is still predominant. The main purpose of this article is therefore to pave new ways of phenomenologically thinking the social dimension of schizophrenic experience, both in diagnostic and therapeutic terms.

More specifically, in this article, we claim that modifications of self-experience in terms of openness and closedness are – in Husserlian terms – always “noetic-noe- matically correlated” with an open or closed (social) world. We thus explore the dynamics of opening and closing up between self and (social) world with regard to schizophrenic experience.

Openness-closure is only one of the many dimensions that characterize our experience such as proximity and distance, activity and passivity, and attachment or detachment. However, we believe the concept of openness to be of special interest and importance, especially in relation to the aforementioned notion of self-affection, which is central for the understanding of schizophrenia. The minimal self (or mineness of experience) necessarily needs to be open and to be affected by the world and by others, in order to actually feel itself in the world, in interaction, and finally in order to intentionally and commonsensically project itself into the world. This idea is echoed both in classical approaches to schizophrenia by Boss [14] and in more recent ones such as in Kyselo’s [15] theory of the social self or Van Duppen’s [16] notion of “open intersubjectivity.” Most of all, the idea of openness is expressed in the concept of receptivity (transpassibilité) by the philosopher and phenomenologist Maldiney [17, 18]. Maldiney fervently asserts that a self can only exist in “sympathetic communication” with the world and with unexpected alterity [17, 19]. Accordingly, openness and closedness are for Maldiney relational terms that always refer to the in-between of self and world. This open sympathetic communication consists in bodily sensing, which for Maldiney is always a form of movement. We can discover the world only through our own bodily movement: by sensing the world we move towards it, get in contact with it, and are at the same time moved by it [18]. Openness is thus the condition for us to move and to be moved by the world. In contrast, schizophrenia is for Maldiney the result of the world having lost its openness, leaving no more room to move or to move on. At the same time, the self closes up, seals off from the world, and gets enclosed in a delusional system where everything is already said and known, without surprises. Drawing on Maldiney’s theory, we suggest that at the onset of schizophrenic experience, the person experiences a loss of openness to the
world and of the world: We thus argue that it is primarily the structure of the self-world relation – and not necessarily of the self, which seems to be disturbed in schizophrenia. Following this logic, the essence of mental disorders cannot be reduced to individuals but resides in the dynamic interplay between the self and its social context.

In this article, we explore the dynamics of openness and closure in the relation between self and (social) world in the case of schizophrenic experience. The article is structured into 2 main sections:

1. In the first part, we focus on and describe trigger situations at the onset of psychosis – such as events with traumatic character and the experience of migration and of social exclusion – as paradigmatic examples for the tight intertwine ment of self and social world in the phenomenological alterations of schizophrenia. In these examples, the schizophrenic experience seems to be structurally constituted by a closed world having lost its habitability. It is important to specify that, keeping with a phenomenological methodology, our approach is not explanatory but descriptive, which means that our analysis remains focused on the experiential level of the subject, without trying to construe causal mechanisms outside of the realm of experience. In other words, our aim is not to explain how schizophrenia is caused by the social world outside of subjective experience but to understand how it is constituted, that is, experienced by someone (i.e. a self) in interaction with that world. This is also why in this article we prefer to speak of schizophrenic experience than of schizophrenia itself.

2. In the second part, we thus claim that, as a consequence, psychiatry needs to critically reflect upon the openness or closedness of institutional settings and its effects on patients. We first present closed wards, stigma, and coercion as phenomena characterizing what we may call a “closing psychiatry.” Such phenomena may have detrimental consequences for persons with schizophrenia and reinforce their sealing-off from the social world. We then focus on therapeutic settings such as open-ward concepts, home treatment, open dialogue, and psychosis seminars. We claim that these “opening approaches” may enable an opening of the patients’ self. Such reopening is consequently described as an institutionally mediated and shared process. We finally reflect on how the issue of openness not only applies to patients and institutions but also to professionals and their therapeutic stance. We highlight how openness in the professional’s stance can also support a reopening of experience on the patient’s side. The dynamics of “reopening”, we argue, thus not only apply to patients but also to professionals, which is why we talk of a reopening of plural selves. Finally, we acknowledge that the reopening of selves only as the first step towards recovery from schizophrenia: Once a reopening of selves has taken place, new, flexible, and need-adapted forms of interaction can be established, allowing for a rebalancing of openness and closedness, proximity and distance, and attachment and demarcation. We thus briefly propose more general considerations on the psychotherapeutic process in schizophrenia therapy.

Self and World in Schizophrenia: A Phenomenological Analysis of Trigger Situations

In this section, we present some examples of trigger situations at the beginning of schizophrenic experience from the classical phenomenological-psychiatric literature. We hereby especially focus and explore the experience of gazes as dense expressions of a threatening intersubjectivity, gazes that – we suggest, drawing on Maldey’s theory – lead to a loss of the world’s openness, leaving no room for the self to move, that is, to respond and to remain open to the world. First, this analysis aims at delivering an example for how the social world and the self co-constitute each other in the onset of schizophrenic experience (i.e., at the phenomenological level). We then also relate these phenomenological reflections to empirical research on environmental phenomena such as trauma or migration, thus stressing the importance of integrating phenomenological and social empirical findings on schizophrenia.

As a first example of trigger situations, we take Binswanger’s [20] case study on Suzanne Urban. Here, Urban describes a crucial moment that occurred at the beginning of her schizophrenic episode: She was sitting in a doctor’s room, witnessing the doctor’s examination of her husband, who suffered from cancer [20]. Urban was very dependent on her husband. In that moment, the doctor gave her a look of dread, which expressed the bad result of the examination and implied the possibility that her husband would die. This look had a profound effect on her, affecting her most intimate self and its fundamental sympathetic communication with the world. The entire scene seems suddenly filled with a threatening and uncanny atmosphere, leaving no space for her to move or escape. In face of this threatening “absolute proximity without distance” [21] of the doctor’s look implying the
bad result of the examination, Urban experiences the paradoxicality of common sense responses, which would typically involve “pulling herself together” in the public context of the doctor’s room [21]. On the contrary, she wants to scream, but the doctor’s gaze also implies that she should not, for the sake of her husband. Hence, the only possible way for her to react to this extraordinary event, screaming, is precisely what the situation does not allow. As a consequence, the overwhelming event of her husband’s possible death leads to a closure of Urban’s receptive openness to any other event, which for Maldiney is the essential aspect of schizophrenia. Maldiney comments: “A scream launched into the world would have led to loss of room to move and to an experiential ‘atmospherization’ of the world that sets in following such a terrifying event, such as in Suzanne Urban’s case, can be understood as a typical “delusional mood” within the development of a delusion [20, 23].

Kuhn [22] offers another example for the profound experience of another person’s gaze or facial expression in the context of the onset of schizophrenic experience. A young woman was having breakfast with her family when suddenly a gunshot – of her brother taking his own life – reverberated from the first floor. In hindsight, the woman identified as trigger moment for her madness not the sight of her brother covered in blood but the speechless expression of her father’s face sitting at the dining table at the moment of the shooting. The uncanny “atmospherization” of the world that sets in following such a terrifying event, such as in Suzanne Urban’s case, can be understood as a typical “delusional mood” within the development of a delusion [20, 23].

One might argue that these examples have a traumatic character. Indeed, the essence of traumatic experience may be understood in the sense of freezing (impossibility of moving) or impossibility of expression in response to a threatening situation [24]. Of course, the traumatogenic effect of specific events is highly relative and depends on the biography and the social context of the person, which plays a decisive role in whether an event leads to such experiential “freezing”. For instance, although a cancer diagnosis is not per se a traumatic experience, but in Urban’s case, who felt especially dependent on her husband, this was an event that put her entire life at stake [20]. Interestingly, the role of trauma, especially childhood trauma, has also recently received a lot of attention with regard to a psychosocial origin of schizophrenia [25, 26]. Yet, we here do not want to make the case for a direct causal nexus but instead only show that in such traumatic situations, which seem to be typical at the onset of schizophrenic experience, the intertwinement of and co-constitution between a threatening and closing up world and the closing up of self-experience become evident.

Examples of trigger situations, that is, situations associated with the onset of schizophrenic experience, are not only limited to single events. For instance, Kisker [27] pointed out that only seldom the development of schizophrenic experience was associated to a single traumatic event, but it was rather related to “critical permanent circumstances”. In this regard, current studies on the increased risk of schizophrenia among migrants and especially among refugees are a significant example of critical permanent circumstances from a social space perspective [28, 29]. Das-Munshi et al. [30] show that the occurrence of psychotic experiences, such as hearing voices or persecutory delusions, can be directly correlated with the extent of discrimination and racism as well as various “chronic strains” (such as financial or housing problems). The authors’ research refers to a specific neighbourhood where those affected with schizophrenia live with low “own-group density” (i.e., as a minority group). In phenomenological terms, one could suppose that members of a minority group do not share the common sense of a majority group, which may result in a constant interactional crisis due to the lack of a shared “natural evidence”. Also, these more chronic and permanent trigger situations are to be found in classical phenomenological descriptions. The German phenomenological psychiatrist Kulenkampff [31], for instance, reports the case of a patient who escaped in 1950/51 from the Sudetenland to Frankfurt, and who then, in her new social environment and in the changed “order of inhabiting” (“Wohnordnung”), started suffering from schizophrenia. Later, Kulenkampff [32] described from a phenomenological-anthropological perspective the “sociological phenomenon of isolation” as a “fading of communicative connectedness” and he particularly emphasized relocations – which imply a loss of “order of inhabiting” and “social rank(s)” – as triggering factors for the development of schizophrenic experience [32]. Both in these classical studies and in current empirical research, these seem to be permanent crises of the social world, that is, again, they represent a closedness of the (social) environment, which leads to loss of room to move and to an experiential
“freezing”. The relevance and impact of migration and more generally of the social status and of “social defeat” [33] for the possible onset of schizophrenic experience underlines the necessity to include in the phenomenological analysis the entire social landscape inhabited by a person in order to understand the vulnerability and susceptibility to schizophrenic experience (see [34]). It also speaks for the importance of an integration between the phenomenological method and other empirical methods, which might better capture such social factors (see [35–37]). Essential to this methodological integration would be to describe how such social and environmental factors concretely constitute the lived world before and during the emergence of schizophrenic experiences.

If we now bring together all the examples of trigger situations we gave with regard to trauma and migration, we can observe that they are all characterized by a “loss of openness”. They are also all linked to a self that, as a reaction, withdrew from or sealed itself off from the social world, with delusional and seemingly incomprehensible convictions, which might be understood as a “the defensive counter-manifestation” towards a world that had become uninhabitable [21], without “communication, because there is no room to move” [21]. One thus might speak of the self’s reactive freezing and closing up or loss of openness in relation to a world that has become terrifying, such as the doctor’s look in the examination room for Suzanne Urban, or segregating, such as certain majority groups or urban districts for members of a minority group, that is, a world that does not leave any more room to move. As anticipated at the beginning of this section, we thus suggest that such rigid closing or loss of openness of the self is correlated with a loss of openness of its very world and that schizophrenic experience might be therefore characterized by a collapse of openness between self and world. Importantly, the others’ gaze seems to play an essential role in this collapse of openness. As mentioned before, Maldiney [21] describes the doctor’s look as imposing itself on Suzanne Urban “in an absolute proximity, like that of a face glimpsed in the night, glued to the window, erasing the entire space of the room – and whose distance-less expression is upon us.” The same goes for Kuhn’s patient Anne Rau, who describes her experience of others’ gazes as an unbearable torture [1]1. Phenomena of segregation exerted by majority groups on minority groups such as racism could also be conceived in terms of a phenomenology of the gaze. One of the best examples here would be Fanon’s [38] phenomenological analysis of the racializing and objectifying gaze: The author reports being stared at by a child, who commented “Tiens, un nègre!” (“Look, a Negro!”). Fanon [38] then continues to describe how this racializing gaze nailed him down to the fixed essence of an inferior being, which consequently inscribes itself into his body schema, structuring his being-in-the-world as constantly excluded and alienated from the social world around him.

To conclude, in all the above-mentioned examples of trigger situations, it becomes particularly evident how schizophrenic experience is socially constituted. Referring to Conrad [39], who describes delusional mood as a “questioning of one’s own existence”, we thus suggest that this very experience may be indeed rooted in social situations that challenge one’s own existence. At the onset of psychosis, the world seems to have lost its receptivity and habitability, that is, the open space for a self to move or even to be. One could thus conclude that, as a therapeutic consequence, the communication and the world’s openness, that is, its room to move and room to exist, need to be restored. This is what we will grapple with in the following section.

Closing and Opening Psychiatric Institutions

In this section, we argue that if schizophrenia is understood as a loss of openness between the self and the social world, psychiatric institutions should be transformed into spaces that enable a reopening of the self. We first describe particular forms of closed psychiatric spaces and practices such as closed wards, diagnostic labelling (with the associated phenomenon of stigma), and coercive treatment, which we will then contrast with open spaces and forms of treatment such as open door approaches, home treatment, open dialogue, and psychosis seminars. By analogy with the loss of openness between self and social world, such reopening also turns out to be a mediated process involving not only the patient’s self but also the institutional context and therapist’s self – that is why we speak of a reciprocal process of reopening selves. In order to better understand this process, we thus also need to focus on the openness in the therapeutic stance. We finally also suggest that such reopening is what in principle also allows and enables the psychotherapeutic process of reattunement between selves.

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1 It is important to note that Blankenburg [1] recommended to make an “anamnesis of gaze experience” (“Blick-Anamnese”) when diagnosing persons with schizophrenia.
Closing Psychiatry: Closed Wards, Stigma, and Coercion

When speaking of psychiatric treatment and psychiatric institutions (as the space and frame of therapeutic practice), it first must be noted that psychiatry itself often has a tendency to in fact enclose people, and it does so both on the experiential and physical level. This tendency comes to the fore especially in phenomena such as closed wards, diagnostic labelling (with related stigma), and coercive treatment.

In his seminal study from 1961, Goffman [40] analysed psychiatric institutions as “total institutions”, in which reciprocal social interaction was reduced to submission of patients to a given institutional law and order. In this institution, people are assigned the role of patients and they get enclosed within this role, that is, everything they say or do is interpreted as part and partial of their status of patient and of mentally ill. Goffman [40] termed this process of the total psychiatric institution as “looping”, whereby he means an interactional pattern by which, if, for instance, a patient would resist psychiatric treatment – or to the contrary would abide to it in a very dedicated manner, this would be considered as just another proof for his mental illness [40].

Nowadays, it may seem obvious to consider such criticism of psychiatry as being rather historical and outdated, since psychiatry (in central Europe) has generally been transformed from remote, almost prison-like institutions into smaller treatment centres, closer to the patient’s home with much shorter stays and a wide range of psycho- and sociotherapeutic services. Yet, this might not be entirely true; besides a recent increase in large institutions, especially in the geriatric and forensic sectors [41, 42], the above-mentioned looping interactional pattern is what most of all seems to still be present – and observable on a day-to-day basis – in current psychiatric practice. Indeed, service users still report that their behaviour – which they consider to be appropriate to the circumstances – is regarded only as a symptom and confirmation of their illness by those around them, both within psychiatry and outside it [43, 44]. Despite all psychiatric progress, at the micro-social level, looping patterns and social exclusion still seem to happen.

Another form of socially excluding patients’ altered experience is certainly the label and stigma of chronicity, which is often (although not intentionally) produced by professionals (see [45, 46]). To clarify this point, we present an example from our clinical practice. A person diagnosed with schizophrenia, who we here call O., reported that he was once told by one of our colleagues: “I’m afraid you won’t make it without life-long medication”. Despite hearing voices from time to time, O. has lived without medication for the last few years and he told us about the very violent impact this professional assessment had on him. Even if expressed with good intentions by our colleague, this assessment felt to him like an omen haunting him for the rest of his life: Would it turn out to be right if, by not taking medication, he somehow ended up “failing” in his life? What would “not making it” mean? As professionals, this makes us wonder, if such medical verdicts tend to enclose people’s experiences in pre-defined categories. Just like in the case of racism, as analysed above by Fanon [38], we could find analogous situations experienced by patients in clinical encounters, for instance, when being hospitalized and being labelled as “just another chronic schizophrenic (or addict or anorectic, etc.).” Diagnostic categories here seem to have a strong stigmatizing effect, thus leaving the labelled person no room to move. This lack of room and impossibility to move becomes especially evident in that O. emphasized how this medical verdict had been for him no less violent than the coercive treatment he had undergone in psychiatric clinics in acute phases of his psychosis.

Future phenomenological investigations could help further understand how a (chronic) psychiatric diagnosis might inscribe itself into the person’s experience and enclose – and thus limit and hinder – a person’s sense of self (see [47]). Despite the lack of consideration for this issue so far, we believe that phenomenological psychopathology cannot do without an analysis of such experience of diagnosis (and diagnostic labelling), which is indeed an inextricable component of the very experience of mental disorders. For instance, could not the phenomenological diminishment of self described in schizophrenia also (or at least in part) be related to the diminished and stigmatizing experience of self given by this very diagnosis?

Not only psychiatric diagnoses but also coercive treatment has a profound and constitutive effect on patients’ (self-)experience. Indeed, the potential traumatizing effect of coercive treatment is nowadays widely recognized [48, 49]. Also here, a phenomenological approach could help better understand the lived experience of compulsory treatment in its different forms (such as involuntary medication or mechanical restraint) and its possible effects. Such a phenomenology of psychiatric coercion should, of course, at least be user-involved if not user-controlled (see [50, 51]). This phenomenological analysis would have to take into consideration the atmosphere and the implicit and explicit rules in a closed nursing home or psychiatric ward. Furthermore, it would also...
have to analyse the intersubjective production (and constitution) of that common sense, on the basis of which professionals (i.e., psychiatrists, judges, and nursing staff) and family members reach the judgement that a certain point there is "no more room" for certain behaviours of the patient and thus these must be limited or prevented by coercive measures. We do not hereby refer to the legal grounds of coercive treatment but rather to what intersubjectively precedes such regulations: for example, to the self-evidence in the decision of admitting a patient in a closed ward ("she is too acute, she must go to a closed ward now!") or to the self-evidence with which a professional would, after certain events, judge as necessary the restraining of a person in her room. In the latter case, the phenomenological closing up of a space becomes especially evident: in the restraining moment, the room suddenly becomes a space separated from the rest of the ward, the door is closed, fellow patients have no access, and a strict and serious silence prevails while a sedative is injected. This mechanical and medical restraint in a way replaces the reciprocal human relation, that is, an inescapable closedness replaces the openness of the world.

Based on these tentative phenomenological remarks on closed wards, diagnostic labelling and coercive treatment we suggest that all these phenomena share the general structure or eidos of a closing up of psychiatric space, leaving no room to move for patients, be in their self-experience and self-understanding (as in terms of an internalized stigma) or even their experienced (and physical) mobility (as in mechanical, physical, or social restraint). This structure becomes especially problematic for persons with schizophrenia whose self might be particularly at stake of losing its openness to the world.

Opening Institutions and Reopening Selves

In our phenomenological description of trigger situations, we have attempted to show how the phenomenological constitution of schizophrenic experience might be characterized by a closing up of the space between self and world. If this holds true, it seems obvious that a psychiatric space that emphasizes and enacts closedness cannot be but a detrimental one. On the contrary, a therapeutic aim should be to support a reopening of the patient’s self by providing a secure, shared, and open therapeutic space. In what follows, we address this issue by exploring some examples of what we consider to be open psychiatric spaces and forms of treatment.

The opening up of psychiatric hospitals has been, as it is generally known, intensely debated in the context of critical psychiatry in the 1960s and 1970s.Franca Basaglia and Franco Basaglia [52] pointed out that the “open institution” is led by the goal of “preserving the subjectivity of the sick person, even at the expense of the general efficiency of the organisation” and that it thus presents itself to the patient as “an open world, that offers more than one alternative and depicts the patient’s life as worth living”. The Basaglias emphasize above all the importance of the open ward door and thus the possibility for patients to leave the clinic at their own discretion: “The door becomes a symbol; the patient suddenly recognises and understands himself as ‘not dangerous to himself and others’” [52]. This might give the patient the feeling to “still exist, and namely in an institution that constantly sets out to re-create the conditions for her existence” [52]. The word “existing” could be interpreted in the emphatic sense of "standing outside (Latin: exsisto) oneself" or “standing open” [53], that is, as an opening of the self by means of an open/opening institution.

Today, the question of the benefits and risks of open and closed wards is still a central research topic in psychiatry. Lang et al. [54], for instance, focus especially on the atmospheric and relational aspects that are generated by open or closed ward doors. An open ward has a considerable influence on “the atmosphere in the ward, the way contact is established, the relationship of trust and the attractiveness of the treatment. The security of the closed door is replaced, so to speak, by the safety of the successful relationship”, as the treatment team has to make more effort to build a relationship with the patient [54]. Such a relationship therefore crucially depends on the therapeutic stance of the professionals (see below) and their readiness to engage with the patient again and again in new and unexpected ways.

Such an opening up of psychiatric institutions not only includes structural changes within the hospital (e.g., open doors), but in some cases, also a movement beyond it. Home treatment is an example of a therapeutic approach, where psychiatric treatment is taken to the patients’ homes and is thus provided in a flexible and mobile fashion. Interestingly, in this approach, the openness of professionals is also rendered possible by the openness of patients, both in a literal and symbolic sense; in home treatment, the professionals’ possibility to actually show up and be in contact with the patient depends on her willingness to literally open the door of her apartment. The patient thus becomes the host and decides on the admission and limits of the visit. This thus also means an overturn of agency and power, whereby the patient is in her own familiar space, which she defines and shapes, and professionals have to adapt and move in it. Yet, in the case of
severe psychotic crises, where the boundaries of the self are threatened in a terrifying way, the risk is that a psychiatric visit might be experienced as a violating assault or invasion. That is why it is of vital importance that professionals assume a respectful stance, one that leaves patients their “room to move” and that does not rigidly impose the psychiatric rules and treatment indication into their space. This can mean, for example, to conduct a therapeutic consultation via entry phone, thus respecting the need of distance of the person. This respectful stance is thus aimed at enabling the other person to have a “home game”, as Bock [55] puts it, thereby he refers to a situation where the patients themselves can determine the openness but also the boundaries of their inhabited space.

A similar approach, which also takes place both within and beyond the hospital walls, is the open dialogue approach, developed in Finland by Seikkula and colleagues [56] and Seikkula et al. [57]. Open dialogue consists in a radical restructuring of the whole psychiatric system, which also implies a decentering of treatment, flexibly administered at patients’ home or wherever they wish to be. It is based on regular joint meeting (so-called network meetings) with the patient, her family, and any other relevant persons from her network, as well as the professionals. These meetings are characterized by dialogical relations, whereby the focus is not on any pre-defined intervention but simply on putting and expressing one’s own experience into words – and thus on the inclusion and mutual understanding of different narratives and voices (polyphony). This opening up and sharing of experience in dialogue is especially important, given that often the patients and the other persons involved have been closing up and keeping their sufferance for themselves for a long time.

A similar example is psychosis seminars [58] developed by Dorothea Buck and Thomas Bock in Germany. In analogy to open dialogue, they are a paradigmatic example of a collaborative opening up of the interactional and therapeutic space. These seminars are meetings, open to the general public, that are organized “trialogically”, which means that they take place with an equal involvement of three stakeholder groups: people with psychosis, relatives, and professionals. The place of the meeting is usually neither within the psychiatric hospital nor at the private homes of patients but in public and neutral spaces such as communal halls. Again, similarly to open dialogue, central to this approach is that the participants can express and talk about their subjective experiences in a non-judgemental and respectful way and listen to each other. A specific medical-therapeutic goal is not pursued [58]. According to a study by von Peter et al. [59], persons with psychosis who participate in psychosis seminars especially value the “atmosphere (…) of ‘mutual acceptance and tolerance.’” This atmosphere makes it possible for the patients – but also for their relatives and for the professionals – to express their own, different, and even unusual experiences, to which they would perhaps find difficult to open up to on their own. The open and receptive presence of fellow human beings, who can both hear and respond to the in other contexts often “unheard” experiences of the narrators, thus hereby plays a decisive role.

In contrast to the previous section, where we looked at from a therapeutic perspective rather detrimental forms of psychiatric institutions, we now presented institutional approaches that we believe to be exemplary for fostering a reopening of selves. The institution thus has a deep impact on the process of reopening of the self. Still, in order to fully understand this process, we need to not only reflect on the influence of psychiatric institutions but to also take the openness of professionals into account. Indeed, as in the experience of schizophrenia, where the closing up characterized the relation between self and social world, the reopening process is also to be conceived in relational terms. It is in this sense a shared process, which involves the reopening of plural selves. In the following section, we thus focus more specifically on openness in the stance of professionals, and we thereby draw final reflections on the psychotherapeutic process. We conceive of it as a process of interpersonal reattunement, which might be enabled and supported by such open therapeutic stance.

**Therapeutic Stance and Therapeutic Process – The Reattunement of Selves**

To support the reopening of an enclosed self, therapists themselves need to be open, thereby enabling openness as a shared and plural process. This became, for instance, obvious when we introduced open ward concepts, in which the therapeutic relationship had to replace a closed ward door.

In order to qualify and grasp openness in the therapeutic relationship, we first need to understand how openness is lived, expressed, and enacted by the therapist through her stance. Kurbacher [60] defines stance (German: Haltung) as a holistic and interpersonal expression of a person. It refers to our practical engagement in the world, which is at the same time emotional, bodily, and cognitive [61]. A therapeutic stance characterized by openness thus means that the therapist is open to her patients on both an emotional-bodily and cognitive level,
willing and ready to receive her bodily expressions and her narratives of suffering. An open therapeutic stance might then initiate a fundamental opening of the patients, not only in terms of a single person and their relation to the environment but also and especially for the case of open dialogue [62] of the entire interactional family system or social network, which might have been previously blocked or paralysed by the onset of psychosis or a traumatic experience (see above).

The reopening of selves, which is fostered and supported by a stance of openness, should be conceived only as a first step in the very complex process of therapy and recovery. Recovery is indeed not only about openness but boundaries and even distance may, for instance, also play an important role. Yet, we believe that openness has the special and important function to allow an interpersonal engagement between persons in the first place. The immediate consequence of opening up is the possibility to engage in what we may call a process of dialogical reattunement of selves, which allows for and includes both connection and separation, togetherness and boundaries. In order to briefly sketch out what we mean by dialogical reattunement, we will now finally focus on the psychotherapeutic process. Irrespective of the psychotherapeutic approach, from a phenomenological-experiential point of view, one might always distinguish between a pre-reflective bodily and a more reflective narrative dimension in the process of therapy, in which the reattunement of selves happens.

The pre-reflective bodily dimension can best be grasped through the concept of intercorporeality – a concept especially central to body-oriented psychotherapy [63]: in the therapeutic relation, the lived bodies of patients and therapists form a dynamic gestaltkreis, that is, a circle of reciprocal pre-reflective experiences, nonverbal expressions, and bodily reactions. In this circular process, openness and closedness and proximity and distance but also activity and passivity of interaction and the respective regulation of boundaries are constantly and intuitively negotiated and rebalanced. If this process is successful, it may finally allow for the patient to gradually re-acquire confidence and familiarity not only with others but also with herself. Indeed, such intercorporeal processes and negotiations in the therapeutic encounter have been shown to lead to an increased bodily interpersonal attunement with others and to support the recovery of a pre-reflective and bodily sense of self [64].

Similarly, the opening up of a narrative space between persons allows for biographical reflections and stories of personal suffering to be told. The reattunement of selves is here thus understood as a moving on of self-narrations and an exchange of perspectives [62]. Lysaker and Lysaker [65] and Lysaker et al. [66] have emphasized the importance of fostering and engaging in narrative dialogical processes for supporting the process of recovery from schizophrenia. They characterize schizophrenia as a collapse of the narrative self, which is also viewed as being tightly related to a collapse of dialogical possibilities and interpersonal engagement [67]. Allowing and encouraging the polyphony of voices in the therapeutic encounter allows not only for a reattunement of narratives between the persons involved but also between different inner voices and narratives, thus also supporting the recovery of narrative coherence within the self. Finally, from a psychodynamic point of view, the power of narration with regard to the threatening experience of a closing world lies in the capacity to put into words this experience. By giving words to unutterable experiences, these experiences are contained and regulated by language and thus lose their frightening immediacy [68]. At the same time, this allows for a reconnection of the narrative self to the social world, the moment in which such words are heard and understood by others.

As we have outlined so far, in the psychotherapeutic relationship and process, both at the intercorporeal and narrative level, a re-encountering, re-negotiation, and re-attunement of selves take place. Yet, in order for this to happen, the first step is a reopening of the intersubjective space. We thus believe that openness in the therapeutic stance plays a crucial role in enabling the very therapeutic encounter and – in the case of schizophrenia – in overcoming the rigidity, closedness and immobility of schizophrenic experience.

We would like to give a final example for the importance of openness in the therapeutic stance by briefly describing an outpatient recovery group for persons with schizophrenia that we offer at our clinic. The therapy sessions share the typical group therapy framework such as pre-defined time, place, duration, a procedure with mindfulness exercises at the beginning, and a shared negotiation and decision on the topics to be discussed. Yet, the characteristic aspect of this therapeutic offer is that – inspired by, for example, open dialogue and similar approaches – it is not based on any therapeutic concept or intervention but it essentially consists in practicing openness in the therapeutic stance. This means that in contrast to other group therapies, patients and therapists of the recovery group meet as rather equal (although different) participants and the sessions are structured in a much more participative way. On the one hand, we as therapists

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intentionally disclose ourselves in a therapeutically acceptable way to the group. Thereby, we try to invite the participants to open up themselves on the bodily and narrative levels and to establish a relation of trust and authenticity. On the other hand, we hold back and regulate as little as possible, thus letting the group of participants create their open space to move and to express themselves. This expressive space then allows for everyone, even sometimes for us as therapists, to rebalance one’s individual need for openness and closedness, proximity and distance, listening and responding, and so on, and to partially reclaim one’s place in the world [67]. This positive effect became also visible in the fact that many of the participants underwent fewer hospitalizations since they took part in the recovery group.

**Conclusion**

In this article, we drew on the idea of openness of selfhood (mainly referring to Maldiney) and showed how an open or closed self might be related to an open or closed world. This became particularly evident in trigger situations such as terrifying experiences of others’ gazes, where a sudden closing up of the patient’s experience is concurrent with a closing up of her world. Based on these considerations, we claimed that therapy should aim at enabling a reopening of the patient’s self, which might in turn – so we argue – be supported by respective opening spaces. In the second and main part of this article, we thus have critically analysed how different institutional spaces might entail aspects of closure or openness, which could hinder or support the reopening of the self. Importantly, we described openness as a necessarily shared process, which is why in the end we deem more adequate to speak of (re)opening selves of both patients and professionals (and other stakeholders involved) and not of a single self of the patient. Indeed, we have emphasized how openness may not only be influenced and supported by an open institutional setting but also by an open therapeutic stance. Last but not least, we argued that the reopening of selves may initiate a dialogical process of recovery, where a readjustment of proximity and distance, togetherness and boundaries, and thus a reattunement of selves can take place, both on the bodily and the narrative level.

To conclude, we believe that for a better phenomenological understanding of the openness or closedness of psychiatric spaces, further research is necessary. One possible research path could be to develop a phenomenological tool for the exploration of the psychiatric space, similar to the already existing semi-structured interviews EASE and EAWE [3, 6]. While EASE focuses on self-experience, EAWE tries to widen the focus by analysing the self’s world experience. However, EAWE does not take specific therapeutic spaces or worlds into account. What is thus still needed is an *Examination of Psychiatric Space Experience* (EPSE). This examination could combine phenomenological knowledge on space and world experience with empirical measures such as the *Ward Atmosphere Scale* and the collaborative involvement of service users [69]. Another promising and much needed focus of research is on the therapeutic stance of professionals in the different psychiatric spaces and settings, which the authors of this article currently examine in an ongoing qualitative research project [70]. Preliminary results of this study show that one recurring motive of professionals’ therapeutic stance towards persons with psychosis might be the capacity to empathize with psychotic experiences or even to consider them as one’s own existential possibility. Whereas the qualities and effects of such a therapeutic stance of professionals still need to be investigated in more detail, we firmly believe that the relevance of such stance should not be restricted to the mental health and psychotherapy settings but it is also crucial at a broader societal level. Indeed, the loss of dialogical connection to the social world that persons with schizophrenia experience is still and all too often mirrored by society’s loss of dialogue with them.

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