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Angaben zur Veröffentlichung / Publication details:

Lyons, Naomi, Maren M. Michaelsen, Johannes Graser, Karin Bundschuh-Müller, Tobias Esch, and Johannes Michalak. 2021. "Bodily experience in depression: using focusing as a new interview technique." *Psychopathology* 54 (3): 150–58. https://doi.org/10.1159/000514128.

Bodily Experience in Depression: Using Focusing as a New Interview Technique

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Introduction

Depression is a mental disorder that is characterized by depressed mood and diminished interest or pleasure in most activities, as well as several additional physiological and cognitive symptoms (DSM-5 [1]). Even though the body may be affected in depression (i.e., psychomotor agitation or retardation, appetite loss, and decreased or increased sleep), in mainstream psychopathology research, little attention has been directed towards the body's impact on depression. Phenomenological studies, on the contrary, claim that the most prominent symptoms of depression are not depressed mood but a loss of vitality and somatic complaints (i.e., feelings of pain, tension, or numbness [2, 3]). Vitality is here defined as somatic affects that are localized in different body parts and, in depression, come to the fore and are felt painfully [3].

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Note that in Non-Western-collectivist societies, whose members do not feel as separate from each other as do those in Western-individualist societies, depression is considered to be mostly a bodily and interpersonal rather than mood disorder [2].

The Body in Depression

The high prevalence of body symptoms in depression led Fuchs [2, 4–6] to an embodiment thesis of depression. According to this thesis, in healthy individuals, the body is the transparent medium through which the individual perceives and interacts with the world. If the body loses its transparency and becomes opaque, it no longer allows a connection with the outer world but creates resistance in any act of interaction. He calls this process corporealization: the material body coming to the fore of awareness and being present in everyday activities (e.g., "feeling of an armour vest or tire around the chest, lump in the throat, or pressure in the head" [4], p. 99). Therefore, in the experience of corporealization in depression, the individual is partially cut off from the world and left with an exaggerated awareness of his or her own inner world.

So far, little empirical research has been conducted on the bodily experiences of individuals with depression to support assumptions of a corporealization in depression. Studies that qualitatively analyse experiences of depression with interviews rarely focus on the subjective body[1] during the interview itself but occasionally refer to it in the data analysis (e.g., [7, 8]). An exception is a study conducted by Ratcliffe [9]. He assessed an internet survey with open-end questions on the experience of depression with 136 depressed or formerly depressed participants. One question was "How does your body feel when you're depressed?" The vast majority of participants reported at least some physical ailments, like feeling tired, heavy, lethargic, or exhausted. In addition, most participants complained about pain or general aches or the feeling of illness. He concluded from the entire interview (other questions dealt with mood, emotions, social aspects, time perception, etc., when feeling depressed) that depressed individuals experience a changed existential feeling of belonging to a shared world, which is manifested by a changed bodily experience and a changed feeling of being in the world. Even though Ratcliffe accredits an important impact of the depressed experience to the subjective body, the survey question used refers to the associational space of physical symptoms of depression and not to the impact of the pre-reflective, subjective body or the experience of it. As it is the latter that was described as a core characteristic of depression by him and Fuchs (e.g., [2, 4, 6]), the gap of an empirical examination of the subjective body in depression is still to be closed. In order to assess the subjective bodily experience, it might be more important to focus on feelings emerging in the present moment and not focus on the "knowledge" someone has about his or her body in general, as is done by the survey question mentioned above [10].

A tool to translate the pre-reflective body experience "into language as the digital mode of information" ([11], p. 63) is the use of metaphor. In fact, several authors have assessed metaphor use in psychotherapy in depression. McMullen and Conway [12] analysed 471 taped psychodynamic psychotherapy sessions from 21 clients and identified 4 prevalent groups of metaphors: depression as descent (e.g., "I just was down," p. 171; accounting for 90% of all metaphors), as darkness (e.g., "It's really like a black cloud," p. 170), as weight (e.g., "I feel just so so heavy," p. 170), and as a captor (e.g., "I feel trapped," p. 171). Fullagar and O'Brien [13] also found a reported immobilizing effect of being trapped, descent, and loss of control in depression. Metaphor researchers as well as embodiment theorists assume that metaphors arise as a result of the embodied development of language. The idea is that all metaphors contain a sensorimotor representation of relevant bodily states. Therefore, in the metaphor of descent, these researchers would assume that in depression a pre-reflective bodily feeling of descent is present [14–16].

Focusing

With *Focusing* [17, 18], the present study uses a methodological approach to directly assess the pre-reflective body experience of individuals with depression. In the psychotherapeutic method of *Focusing* [17], a person makes contact with his or her implicit[2] knowledge about an external or internal state through an oscillation between the experiencing[3] of the current Felt Sense and possible symbolizations for this Felt Sense. Gendlin coined the term Felt Sense, defining it as all pre-verbal sensing in a specific situation. He assumes that when a congruent symbolization is found for that Felt Sense, a Felt Shift oc-

[1] Subjective body, as opposed to the physical body that is perceived by me or others, is the felt or lived body of an individual. (For more detail on the subjective body, see [6]).

[2] For *Focusing*, Gendlin coins the term "implicit" meaning everything that is pre-reflective, pre-verbal and pre-conceptual.

[3] With the progressive form of the verb experien*cing*, the intended meaning is the quality of a flow of feeling to which one can attend inwardly every moment [10 p. 3]. Gendlin also described experiencing as the "inward sensitivity of the living body" [ibid., p. 27].

curs: that is, the present feeling changes, and the change itself feels harmonious. The guided process of Focusing might be a path to the pre-reflective body experience in depression. Therefore, in the current study, a semi-structured, in-depth interview was developed that used the method of Focusing with the aim to ask participants suffering from major depression about their experiencing related to a depressed episode. The research aims were two-fold. Firstly, we examined whether it is possible to assess the pre-reflective body experience through Focusing, and secondly, we qualitatively aimed to explore the experience of depression in the body and find a model that describes it comprehensibly.

Table 1. Demographic data on the participants ($N = 10$)

Mean age (standard deviation), years	31.4 (9.4)
Gender (female), *n*	6
Family status, *n*	
Single	8
Married	2
Psychotherapy experience, *n*	10
Current psychotherapy, *n*	9
Support group, *n*	1
Body-oriented techniques (multiple options possible), *n*	
Progressive muscle relaxation	3
Yoga/meditation	5
Body therapy	3

Materials and Methods

Participants

A semi-structured, in-depth, face-to-face interview was developed and applied to 10 participants with depression. Demographics of the 10 participants are presented in Table 1. One participant had comorbid social phobia and one mild delusional beliefs. Interviews were held at the psychotherapy outpatient clinic of the university in order to ensure psychotherapeutic support for the patients if needed. Despite the offer to talk to a trained psychotherapist, no participant made use of this opportunity. The inclusion criterion for participants was a previously given primary diagnosis of major depressive disorder. Participants were excluded if they were currently suicidal or had lifetime posttraumatic stress disorder because of the possibly higher vulnerability of the sample, or if they had a current pain or somatoform disorder because of the possibility of altered body sensations through the extensive feelings of pain.

Participants were recruited via Facebook groups and through word of mouth. The diagnosis of major depressive disorder was validated with the German version of the Structured Clinical Interview for DSM-IV, Axis I Disorders (SCID-I [19]), based on the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV [20]). The study was approved by the local ethics committee of the university (application #13/2018) and was conducted in accordance with the Declaration of Helsinki. Participants gave written informed consent after being informed about the risks and their rights.

Procedure

The semi-structured interview was developed in cooperation with a Focusing therapists' instructor (co-author K.B.-M.). In the introduction part of the interview, participants were asked to identify a particularly burdensome situation when being depressed. The rationale behind the instruction was for each participant to get in touch with the individual feeling of depression. Ideally, a situation was selected that happened recently; however, one participant was not able to identify a specific situation and therefore chose a typical situation ("lack of drive" Mrs. A.). The identified situation was then described in detail. Afterwards, as part of the Focusing process, a relaxation exercise (i.e., body scan) was administered in order to facilitate a mindful contact with unconditional positive regard with the subjective body, followed by the instructions to "clear the space" [17], that is, let go of thoughts and burdens that are troubling the person during the interview but are not related to the selected situation. In the next step of the Focusing procedure, participants were guided to build a Felt Sense towards the previously selected situation: they were asked to pay attention to their body and the bodily feelings that arose when recollecting the situation. These feelings constitute the Felt Sense. Then, participants tried to get a better understanding of the Felt Sense through testing symbolizations with the aim of experiencing a feeling of congruence with the Felt Sense. Symbolizations could be words, images, gestures, meanings, and others. The interviewer guided the participant through this process by asking questions like "Where exactly do you feel the [word used by the participant] in the body?," "What does it feel like in your body/chest/head/arms, etc.?," and "Is there a word/picture/colour/gesture to describe it even further?"

Analysis

Data were transcribed in part (without the standardized introductory and relaxation exercise) according to transcription guidelines by Dresing and Pehl [21].

Depth of Experiencing Rating

In order to assess the intensity of actual experiencing, the Experiencing Scale (EXP) was applied [22]. The EXP, originally created to measure the emotional involvement in psychotherapy, was chosen here because it follows Gendlin's [17] idea of experiencing one's feelings when being in contact with the Felt Sense. Its aim is to assess whether an exploration of feelings in that moment, as we aimed for in the present study, actually occurred. In the EXP, segments of an interview are rated in stages from 1 to 7. Stages 1–3 indicate an increasing connection to emotional content starting with an impersonal description of events (stage 1), followed by an explicit association between speaker and content without personal involvement (stage 2) and then limited comments on private feelings or experiences (stage 3). At stage 4, a direct exploration of feelings and experiencing occurs. In stages 5–7, an identification and exploration of problems and solutions occurs while also considering feelings and emotions that are sensed in the moment. Stage 5 contains 2 components: defining a problem in terms of a personal feeling and exploration of it in a personal way. Higher stages add readily accessible feelings and experiencing in order to produce a personally meaningful structure (stage 6) and new insights advancing this structure (stage 7). In accordance with the

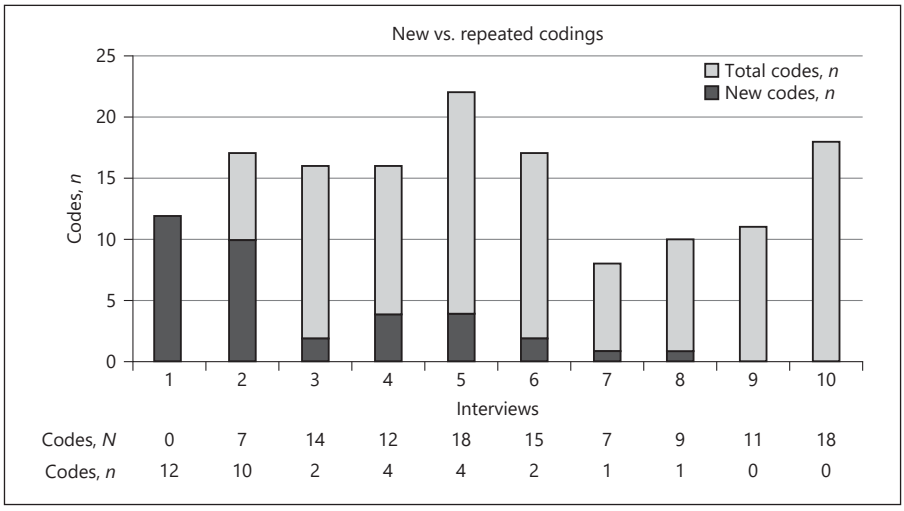

Fig. 1. Code saturation. Presented are the number of codes total and the number of new codes for the 10 participants.

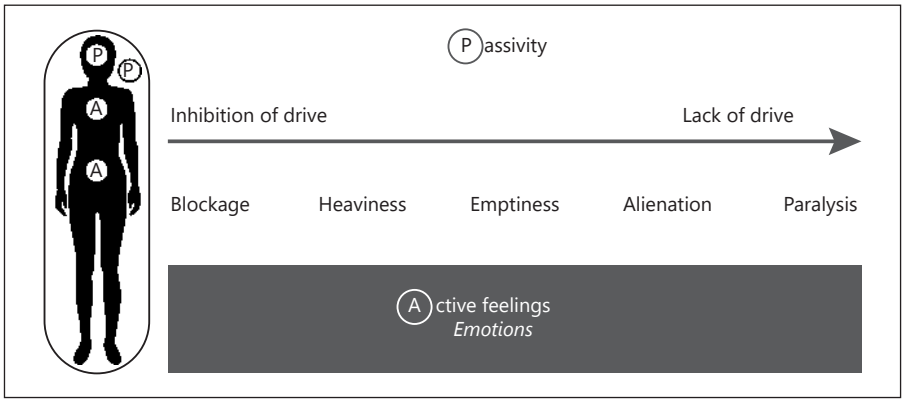

Fig. 2. Model development. The model points out the descriptions of bodily feelings experienced during depressive episodes. The 5 components of passivity can be arranged among a continuum of drive (inhibition vs. lack of drive). Furthermore, the figure depicts how or where individuals experience passive feelings versus active feelings. Passivity is most frequently experienced in or around the head or the whole body, while more active sensations emerge in the chest area and the stomach.

original manual, peak as well as modal scores were assessed by two trained independent raters for each interview [23]. Raters reached an inter-rater reliability of $\kappa = 0.46$, which is moderate but can be considered good for the EXP (for overview, see [24]). Diverging ratings were discussed, and an agreement was achieved.

Model Development

Qualitative analysis was conducted with MAXQDA 2020 [25]. In the first step, an open coding phase was conducted where body-related themes and figurative themes were extracted. Thereafter, the themes that were chosen by the participants to focus on were worked out, and the Focusing process on these themes was analysed. For each individual, described experiences for the relevant body parts were compared to each other and afterward compared among individuals. Themes that emerged were peer validated with the second author, who is trained in micro-phenomenological interviewing, and discussed in a content expert group containing health professionals and researchers. After each step, analysis was iterated and results funnelled. A model was developed from the data, and in the last step, each individual was compared to the model to examine the fit of the model. Data saturation [26] was achieved after 8 interviews (see Fig. 1).

Results

The interviews lasted on average around 37.46 min each with 340 min of interview analysed overall. In the open coding phase, 501 codings were done. In the final coding phase for the Focusing part, 242 codings were extracted for body areas (61 codings overall) and descriptions for feelings in these areas. Body areas were dividable into the head region, trunk, arms and legs, and whole body. Additionally, in the final coding phase, 31 emotion codings followed.

Experiencing Scale

Modal EXP scores for the Focusing part varied between 2 and 4 with a mean modal score of 3.6 and peak EXP score between 3 and 6 with a mean peak score of 4.6, indicating a wide variety of depth of experiencing capability between individuals. For the introduction, modal EXP scores varied between 2 and 4, while peak scores reached up to 5. In conclusion, the EXP shows that the

expected exploration of feelings and experiences in peak instances was found in the Focusing part (for comparison to psychotherapy EXP scores, see [27]).

Model Development[4]

Themes chosen by the participants in the introduction part that were especially burdensome were either lack of drive (6 participants) or social situations (3 participants)[5]. As for all participants, the theme of lack of drive emerged at some point, and the following analysis concentrated on situations of lack of drive. The model that emerged can be seen in Figure 2. Overall, a feeling of passivity that ranged on a continuum from inhibition of drive to a total lack of drive was the most prominent in these situations (see Passivity). Additionally, participants stated a more active, pressuring feeling that was locally distinguishable from the passivity feeling (see Active Feelings).

Passivity

In situations involving lack of drive, 5 categories were extractable in the Focusing part that described the burdensome feelings participants experienced when depressed.

Heaviness

Seven participants described the feeling of heaviness as central. Mrs. B. outlined her feeling as, "Yes, it's just as if I had to put my head down on something the whole time, as if my neck or my body is not strong enough to hold my head up." Heaviness was felt by many in the whole body or more specifically in the head region as in the quotation from Mrs. B. Another participant described how she sensed her whole posture changing due to the heaviness she felt in her body. The feeling of heaviness was, by our participants, either associated with the body itself or with a feeling of something external like a heavy stone or water in the body.

Emptiness

Four participants described emptiness. Mr. C. said, "But so it is a bit as if this emptiness was causing emptiness in other parts of my body too, but it originates in the head." Again, the same bodily pattern can be seen as in heaviness: participants outlined the feeling of emptiness in the whole body but especially in the head. Emptiness was also mentioned in the introduction and the metaphor part. In the introduction, Mr. F. said: "And after that it then started with this emptiness. I just noticed I have shut down. I have allowed everything around to work on me without feeling anything. What I mean to say, I was completely dead as far as emotions are concerned, I would say."

Mr. F. said, "It is like a living mannequin. […] Mannequins are usually hollow." Some participants drew the picture of emptiness more like fog or cotton wool in the head and others like a vacuum. Mr. C. stated, "And it is a little as if around me there is nothing, a vacuum, and from me, from the inside something is pushing, but because it is empty outside, nothing pushes back." Similar to the heaviness that was either associated with the body itself or with an object working on the body, emptiness was mostly described as being inside the body, but in this one case was felt outside the body.

Paralysis

Five participants described a feeling of paralysis. Mr. G. described his feeling as "Lack of strength. So, I want to touch my face, but somehow I don't have the strength to do it. Sometimes it feels like a paralysis. As if there was no connection to the muscle." Others outlined it more metaphorically, like Mrs. B.: "As if one was simply a lifeless, numb sack. Just thrown down." Paralysis was felt in the whole body or sometimes more specifically in the chest area.

Blockage

Six participants described a blocking of intended or automatic movement. This blockage took on different forms, such as a knot around the soul that was located in the chest area, rocks that blocked the exit around the water the person was imagining lying in, or a sack someone was in. "Yes, it might not be a parcel but more like a bag of potatoes or something in which I can't move my hands and feed properly somehow," said Mrs. D. Mr. G. referred to the association of "Sometimes my skin or my body feels like a diver's suit, and between me and the diver's suit there is 1 cm of space. And in there, I don't know, the space is a little as if filled with a liquid, like liquor. And in there I sometimes move to and fro very slowly and sometimes I tick very quickly and then I feel unwell."

Alternatively, there were descriptions of rumination that felt like thoughts being trapped in a birdcage. Especially related to anxiety, some kind of blockage was felt as a tightening in the chest or throat areas. Mrs. H. described

[4] Quotations were translated from German to English by a bilingual speaker and revised by a native English speaker in consultation with the first author. For the original German versions, please contact the first author.

[5] For the last interview, the introduction part was mistakenly not audiotaped. Therefore, the selected situation is not known.

it as, "my chest is as if I was wearing a tight corset and couldn't breathe properly." It is, though, important to note that the overall description changed when anxiety was present in the report of a participant. In the context of anxiety, participants were not passive anymore but restricted (for a discussion on anxiety in depression, see, e.g., [28]). Localization of the feeling of blockage varied from the chest to the head to the whole body.

Alienation

The last category associated with situations of lack of drive was the feeling of alienation. Three participants reported a feeling of an alien world or of a separation from the body. In that sense, body parts might have felt bigger than they were or as if they did not belong to the body anymore. Mrs. H. states "Yes, alienation is maybe…that would fit quite well, as if it wasn't one's hands or one's feet. As if I was looking at myself from the outside, too, the body parts somehow." Alienation from the world was present in the introduction part of Mr. C., who described a change in his perception of the world. "Somehow a sort of detachment, too. I always describe it a little bit like I am sitting in a box and around me a lot is happening, but I have…well I only see that it flashes by." Alienation was not felt in one specific body part. However, when participants outlined it as a bodily feeling, it was either a full-bodily feeling or in relation to legs and arms not being present in the experiencing.

As mentioned above, these 5 categories can be arranged on a drive continuum between an inhibition of drive and a total lack of drive. When participants felt a blocking of impulses, drive was inhibited, while in paralysis and partly in alienation, drive was fully lacking. In heaviness and in emptiness, some participants experienced a lack of drive and others an inhibition. Overall, the theme that was considered as the most burdensome in this sample could be subsumed under the term of passivity. Passivity was felt in the whole body, but several participants described it as being initiated in the head.

Active Feelings

Contrary to the presented feelings of passivity, in 8 participants, there was a report of something more "active," pressuring," or "moving" described as being uncomfortable or experienced in a negative way. These pressuring feelings manifested in the stomach or chest. In the following, several examples are given.

Mrs. E.: "Hm, a bit, yes, queasy-ish,[6]" yes, difficult, ehm. Yes, it is a bit as if one, no idea, jumps out of an airplane or something like that. Yes, like a parachute jump or something and just before that; at least that's how I imagine that."

Mrs. D.: "Yes, that is strange but something warm, large which moves in there. In the belly. And what it looks like, I don't know. Somehow round and mobile and large and heavy" (spoken in response to "Can you find a description for it?" after feeling something in the stomach).

Mrs. L.: "It feels a bit as if the image of the heart which one always visualizes in one's head, as if one was tearing away at it and try to pull it apart. (…) Into the belly. It is red I think. It is like a bright glowing hot bowl which threatens to burn everything around it."

Some participants associated these active feelings in the chest and stomach area with specific emotions, like Mr. C.: "I find it very difficult, the correct... Really, when I am imagining the situation in its entirety, with this image I notice very, very slightly in its beginnings that somehow there is rage. But I was not at all aware of it. I just thought that perhaps it might help to say that because it just occurred to me. Yes, also that in the area of the chest. Something which contracts and hardens a little. But I can't really feel any more in connection with that. It is more a spontaneous discovery."

The emotion that was reported most often was anger (4 participants). Other emotion-related constructs were anxiety, the need to cry, and pain.

Ambivalence

Some participants further presented an ambivalence between the active, moving feelings and the passive components. The relation between these two pre-reflective feelings was described by Mr. C.: "Ehm, really there is always the emptiness, and it is as if in between a picture pops up very briefly of this chaos but so briefly that I don't consciously register it. Only now when I am thinking about it, I notice: "Okay, somehow it is here." And in the moment itself, there are perhaps only short thoughts which immediately disappear again or something like that."

Mrs. H., on the contrary, described the relationship more like a difference between inside and outside: "Outwardly, there is a calmer activity, like 'I want to avoid, I don't even want to go out, I am apathetic, I am slow, I am calm.' And inside is just a huge pressure and tension." Still another example for this ambivalence came from Mrs. D., who described a detached head from the body. The head

[6] German original word „flauig" is a neologism and therefore not directly translatable. A searching process with individual and novel terms is characteristic for the experiencing process in *Focusing* psychotherapy and might lead to a feeling of congruence between the *Felt Sense* and the symbolization.

in this case had a feeling of containing a heavy stone, while in the stomach something moving and warm was present. However, the examples of a segregation of the active and the passive feelings should be considered as exploratory.

Discussion

The current study aimed to explore the pre-reflective body experience with an in-depth interview technique based on Focusing. The depth of experiencing was assessed with the EXP scale. Peak as well as modal scores were slightly above mean scores for psychotherapy session (for overview, see meta-analysis from [27]). Therefore, we were able to assess pre-reflective body experience through Focusing. When bodily experiencing was promoted in an interview, aspects of depression were felt that paint a more nuanced picture than previous findings have reported.

Passivity

On the one hand, the model that was developed comprises 5 components on a passivity continuum ranging from inhibition of drive to total lack of drive: heaviness, emptiness, paralysis, blockage, and alienation. These components are felt throughout the whole body, especially in the head region. It is noteworthy to mention that during these interviews, the head region was not a synonym for cognition but was actually the physical location where bodily feelings emerged. Parts of the passive feelings participants presented are well known in the literature, such as the feeling of heaviness (e.g., [9, 12, 29]) or the feeling of a blockage that is either described as an "incarceration" [30], a feeling of confinement [28], or in metaphor research as captor [12]. Overall, the work by Danielsson and Rosberg [29] yielded categories that are very close to the passivity components established here. They conducted a phenomenological in-depth interview with a group of individuals with major depressive disorder with the aim to receive rich descriptions of specific episodes of living with depression. The emerging overall theme of the analysis was "an ambiguous striving against fading" that was described as "a struggle to overcome a numb sense of "nothingness" and a strong resistance to act and participate in life, fighting withdrawal but paradoxically needing and embracing it, as a pause from life" (p. 503). Hence, the focus of their study led to a stronger emphasis on the relation of the depressed individual with the environment compared to the current study.

Active Feelings

On the other hand, active pressuring feelings in the chest and stomach arose. According to embodied emotion researchers, the active feelings described above and emotions are considered a single category. James [31] was the first to claim that emotion is the conscious perception of bodily changes, which might have an unconscious origin. Niedenthal et al. [32] call these bodily changes the bodily state of an emotion that precedes the feeling state of it, while Barrett [33] coins the term core affect for this phenomenon that is in a second step conceptualized as a distinct emotion. It is therefore possible that the bodily feelings presented above that occurred in the same region as the so-called emotions and shared properties with them were exactly these bodily states or core affects that precede categorical emotions. Support for this assumption comes from studies assessing bodily maps of emotions in healthy individuals and in individuals with depression [34, 35]. In these studies, participants paint areas in body silhouettes where they feel bodily activation or deactivation when experiencing emotions. It has been shown that distinct body-sensation maps emerged for the different emotions across participants. These results support the notion that distinct bodily states are associated with the felt emotion. As in the present interviews emotions were not explicitly asked about, it was rather surprising that, in some cases, the Felt Sense was labelled as a concrete emotion.

Ambivalence

As in the present study the pre-reflective bodily feelings were emphasized, another aspect emerged that has not been presented in qualitative or metaphor studies before: the bodily felt ambivalence between the passive components and the pressuring, active, moving feelings that were present. Future research needs to investigate the relation between emotions and the passivity felt by individuals with depressive symptoms further. Additionally, the feeling of passivity was changed when anxiety was a relevant aspect of a participant's experience. A blocking of drive from the outside was described in these instances. Therefore, the relation between anxiety and depression should be addressed more thoroughly as well.

Integration and Limitations

Results overall show some divergence to findings presented above and to the corporealization model [4]. Compared to metaphor research, components differed in some respect. Metaphor of descent and darkness [12, 13, 36] was not found when pre-reflective bodily experienc-

ing in depression was assessed with a Focusing-based interview. On the one hand, this divergence might be caused by the study's language. In the English language, descent is a frequent metaphor group overall for depressed mood while in the German language heaviness might be a more prominent metaphor. On the other hand, even though metaphors might have developed from embodied states originally, it does not mean that every individual with depression experiences the same pre-reflective sensations. They might use commonplace metaphors to describe their feelings; this is quite possible as individuals with depression state that "Depression is close to being beyond description" ([37], p. 5). In a process that is largely preverbal and difficult to describe, individuals might rely on frequently used metaphors, while in the Focusing part, participants searched for a congruent symbolization for their Felt Sense until they found one that fit well.

The feeling of corporealization Fuchs claimed, of being cut off from the world through a body that lost its transparency, might be present in these descriptions of passivity. When bodily feelings of heaviness, emptiness, paralysis, blockage, and alienation arise and replace the transparency of the body, they might distance the individual from the surrounding world. Therefore, with the present study, we are able to support the notion of the corporealization assumption. Still, its effect on the relation to the outer world is not directly targeted and needs further investigation.

Our results need to be interpreted in the context of several limitations. Sample size was considerably small, and results need to be replicated in a bigger sample, possibly with a quantitative design. Nevertheless, as Danielsson and Rosberg [29] stated that for phenomenological research, the aim was to collect enough data to be able to describe the phenomenon of the "body experience in depression" in a "rich and complex way, uncovering new ways of understanding it" (p. 507f.), which was achieved in the current study. For a further qualitative analysis, it might be of interest to account for the high rate of individuals with major depressive disorder and comorbid disorders [38]. Finally, it should be worthy of discussion whether a method that was originally designed as a tool for psychotherapy, which is the case for Focusing as well as the EXP, is as appropriate for an empirical study. Nevertheless, the authors believe that psychotherapy itself is a kind of a qualitative analysis among the client and the therapist and therefore a possibly fruitful source for researchers' inspirations and for individuals with depression to describe how they feel in a satisfying way.

Conclusion

In summary, the current study demonstrates that focusing on the pre-reflective body experiences might provide a possible way to counter the indescribability of the experience of depression. The subjective body plays an important role in the experience of depression, which is why it might be useful to integrate subjective bodily experiencing in psychotherapy, as is already done, for example, in Focusing therapy. In conclusion, passive components might describe the lost transparency of the lived body, and they seem to have an opponent in the active, moving feelings that interact with them. Furthermore, the Focusing method was shown to be effective in researching the subjective experience of individuals with depression and might be used in the future for a better understanding of the subjective experience of mental disorder overall.

Acknowledgement

The authors thank Mrs. Clara Nöring and Mrs. Ann-Katrin Bode.

Statement of Ethics

The study was approved by the Local Ethics Committee of the Witten/Herdecke University (application #13/2018) and adhered to the Declaration of Helsinki. Participants gave informed consent by signature after being extensively informed about their rights and risks.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Funding Sources

The authors did not receive any funding.

Author Contributions

N.L. and J.M. developed the study concept. All authors contributed to the study design. Set up, testing, data collection, and data analysis and interpretation were performed by N.L. under the supervision of J.M. N.L. drafted the manuscript, and all authors provided critical revisions. All authors approved the final version of the manuscript for submission.

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