The Existential-Phenomenological Approach to Consciousness and Treatment of Unconscious Patients

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The human beings are characterized as subjects. Their essence is understood as Person. A treatment that does not consider the “subjective” and the Person would not correspond to their essence. For a sentient and autonomous being consciousness matters, but it does not fully unravel a human existence as Person. This has a therapeutic impact on the treatment of unconscious patients and gives a specific character to the treatment approach. Some instructions for therapeutic application of the phenomenological-existential concept and the phenomenological attitude towards unconscious patients or those having brain trauma are given. The role of consciousness in human existence is briefly reflected from an existential perspective.

Keywords: unconsciousness, consciousness, existential procedure, phenomenology, fundamental existential motivations.

An existential view of the human

What defines human and, apparently, differentiates him from other living beings is the special character of his existence, that of his being a subject. This fact stipulates certain angle to human, which is that he should be considered a subject. The treatment of human only as an object, which corresponds in misinterpreted evidence-based medicine to the main principle of natural sciences, adhering to only empirically supported procedures, does not reflect the human essence. Evidence-based medicine relies on two other factors as well: individual clinical experience of a physician and values and desires of the patient (G. Guyatt et al. [5]; D. Sackett et al. [23]), though attention paid to these subjective aspects is often insufficient (H.Wesling [27]). The human essence, its Person, stems from its subjectivity1 (V. Frankl [4]; A. Längle [11]; R. Spaemann [25]). A human as Person is a being that was granted to himself and whose principal trait is that he possesses a right to have its own way and his own will. When a physician treats patient’s body, the patient is never just a “matter”. However much attention is paid to physiological, chemical and energy aspects, the human body is always something of a bigger scale, containing an untouchable essence in its depth. This “something that could not be apprehended” is Person, dignifying a human. In the present context we are interested to which extent consciousness defines human’s existence. Consciousness is often believed to be the same as dignity. Indeed, consciousness is associated with dignity to a large extent. Whenever a person makes decisions, or takes responsibility, or feels guilty, we speak of dignity. Decisions taken at one’s own will let him save his own dignity or dignity of the other person as it is up to a person to bear himself with dignity or to lose it. This is where consciousness plays the dominant role. The body is also inextricably connected with the human essence as it could be employed in either decent or disgraceful way of behavior, like that of sexual intimacy or in decisions related to treatment (again and again, the issue of whether measures sustaining life in end-of-life situations are appropriate for human dignity becomes the topic of discussion). The body and psyche are important forms of human existence, whereas consciousness, thinking and memory are its principal functions. Nevertheless, the essence of human lies significantly deeper. It is crucially important that physicians would realize the presence of this deep layer. Human is a sentient autonomous being. “Sentient” means that he is self-identified, which physiologically is mediated by reafferent neuronal loops and thus allows human to be given to himself. By “autonomous” we mean that human rests in himself, eventually does not depend on other people and circumstances in his decisions and self-formation, and acts on his own will. As a sentient autonomous being, human originates from himself and is

1According to the anthropological model adopted in modern existential analysis, a human is an entity of three dimensions: somatic, psychic and spiritual ones. Here, “spiritual” is understood not as the religious component, but as “human” in a human being (the one that differentiates him from plants and animal life). This is, for instance, his ability to make a choice or decision, to live up personal freedom and responsibilities, etc. The term “Person” corresponds to the spiritual dimension of human. We left it “as it is”, as a special term, accepted in the present psychotherapeutic paradigm as a synonym for spirit that each person possesses. It is free and is not prone to any diseases (all diseases occur in the somatomedical dimension and may block the access to the depth of Person’s existence, simplifying his personality in such way). The main meaning of the term “Person” is close to the notion “essence”. (Note of the science editor).
able to form himself autopoetically\(^2\). There is nothing more we can say about these interior roots of Person: we do not know their nature or origin of life; the only fact we know is that these were not our efforts it was created with. Such limits of our knowledge should be treated with respect (R. Spaemann [25]; A. Längle [14]). Respect is an inner posture in which individual distances himself in order not to disturb the intrinsic value of the thing (in this particular case — the incomprehensibility of origins, namely, the incomprehensibility of Person).

What physicians treat are not dead bodies, but alive ones. While it lives, the body is the one entity with the physical vitality of life and the mental presence of one’s personal existence (V. Frankl [4]). The living body is filled with Person, it is the Person. Person in man represents spiritual strength, the “spark of life” that lies beyond our comprehension. “Man is always something more than what he knows of himself” said Karl Jaspers [8].

As far as it goes to the patients with deprived consciousness or who lost it temporarily due to an accident or a disease, there is a profound existential question: what counts in human life? What for it is important to live? What is the value of life? These existential questions indicate the importance of anthropological understanding of the man’s existence. This is the background to treatment. Each physician has his or her own anthropological view and existential understanding of what the man’s existence is (realized by him to a more or less extent), which defines his decisions in extreme situations.

But what is it that matters in life? Is the preserved consciousness, assuming one’s realization of his actions, the key factor? Or the most important thing is to remember what one has experienced and done? Does it mean that it is preserved memory that is crucially important for human existence? Or the defining factor is how much one has created in his life, that is, how broad his experience is? It turns out that it is not easy to answer these questions.

Existential answers refer neither to “to have”, nor to preserved functions, nor to spent abilities. From the existential point of view “existence” means that the man has been there with his body, his feelings, more or less consciously. This is what lies in the background. What counts is that the man had the possibility to be himself, came through many experiences, and had an inner dialog regarding his own senses and his body. It is where different aspects of the human existence, which may manifest itself in sometimes opposite forms like in body and psyche, coexist. Mediated by the man, they unite in spiritual dimension of personal existence (V. Frankl [4]; Fig. 1).

An interpretation that does not take into account this integrity of different dimensions of a man and leads to an approach that deals only with one dimension while neglecting others is called reductive. Such viewpoint damages the integrity of the individual and hurts its dignity.

It should be mentioned here that psyche and the body may manifest themselves in opposite ways (Fig. 2). While the body might have no reflexes, in the psyche dimension there might be fear and inner life. The fact that both dimensions comprise a unity is what defines human dignity and makes him impenetrable.

**Basic principles of treating consciousness disorders:** “personal stimulation”

The core basis of the approach to patients with consciousness disorders is that a man should be treated with respect, which means that one should take into account his autonomous nature and ability to make decisions as manifestation of Person. Being Person stands for being associated with the inner and the outer world, being on one’s own and being with others, (Fig. 3) regardless of whether the person is conscious or not.

\(^2\)Autopoiesis (from Greek “creation, production”) is the term introduced in the early 1970s by Chilean scientists H. Maturana and F. Var- ela. According to their theory, all living beings (including human) are featured by “autopoietic organization” meaning that they are capable of reproducing themselves. The fact that an autopoietic system generates, “builds” itself and creates its own components could be compared to one’s “pulling himself by his own hair”. (Note of the science editor).
The man is open and incomplete at both poles, so he cannot deal without another other person. At the outer pole he is open towards differentness (of other people and the world) and at the inner — towards his own depth (personal intimacy). Psychotherapy can address both poles. As a matter of a principle it means accompanying the other in his world. The basis of all psychotherapeutic measures is to stay on the horizon where patient learns to deal with strangeness. Of course, such presence cannot be compared to the mechanical stimulation of the body, which physicians often resort to in order to wake up an unconscious patient. Instead of stimulating the object, one would rather address the personal level and try to enter the outer world of the patient, to be in front of him, to meet him with respect and keep in mind the depth of his personality regardless of whether he can act at the moment or not.

This double association with the inner and the outer world reveals the unique capability of human to be unconditionally open. Such perceptivity as if gives the man ‘antennas’ and makes his inner essence accessible from the outside. One may contact this self-contained dimension using body, psyche and noetic tools. This unconditional openness does not anyhow depend on the awake state of consciousness of an individual. It is well-known that the major part of the perceived information is not realized (P. Merikle et al. [19]). Even Pascal ([21]) noted that a sense has reasons impenetrable to the mind. The openness of the man’s experience as Person corresponds to the so-called phenomenal consciousness and concerns the notion of qualia, i.e. the issue of distinguishing the subjective content of the mental processes (A. Becker-mann [1]; M. Nida-Rumelin [20]).

When the consciousness of a severely injured patient becomes accessible again, there appears a question of how to reach Person of the patient. The basis of it is the dialog, the requesting and taking up personal position by both physician and the patient. A man who endured severe trauma and lost consciousness needs an outside assistance to get back to the existential dimension of life, to catch it. Accepting the givenness means one is ready to be, to live with new, most likely changed conditions and past experience. Patient is facing the existential choice of whether he is willing to live further or not. He needs an outside assistance and guidance in order to build the core existential structures inside (A. Längle [14]). Otherwise, treatment and recovery will be significantly slowed down (see the study of salutogenesis, tolerance and resistance by A. Längle et al. [10]).

At injury-caused traumas and crises damaging consciousness, psychotherapy is as much required as the personal contact and stimulation. Such experience may shutter one’s existence to the point after which one loses the prop and ability to revise (A. Längle [12, 13, 16]).

Main steps in the assistance are stipulated by the theory of existential fundamental motivations (A. Längle, [14]) and have already been described by N.S. Ignatieva [7] in respect of after-coma states:

1. The first and foremost factor is to-be-here (Dasein) of a physician for the patient, his inner presence, being felt by the patient. This is an ontological basis.

2. The second aspect is emotional contact: it is necessary to establish emotional relationship with the patient, to address him, to be close to him, while observing one’s own feelings and revising them.

3. The third aspect is personal contact: a physician should talk to the patient even if one is not yet able to reply, adjust himself to feel the patient (attention focusing) and connect him with ‘his own’, important to him (to invite people close to him for instance) things.

4. The fourth aspect is to introduce perspective for the future (progress is always possible, even in the absence of consciousness, up to the death) and to outline the most prominent contexts of the particular patient’s existence like family, children and projects. As for the conscious level, it is of course, existence and decent future that are mostly considered.

In clinical practice, the aforementioned dimensions can be extended by special techniques used by psychologists and counselors. For instance, the first factor, namely to-be-here with the patient, could be extended if one silently concentrates on him, attentively looks at him, observes, makes inner contact, touches, keeps with the pattern “I keep you, with all that you are” etc.

The outer presence, an attempt to meet the man as Person and to focus his personal strength, stimulates his inner life. It also triggers the inner dialog and relationship with the inner self: trying to be himself, to find a way to himself in life (this could be called “existential consciousness”). At the later stage this inner presence may reveal itself. The man will be able to tell something about himself and to start a dialog. Realization-of-being-here relies on two traits of man as Person: being on his own in the inner world and being with the other person in the outside world. The former makes the man able to perceive impressions. This dimension is the most important at serious disorders of consciousness. “Being with others” defines relationships, contacts. Both dimensions create possibilities for the interchange and communication. In the end, this is what allows the man to be a part of the outer world again (see the personal model of revision and communication — A. Längle [9, 16, 17]).

3. The role of consciousness

In the context of our problem it is important to reflect the task of consciousness. What function does consciousness perform for a man? The main component of consciousness in the awake state is the self awareness,
meaning that person knows that he is he, who is doing and feeling something. D. Chalmers [2] develops this idea and suggests “… the mental state is consciousness on condition it has attributive feeling” or “…realizing is almost the same to having a subjective experience (ibd. 6). Furthermore, consciousness performs such tasks as thinking, remembering, perceiving, feeling, being alert (attentive and vigilant), decision-making and communicating. It permanently and intentionally focuses on the content that it seizes (realization is always a realization of something), etc. (see D. Chalmers [2]).

From the existential point of view, the principal function of consciousness is to be one’s own inner counterpart. It gives man the knowledge of being here. Realization is always equal to self-awareness: “I am the one doing it”. That is why consciousness is a basis for reflection; it is able to make the experience more intensive. This distinguishes consciousness as the means rather than the objective. The objective is to live, to be oneself and also, to a larger extent, to find, to become oneself.

Revising and reflecting “Me” depends on consciousness in the sense that it is consciousness that creates the inner vis-à-vis enabling deliberate integration and taking certain position towards the information and experience. This is what makes consciousness, existence as Person and selfhood close as consciousness processes are all realized (not on-the-spot, intuitive) decisions. Nevertheless, consciousness cannot be set equal to existence as Person, the human essence. Consciousness is not the content that defines man, but the means making functioning of “Me” possible and playing the crucial role in decision-making.

4. How does phenomenology contribute to treatment?

Contemporary methods for treating human psychosomatics indicate two significant aspects related to the personal existence that are essential when working with patients suffering from consciousness disorders. Both concern the importance of contact with the inner world of the patient as well as the ability to concentrate on the positive things. Thus, T. Wise [28] said: “According to works of Schmale and Engel it is necessary “to look into” the patient... in order to recognize both the subjective and objective phenomena of each experience that patient lives up.” For instance, C. Ryff and B. Singer [22] emphasized the positive basis of treatment: “the path of recovery is not only relieving the negative aspects, but also generating the positive ones”.

Phenomenology is the easiest way to achieve the “look into” and to activate positive strength that is typical of man as Person. By phenomenology we mean settings giving absolute freedom to the other person. His or her essence becomes visible due to the subjective impression that the observer gets at the ontological level. Thus, the observer impersonates the “reflection” of the other’s inner world using his own (A. Längle [18]). This leads to an intensive stimulation of the other’s essence. Such reflection and learned pattern allows one to obtain considerable amount of information about the other person, which contains information about himself as well. This is the approach of an attentive spirit-inquiring vision (M. Scheler [24]). Quoting Plesner, we can say that “what is required instead of a distanced mind-setting of an uninterested scientific observer is full participation of the man with all his resonating dimensions” (S. Strasser [26]).

The key background factor to it is Epoché, “bracketing” the previous assumptions, intentions and prejudices (E. Hyserl [6]). It can be (and should be) learned and trained. When it is possible, one is given space and left to freedom which is a key quality of Person.

Each man, because of his Person dimension, has a basic ability of phenomenological vision. It refers to the intuition by means of which we can recognize and see through the most important content. Thus, we can feel the hostile attitude towards us, even if the person demonstrates surface amicability. This deep vision sheds a new light on what is on the surface (external), provides it with another context, and clarifies discrepancies and contradictions (e.g., when person, despite seemingly friendly attitude, avoids closer contact).

The phenomenological approach results in understanding, seized content, the importance of which for existence becomes clear. This approach is especially efficacious towards people who lost consciousness and so cannot express themselves volitionally. However, they can be understood because of the openness of the observer and his willingness to feel based on the context and unconscious manifestations. The observer who does not hurry and lets the patient to influence him thus obtains unbiased information from minimal signals that the patient gives and from the impact that it has on the patient. He gets an impression, spots certain aspects; something excites and touches him. This is what one pays attention to in phenomenology. The fact that these are subjective perceptions does not contradict the importance of the perceived information, but makes them significant provided that the observer is indeed able to open himself, to get free of himself and his views (Epoché). Once information is retrieved, it reaches the observer and touches him: feeling what touches you is the core of understanding. While using the phenomenological approach, no information is added to the patient’s profile. His behavior is neither explained nor interpreted. This approach is different from the medical ones that are conventionally scientific (W. Dilthey [3]). Explanations are, of course, important as they bring together objective perception with empirical knowledge and the common laws. The explanatory procedure describes particular processes in the body. However, treatment should not be limited to it. Motto of the holistic treatment should sound as follows: “Explain symptoms, but also understand an individual who has them” What is required for understanding him is personal presence of a physician, a psychologist, a paramedic and a counselor. The ability to use the available knowl-
edge at professional level, to participate personally, to open up, to let oneself be approached is the crown of pro-

ficiency, as this way patient is not considered by dimen-
sions, but approached holistically. The phenomenologi-
cal approach creates the atmosphere of sensitiveness and amicability and thus allows patient to be understood.

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Commentary

The present article is written by an acknowledged expert in psychiatry, the founder of the contemporary existential analysis. It continues the more than a century-old argument between apologists of the quantitative and qualitative ap-

proaches to evaluating the human. In the era of differentiation of scientific disciplines, the academic objectifying approach has been a winner and still dominates in medicine. Neverthe-

less, by the end of the XX century psychological anthropology and phenomenology were given a wider conceptual and meth-

odological basis. Addressing the noetic-subjective dimension of the human corresponds to the universally accepted human-

istic tradition of medicine. From our point of view, substantia-

tion of phenomenological study, care and extension of the zones of feeling that remain in difficult neurosurgical patients improves the quality of their rehabilitation. The present article is of apparent value as it enunciates a fresh approach to objec-

tification of the subjective, human dimension of patients in a neurosurgical unit.

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