A Phenomenological Model in the Practice of Psychotherapy

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Abstract
This paper looks at the practice of psychotherapy from a phenomenological approach, covering areas that are not usually within the more traditional 'bio-psycho-social' model, but also include economic, political, cultural, and environmental areas, and possibly several others. It further compares the more philosophical and pragmatic approach of a process-oriented practice of psychotherapy to the biomedical 'treatment' of psychiatry.
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Psychotherapy, Phenomenology, Psychiatry, Practice

Phenomenology (in this context) is defined as being the philosophical doctrine that advocates that the basis of psychology or psychotherapy is the scientific study of immediate experience. A 'phenomenon' is something as it appears to a person's mind. In philosophy, this term stands in a form of contra-distinction to 'noumenon' that indicates the thing in itself (Kant). Phenomenology therefore, is the study of what appears to the mind, in one's intuition, as a form of subjectivity, or as a unique perspective, and/or as personal experience. In the original Greek, a phenomenon is something that manifests, shows itself or shines forth.

> *Phenomenology is a philosophical discipline that focuses on human experience. Tyler for example asserted that the basic idea of phenomenology is to understand human experience as well as our interactions with the environment, and our relationship with each other. In phenomenology, individuals are considered as conscious subjects who act intentionally and who give meaning to their actions. Phenomenological psychology then, becomes the study of the way in which the individual himself or herself understands what he is doing, and how he feels about it.* (Lubisi, 2008, p. 3)

In psychotherapy, phenomenological approaches are those that seek understanding through inquiry into the subjective and perceptual life of the client, and which trust that such an inward-looking approach will speak out for itself (Brazier, 1991). Phenomenology is thus almost at the opposite end of the spectrum of psychotherapy from 'behaviourism', now often called Cognitive Behaviour Therapy (CBT), and is also quite distinct from the various analytical approaches (eg. Freud, Jung, and Berne [Transactional Analysis]) that seek to understand by imposing their own theoretical schema upon the client's subjectivity. However, there is a small problem – of language:

> *Despite the use of "hermeneutics", "intentionality", "empathy" and "intersubjectivity" in some areas of psychotherapy and psychological research, there*

> *has no in-depth explanation from the original source in philosophy about what these ideas mean. ... The ultimate aim of this work is to show the importance and ubiquity of making sense of the psychological world but there are many necessary steps to be trod before the ultimate aim can be achieved.* (Owen, 2006, p. 3)

The philosopher, Edmund Husserl (1859-1938), created phenomenology as a particular school of thought (Husserl, 1960). He was following in the footsteps of Socrates and Descartes, and looking for a form of "radical certitude" (Natanson, 1973).

> *Husserl argued that it was necessary to examine the bedrock of experience, because it was there, in our emotions, actions and perceptions of things and relationships, that an ultimately true understanding could be derived. Phenomenology strives to describe the* ***essence*** *of everyday experience. For Husserl, the attempt to engage with the process of identifying this essence placed a great demand on the inquirer, because it could only be achieved by the individual rigorously examining their own personal experience of the world.* (McLeod, 2001, p. 37)

He was a leading influence in 20th century philosophy and especially that part that subsequently became a focus within psychotherapy. His "phenomenological method" – and its derivatives – have had widespread influences, both direct and indirect, on contemporary psychotherapy and this influence appears to be growing.

Husserl's work also inspired his pupil Heidegger and, through him, subsequently, the French existential school that built up around:

> *Edmund Husserl and Martin Heidegger were the main proponents of the phenomenological thought. Husserl's phenomenology influenced qualitative research and psychotherapy alike. .... He viewed consciousness as intentional and transcendental. Heidegger applied the ontological theme of "being-in-the-world" to Husserl's phenomenology. Ludwig Binswanger imported Heidegger's phenomenology into psychotherapy, culminating in the existential-phenomenological paradigm of psychology.* (Lubisi, 2008, p.5)

Existentialism, as a movement, was quite diverse, though it generally disagreed with psychoanalysis, believing (probably correctly) that it ignored aspects of human existence. But the wider concept of 'existence' – which is that it is not merely to 'be' *(sein),* but to be 'here' *(dasein)* – is very close to Heiddegger's concept. However, it was Sartre's friend, Maurice Merleau-Ponty, who made the contributions that have probably most influenced psychotherapy. Merleau-Ponty's (1962) work is in many respects a critique of the alienating consequences of the over-valuation of objectivity. It presents us with the idea of "pre-reflective communication" as a fundamental basis for mutual comprehension and a vision of human relations rooted in a co-operative inter-subjectivity (Brazier, 1991).

This may be interesting, but is rather historical. So, what does phenomenology in psychotherapy look like nowadays – in this moment in time? The UK Society for Existential Analysis promotes perspectives similar to these through their work and journal.[1] Existential psychotherapy is a method that operates on the belief that inner conflict within a person is due to that individual's confrontation with the 'givens' of existence. These 'givens' are: the inevitability of death; freedom and its attendant responsibility; existential isolation (which refers to phenomenology); and finally meaningless (Yalom, 1980). It draws on the work of Kierkegaard and Neitzsche, who were both trying to explore different forms of reality to the predominant ideologies of the nineteenth century. It has developed through the ideas of Heidegger, Boss, Sartre, Merleau-Ponty, Binswanger, as well as Paul Tillich, Rollo May, Victor Frankl, Irving Yalom, Thomas Szasz, R.D. Laing and David Cooper since then. There is now quite an extensive 'field' of slightly different forms of existential psychotherapy.[2] The field of humanistic psychology was also directly influenced by these ideas.

For Merleau-Ponty, phenomenology *"is largely an expression of surprise at (the) inherence of the self in the world and in others, a description of this paradox and permeation, and an attempt to make us* ***see*** *the bond between subject and world, between subject and others, rather than to explain it"* (Merleau-Ponty, 1964b, p. 58). Others, such as Binswanger and Tillich (1952) have tried to apply some of these concepts to psychotherapy and Viktor Frankl (2004) developed an existential psychotherapy called "Logotherapy".

Digby Tantum and Emmy van Deurzen, both well-known within the EAP, have brought much of this existential thinking up-to-date and they founded an international society of existential analysts, with an international journal.[3] [4] These try to answer questions like: *"What does it mean to be alive? Why is there something rather than nothing? What is the purpose of my existence?"* Phenomenological psychotherapy is slightly different as it asks: *"What is the experience of being alive? How do I view the 'things' that are? How do I understand what I see?"* This moves existential analysis a little towards phenomenological psychotherapy, but they are not irreconcilable (May, 1996)

Personal experience (or 'being', or 'existence' itself) is a phenomena of "being in-relation-to" that which is around one, and it is defined by qualities of directedness, embodiment, centeredness, grounded-ness, worldliness and presence, which can all be evoked by the term 'Being-in-the-World'. One abiding feature of our personal 'experiences' is that, in principle, they are not directly 'observable' by any external person: they can only really be subjectively felt.

The quality or nature of a given experience is often referred to by the term 'qualia', and the archetypical example used is often the concept of 'redness'. (viz. Wittgenstein's *On Certainty* and

Remarks on the Philosophy of Psychology). For example, we might ask, *"Is my experience of 'redness' the same as yours?"* While it is difficult to answer such a question in any concrete way, the concept of inter-subjectivity is often used as a mechanism for understanding how humans are able to empathize with one another's experiences, and indeed to engage in any form of meaningful communication about these experiences. The phenomenological formulation of 'being-in-the-world' or 'being present', where the person and the world (which includes other people, as well as objects and the environment) are mutually constitutive[5], is central here.

Phenomenology is also particularly applicable to … *"the psychology of perception, in the works of Albert Michotte, J.J. Gibson and others",* however, when we come to look at its direct application in the field of counselling and psychotherapy:

> *"… there are points in therapy where most therapists will encourage their clients to bracket off their assumptions about their problems, describe their experiences in detail, express their sense of their experience in fresh language, and in general 'overthrow and build anew' their understanding of self and relationships. … in seeking to bring to light the experiential data that constitute the 'problem' and its 'solution', and in finding ways to uncover the 'essence' of the problem, the therapist can be seen as teaching, guiding or coaching the client in the self-application of phenomenological principles which were first identified by Hummerl."* (McLeod, 1960, p. 40)

Modern developments in phenomenology, particularly in the field of research in psychology and psychotherapy, include … *the Duquesne school of empirical phenomenology; the post-Lewinian method of 'conceptual encounter' developed by Joseph de Rivera; and the existential-phenomenological investigations of R.D. Laing and others"* (Ibid). Combined, these develop into a very rich 'tool' within qualitative research of psychotherapy. *"For anyone seeking to make discoveries about the ways in which personal and social worlds are constructed, it is* ***necessary*** *to adopt a phenomenological stance"* (Ibid, p. 52) and yet the 'yields' from this type of research are relatively low. There are several reasons for this.

This approach totally contradicts the supposedly 'objective' scientific method, as the experiences of the researcher are essential to the research. Hence phenomenological research has largely been marginalized by North American psychology and social sciences. The necessity for producing 'hard', evidence-based research, along the lines of the medical model with randomized controlled trials (RCTs) and a single discovered 'truth', fundamentally contradicts the 'condensation' of experiences of everyone involved in an event, and all their different levels of experience, to come to a greater truth.

Yet R.D. Laing's phenomenological research into schizophrenia is seminal: he carefully explored the actual experiential meanings of the words used by those involved to 'co-construct'

the phenomena of schizophrenia from the accounts of patients and the friends, family members and mental health professionals directly working with them. This led to a totally different 'concept' of schizophrenia: instead of it 'being' an illness that is primarily genetic and/or biological, with symptoms like meaningless language, and only treatable by medication; it can be seen as an individual's rich, metaphoric and high meaningful linguistic reactions and explorations of essentially dysfunctional and distorted relationships and as a desperate attempt to obtain a sense of self. This perception led to new forms of 'treatment', mainly drug-free and in therapeutic communities, where different 'relationships' can be formed (Laing, 1960, 1961; Laing & Esterson, 1964; Laing & Cooper, 1964). This development was unfortunately labeled the 'anti-psychiatry' movement, but it was more like a practical development of 'post-modernist' thinking; realizations further developed by Foucault (2006), though he disclaimed phenomenology.

There are other factors as well that add to these marginalizations and 'splits' within the field of phenomenology, mainly between the 'mainstream' (represented by Husserl and Merleau-Ponty) and the 'new' empirical phenomenology used by modern health researchers (associated with the Duquesne school and others), and developed as an adjunct to the growth of humanistic psychology in the 1960s. The 'new' school is less critical and much more 'subjective', focusing on 'what is' and the individual's actual experience, whereas 'mainstream' phenomenology explores the study of phenomena: the 'objects' of human experience, questioning any 'taken-for-granted' assumptions.

Given this rich background, it seems a little presumptive to propose yet another way of looking at people and their experiences. But … *"the problem of therapy is that the biopsychosocial whole is irreducible to any one of its parts. The first and foremost problem of therapy is the hasty focus on (only) one third of the causal factors involved."* (Owen, 2006, p. 5) There are as many different ways of looking at some thing as there are different ways up an isolated mountain.

Serge Ginger (2010) states that: *"In addition to the traditional needs of psychological help for sick, upset or lonely individuals, numerous problems have been recently identified that are linked to the severe crisis of the "post-industrial" society"* and goes on to list these under the categories of: economic crisis and technological changes; sociological crises and rapid evolution of lifestyles; informational crises (with the permanent eruption of the media into our private lives … and its daily menu of catastrophes); political (and ideological) crises; and so forth. *"In other words, we must consider the interrelationship between the five main dimensions of the human being: physical, emotional, intellectual, social and spiritual."*(Ibid) This view presents us with another set of 'spectacles' with which to view the world and ourselves: another set of lenses,

perhaps with different coloured filters. It is in fact difficult to see that any one specific view of the complexity of a person can be 'correct'.

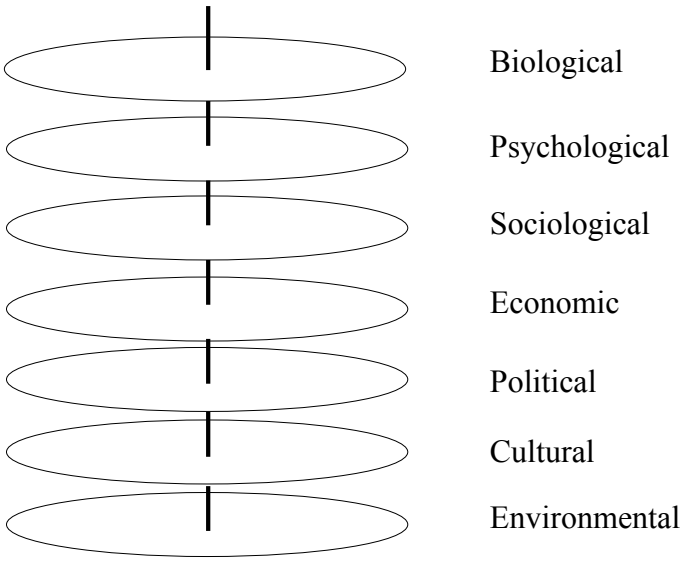
A Phenomenological Model

I would therefore like to introduce a phenomenological model that may help to introduce these ideas a little more concretely, and may also help the debate about phenomenology, and might even (hopefully) widen the scope of the horizons of the debate.

This model is an elaboration of the bio-psycho-social model, first developed by Engel (1977) so let me briefly describe that – the *biological* refers to all within us that is material, physical (physiological) or genetic within us; the *psychological* refers to our memories, thoughts and feelings, perceptions, intentions, free will and choices; and the *social* refers to the intersubjective influences of others around us, the family and cultural norms, language, history that surround us. His systems theory approach (Engel, 1980), with a hierarchy of systems where every system is a component of a higher system and every unit is both a whole and a part, was quite revolutionary (even though something similar was used by the Greeks in 500 BC) and can be very useful. However, I would like to argue – as others have – that there are other significant types of influence and that these three basic ones are now insufficient and need to be refined. Furthermore, the use of the basic biopsychosocial model, whilst it effectively challenges the predominant biomedical model does not permit much understanding on the precise clinical application of the model to psychotherapy. I would, however, like to go a step or two further.

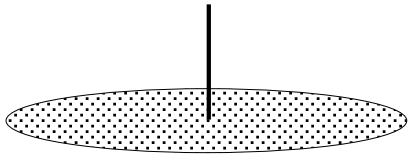
If we can imagine, for a moment, a series of transparent circular discs, a little like computer discs or gramophone records, all stacked up on top of each other, then these are the various phenomenological areas or 'fields' that might predominate in a person's desire to seek psychotherapy, or in the actual content of their psychotherapy. There is a similar concept in some of Arnold Mindell's work, though he describes the person's process as happening in different channels (Mindell, 2002). We can then label these 'fields': and some of the labels might be as follows (see Fig 1):

Fig 1



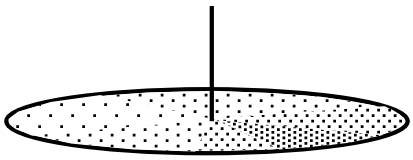
The list of these labels is not exclusive: there can be many more (viz: Religious, Transpersonal, etc.), any of which can be applied appropriately, given a deeper understanding of the person. We could then take one of these discs – this might be the 'Biological' field and realize that, for some (despite the fact that we all have bodies), the Biological field may not be very relevant in that particular person's set of problems: we need to develop an indication of relevance. The diagram of a single field (Fig 2) currently shows a very even distribution across that field.

Fig 2



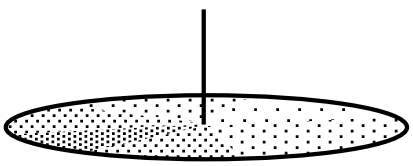
So, instead – to indicate a variety of relevance – we might project a 'scatter' pattern onto the disc. This would represent all the various people who have varying degrees of problems in this area or 'field' This is a more realistic (phenomenological) situation – to have a more uneven distribution or 'scatter': so there would be a grouping or 'cluster' in the population that would have – in this instance – predominantly 'biological' problems, with a variation across the disc and then a few people in the whole population would not manifest problems with any biological components. Therefore let us take just one segment of the disc that represents people with problems predominantly in 'this' particular (biological) field and have the distribution lessening as we move away from this dominant sector. The diagram for this area or 'field' might therefore look more like Fig 3, where the densest area is (here) in the bottom right quadrant (south-east), and the least area is on the extreme left (west).

Fig 3



This field distribution pattern would (of course) be totally different for another field. There, the densest area may be in another quadrant (in this case, the bottom left, south-west) and the least being in a different quadrant (top right, north-east); thus the distribution pattern of this 'field' – perhaps the 'Psychological' field – might look something like Fig 4.

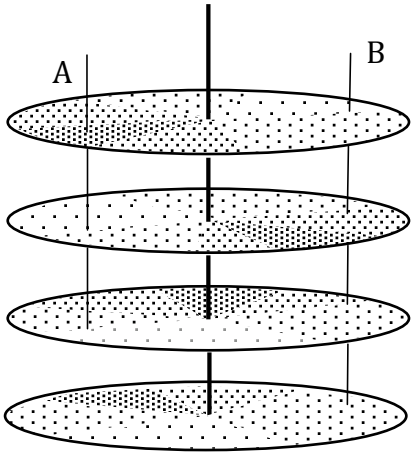
Fig 4



Another field would have a totally different 'scatter' pattern, and so on. If we now superimpose this concept of different shadings to the phenomenological distribution patterns in the particular fields, we can see that any particular point, position or person in the fields (which could be represented by a vertical line through those fields) may have a certain percentage of their issues represented in the different fields.

So, one person (A) may have 60% of their issues relating to (say) the biological field, 15% to the psychological, and 25% to the sociological; whereas another person (B) may have 15% biological issues, 35% sociological, 30% economic, and 25% political (as might be shown in something like Fig 5).

Fig 5



It is easy to extend this model further into all the other various different possible fields. Ginger mentioned the "… *physical, emotional, intellectual, social and spiritual* ..." fields. In Figure 1 above, I mentioned the Biological, Psychological, Sociological, Economic, Political, Cultural, and Environmental fields, but we could also split the Biological into 4 different fields: Biochemical, Physiological, Anatomical and Genetic; or other people might want to sub-divide the Biological into 'Medical' and 'Somatic'; the Psychological could be sub-divided into 'Psychodynamic'; 'Systemic' and (perhaps) 'Process-Oriented' or even 'Cognitive-Behavioural'; the Sociological field could similarly be sub-divided into many different ways, and yet some would say that the "Economic', 'Political' & 'Cultural' fields are sub-divisions of the 'Sociological', others might include 'Religion' or 'Belief Systems' as these can have profound influences on our perspective; and one could also include fields like 'Existential', 'Transpersonal', and so forth. It all depends upon your particular labeling system, but all this actually, really and fundamentally depends on something much more fundamental. How does *your client* experiences these phenomena? This is because – to be effective in the practice of psychotherapy – it has to be framed in *their* terms of reference. However, this does not affect the principle that there are number of different

phenomenological fields; or perhaps even ontological fields. Laing characteristically described it this way:

> *"Phenomenology thus takes us into the issue of what it is one is describing. The discipline that addresses itself to what is this, that, anything is called ontology. Phenomenology is a critical discipline for any science. All explanations require descriptions in order to explain. What we take anything to be profoundly affects how we go about describing it, and how we describe something profoundly affects how we go about explaining, accounting for, or understanding what is what we are, in a sense, defining, by our description. ...*
> *The critical reflective monitoring of all this is existential phenomenology; and the use of this discipline, the effective skillful means of this discipline, its pragmatics, its efficacy in the practice of psychotherapy, is what I want to address ..."* (Laing, 1995, p. 204)

I would like to take up something of Laing's challenge. Clients or patients tend to come for psychotherapy because they either find themselves (or they are 'sent;' because others find them to be) having experiences that they, or others, find undesired or undesirable; or they behave in ways in which they, or others, find to be undesired or undesirable. But what if this so-called 'undesirable' experience or behaviour has another aspect. Maybe it has an undisclosed 'meaning', or its 'content' (rather than form) is significant: we have to hold an open position that can include these possibilities, otherwise we condone the (possibly narrow, or even neurotic) views of the client or their social circles.

Example: One client that I worked with was harming herself – she was scratching her inside arms very badly. As a young woman of about 28, she was in an abusive situation at work (environmental) and an insecure relationship at home (relational), which reminded her – on some level – of when she was a teenager, when she also self-harmed (psychodynamic). Eventually, we got to this and she related how she had had very, very painful periods (biological) throughout adolescence, but her parents wouldn't tell her anything about such things (cultural), and her younger brother had became quite withdrawn at the same time and their parents directed much of their attention towards him (family systemic). Eventually, she had to give up her dream of becoming an athlete (existential), became depressed (psychological), and started cutting herself (psychiatric). None of this was ever treated properly. She left home (sociological), went to teacher training college (educational & social), and became a Physical Education teacher (professional). She started living with her boyfriend (relational), actually an older man whom her parents disapproved of (cultural). A short while later, the abuse at work started, but nobody at the school seemed to do anything or support her (systemic), and her self-esteem (emotional) eventually hit rock-bottom. At this point, she became depressed again (psychological) and started to self-harm

again. She told her doctor and was referred for counselling. I saw her for about 6 sessions spread out over 3 months.

Having heard the story, and having first suggested a few practical things, like joining the trade union and getting some support from them against the systemic indifference of the professional educational system, I suggested that, as well, she could consider increasing her levels of exercise and relaxation to help her rebalance her autonomic nervous system (Young, 2008). Those suggestions helped a little, and the external verification of the union representative that she was indeed in an abusive situation helped her further. We then began to address the self-harming element, and worked with imagining her (turned-in) aggression towards herself – and trying to direct it more outwards. So, by a simple rotation of the hands, her 'scratching' self-harming clawed fingers became instead the talons of an angry animal, and then ended up as something of her hidden potential – a very powerful, angry and also beautiful side of herself – a "Dragon Bitch Queen." She liked that image! The next time her colleague at work said something stupid and nasty to her, she actually rounded on him, and told him off very severely. She obviously had more work to do on herself, and with the school system, but that seemed to be enough for her for the moment. She wanted to feel 'ordinary' again and to reconnect with some of the positive 'normative' aspects in her relationship with her partner.

Example: When I first started to work in south Lanarkshire, a rural area of Scotland, south-east of Glasgow, that used to have a lot of small coal-mining pits, essentially one to each village, I was struck by the level of depression, anxiety, stress, psychosomatic symptoms, and so forth: far away and beyond that of other rural areas of Scotland I was familiar with. It took me a little while to realize that south Lanarkshire was rather like the land or Mordor (in *The Lord of the Rings*) 20 years after the fall of the Dark Tower: the land was green again, 20 years after to closure of the pits in the 1980's, but the people were still devastated – from unemployment, from sectarianism, from isolation, and from the ravages of their childhoods and experiences with industrial poverty, poor housing, alcoholism, violence and abuse. They were collectively highly affected by social, cultural and environmental factors.

So, this is something of the basis of a phenomenological model that I am trying to convey. Every person has had a different set of influences on them, at different times in their life: and these influences all help to 'form' and 'shape' us. We end up thinking, *"This is who we are."* This is not so! This is who we have <u>become</u> – because of 'this', and 'that', and the 'other'. R.D. Laing writes something similar (his emphases are underlined):

> *Social phenomenology is the science of my own and of others' <u>experience</u>. It is concerned with the relation between my experience of you and your experience of me. That is, with <u>inter-experience</u>. It is concerned with your behaviour and my*

> *behaviour as I experience it, and your and my behaviour as you experience it.* (Laing, 1967)

Example: Another person I have seen as a client, had had a severe illness, as a child, and had spent seven years of his childhood in hospital. This was quite amazing! I was somewhat shocked when I heard this. When he emerged from the illness, he did not look physically any different from his siblings or classmates – especially as he was 'well' again now, but he was a very different person – he had 'lost' a large part of his childhood – and, ever afterwards, was somewhat confused about who he was, and about how to 'be' in the world. He had a very different "structure of meaning" – in the sense that Dorothy Rowe (1988) uses the term – than his siblings or classmates: he had both had the 'normal' course of psychic (psychological, mental, educational, emotional, spiritual, etc.) development disrupted, as well as having to develop a very different set of 'explanations' for the world around him: *"Why me?"* or more probably, *"What is wrong with me?"*

These are not very helpful questions, and there are different issues that perhaps can be considered more fruitfully.

> *The innocent self-acceptance with which we arrived at birth was a self-acceptance without an awareness of self. Our self was something we had to construct. The first of the structures that made up our self are images without words, for when we created them we were too young to have language. There are images of being held close and worm, and images of being cold, struggling and unsupported. ... The images we acquire create our expectancy of what life will be, and for the rest of our lives they haunt out fantasies and our dreams.*
>
> *... This (verbal) information becomes for the infant the second kind of structure of the self, the definitions and values which other people impose on us. Thus, we learn not just that we are boy or a girl but how the people around us value boys and girls. ... We gradually become aware of other definitions and values being imposed on us. Again, we learn of our ancestors and what race, or races, defines our appearance and place in society. We learn whether we belong to the upper, middle or working class, whether we are rich or poor, and whether such characteristics make us feel good or make us espies and denigrate ourselves.*
>
> *(But) ... It is the third kind of structure which is less easy to change. This is the structure which came from the* ***conclusions*** *we drew from our experience.* (Rowe, 1988 / 2007, p. 21-22)

What Dorothy Rowe is stating (as I understand it from within the context of this article) is that the 'structures' that we create about our self and the world – in order to give things a sense of meaning – are almost totally based upon our early experiences. They are essentially phenomenological – and then they become interpreted: a "good" experience of a colourful children's ward and caring, considerate staff could provide a very different set of parameters to a hard life at home with numerous competitive siblings in a deprived environment; whereas, by contrast, if the child was

desperately missing the loving care of its parents, he might see the exact same children's ward as false and garish and the staff as professionally indifferent – because they were not what he wanted or needed. The factors that influence us have not changed, but the way in which we interpret them can be very different – dependent on other phenomenological influences in our life.

Given a particular set of influences, we are affected by them, and then construct some form of narrative or meaning as the container for our psychic story. This will get added to and adjusted over time. There is absolutely nothing wrong with this: we all do it.

But we also need to realize that 'our' particular view of that particular reality is something that 'we' (uniquely) have constructed: it is a phenomenological perspective that allows us to survive psychically in that particular set of environmental circumstances, at least for a while. And if – at some later point in time – we 'discover' that this 'view', or that particular 'structure of meaning', becomes dysfunctional, then the "successful self" of the title of the book has to restructure that sense of self towards something more functional.

> *Mastering our experience is the process whereby we alter our structure of meaning so that we can take in something new and assimilate it into our structure without feeling inhibited and restrained by this experience. Not mastering an experience means hedging it about with denials which prevent us from learning anything from experience, and, as Santayana said, 'Those who do not remember the past are condemned to relive it.' Thus some of us go through the pain and disappointment of ending a marriage, and, by mastering the experience, go onto a fuller, different life, and others of us, not mastering the experience, continue to marry the same kind of person and suffer the same pain and disappointment over and over again.* (Ibid, p. 265)

So I sometimes say to my clients, *"Who you think you are is just what you have become – because of different circumstances – in your childhood, in your life. If this or that had happened differently, you would have done things differently. These differences might have 'shaped' you: so, you might seem to be a different person, but who you actually are is much larger and deeper than that. There is all that unrealized potential. That is also a part of who you are."* This relates – in part – to Melanie Klein's later work, and some of C.G. Jung's and D.W. Winnicott's thinking.

Ways of Working Phenomenologically

Let us now try to apply this theoretical model back to the practical application of psychotherapy. Any person, perhaps every person, can be 'seen', or can experience themselves, as being subjected to these various phenomenological aspects or 'fields' to varying degrees. Some of these are very personal and pertinent; some of them are more 'common' or systemic. The émigré, or refugee (possibly a respected medical doctor in his own country), finds that – if he is 'put' into a high-rise flat on the outskirts of Glasgow with drug-dealing happening on the landings; with the stairwells

smelling of urine; with his daughters being verbally assaulted and racially abused on their way to and from school; and that he cannot work at his profession as the British Medical Association hasn't recognized his qualifications (yet); and that his country of origin was divided by civil war, and his home was pillaged, and friends and members of his family were killed – then he may have become clinically depressed. Give him proper work, as a doctor, in a slightly nicer area, and much of the depression may well disappear. So, what is the problem?

Whilst it is tragic that people get treated so, we can continue to bemoan and wail that the "glass is half-empty"; but what happens if we start to see it as "half-full"?

> *The phenomenological method is to try to approach phenomena with a fresh, open and welcoming mind, as coming upon something new, wonderful and strange. It requires a willingness to welcome what is unfamiliar and to be able to regard what is familiar with the same freshness as one perceives what is new.* (Brazier, 1991)

In other branches of psychotherapy, like Gestalt therapy, we can find different aspects of phenomenology. Having said that phenomenology is quite different from Cognitive Behavioural Therapy (CBT), slightly ironically, a modern development of CBT that is being called 'Mindfulness' practice, emphasizes this 'being-ness' in the world, in the moment (Kabat-Zinn et al., 2002). This is a phenomenological perspective. One focuses on what is actually happening right now; what are you experiencing right now; how are you breathing right now? That this is an almost direct 'lifting' of an ancient (2,500 year old) Zen Buddhist practice that is now being woven into CBT is somewhat irrelevant. It seems to work: particularly and especially for people with anxiety. However, I tend to prefer the writings of the Zen Buddhist master, Thich Nhat Hahn (1991) to those of Jon Kabat-Zinn, et al., as they are slightly more poetic and more to do with the 'lived experience'.

Mindfulness practice is phenomenologically very effective with people with anxiety, as anxiety is worrying about what has happened, or what might happen. If you are, or can get into being just "in-the-moment", then there is no room for anxiety: it just cannot exist. Mindfulness practice is therefore the art of being "in-the-moment"; in your body, rather than in your head; with your fuller self, rather than just one aspect of yourself; using all of your senses, rather than the narrow and slightly blinkered focus of vision that is so common, especially in anxiety.

It is obviously sometimes difficult to relax and be in-the-moment if you are chock full of stress hormones from trying to cope with all the ramifications of life, so that some of the preliminary 'work' – before you can 'be' in-the-moment – might be to do some aerobic exercise to burn off the stress hormones first; then you can relax more easily. I have already written about a way of helping the client to rebalance their Autonomic Nervous System as a pre-cursor to effective counselling and psychotherapy (Young, 2008). This is because the phenomenological

experience of their 'biological' field is that they are usually stressed out and often anxious and/or depressed: they do not know properly how to get back 'in balance' – but it is not too difficult. With a little understanding and guidance, balance can soon be restored.

However, there is a very different story with the biomedical model, even though a degree of phenomenology can also be present here.

Psychiatry – the Biomedical model

A sort of phenomenological model can be found in other aspects of mental health, for example in psychiatry. In the ICD-10, the International Classification of Diseases (ICD), which is an international standard diagnostic classification for a wide variety of health conditions, Chapter V. focuses on "mental and behavioural disorders" and consists of 10 main groupings:

- F0: Organic, including symptomatic, mental disorders
- F1: Mental and behavioural disorders due to use of psychoactive substances
- F2: Schizophrenia, schizotypal and delusional disorders
- F3: Mood [affective] disorders
- F4: Neurotic, stress-related and somatoform disorders
- F5: Behavioural syndromes associated with physiological disturbances and physical factors
- F6: Disorders of personality and behaviour in adult persons
- F7: Mental retardation
- F8: Disorders of psychological development
- F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- In addition, there are a group of "unspecified mental disorders".

Within each grouping there are more specific subcategories. The ICD includes personality disorders on the same domain as other mental disorders, unlike the DSM. But, however these are used, the descriptors, particularly like those in F1 above: 'Mental and behavioural disorders due to use of psychoactive substances' are largely phenomenological descriptors:

> *"The main diagnosis should be classified, whenever possible, according to the substance or class of substances that has caused or contributed most to the presenting clinical syndrome. Other diagnoses should be coded when other psychoactive substances have been taken in intoxicating amounts (common fourth character .0) or to the extent of causing harm (common fourth character .1), dependence (common fourth character .2) or other disorders (common fourth character .3-.9)."* (WHO, 2007)

So, we then have a secondary set of phenomenological classifications:

F10: Mental and behavioural disorders due to use of alcohol
F11: Mental and behavioural disorders due to use of opioids
F12: Mental and behavioural disorders due to use of cannabinoids
F13: Mental and behavioural disorders due to use of sedatives or hypnotics
F14: Mental and behavioural disorders due to use of cocaine

F15: Mental and behavioural disorders due to use of other stimulants, including caffeine
F16: Mental and behavioural disorders due to use of hallucinogens
F17: Mental and behavioural disorders due to use of tobacco
F18: Mental and behavioural disorders due to use of volatile solvents
F19: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

And then a tertiary classification, giving the resulting state,

.0: Acute intoxication;
.1: Harmful use
.2: Dependence syndrome
.3: Withdrawal state
.4: Withdrawal state with delirium
.5: Psychotic disorder
.6: Amnesic syndrome
.7: Residual and late-onset psychotic disorder
.8: Other mental and behavioural disorders
.9: Unspecified mental and behavioural disorder

This means that "F16.5" is "Mental and behavioural disorders due to use of hallucinogens" that have resulted in a "Psychotic disorder" – as in a psychosis from taking LSD – unless, of course, the psychosis developed a while after the drug-taking, in which case it would be "F16.7". We find similar phenomenological sub-divisions in the other groupings. Some of these are less related to the actual cause of the problem and are more generally used for classification, insurance companies, and occasionally the type and extent of treatment. Very few of them relate to the actual lived experience of the patient.

Phenomenology has come a lot further than when it was first proposed back at the beginning of the 20th century, and it is not just useful as a classification system: it can assist psychotherapy practice (Owen, 2006). Besides the 'classification' system proposed in ICD-10, there are actual more pragmatic ways of working with these phenomenological perspectives. So I would now like to indicate a little of how phenomenology can be used in psychotherapy.

Leon Mosher (founder of the 'Soteria' communities) used a phenomenological approach in his approach to working with psychiatric patients, and this was mostly done very successfully and without resorting to the use of psychotropic medications.

> *So, I brought to my psychiatric residency a phenomenology-based "what you see is what you've got" bias to my interactions with patients and a sensitivity to the issues of degradation and power especially as embodied in conventional institutional practices. The good mentors (e.g. Drs Elvin Semrad and Norman Paul) in my psychiatric training taught me how to listen and attempt to find meaning in the distorted communications of my patients and their families (in 1962!) by doing my best to put my feet into their shoes. Harry Stack Sullivan (1962) and the double bind theory (Bateson et al., 1956) provided intellectual support. I also learned how to ask and look for answers to questions of interest from research gods (e.g. Dr Martin*

> *Orne). On the other hand, the institution itself gave me master classes in the art of "total institution" (Goffman, 1961); authoritarianism, the degradation ceremony, the induction and perpetuation of powerlessness, unnecessary dependency, labeling, and the primacy of institutional need over those of the persons it was ostensibly there to serve - the patients. These institutional lessons were not part of the training program. In fact, my efforts to be helpful to my patients were interrupted by these institutional needs. When brought up they were denied, rationalized or simply invalidated. "You're just a resident and aren't yet able to understand why these process are not as you see them." From a series of such experiences, I began to believe that psychiatric hospitals were not usually very good places in which to be insane.* (Mosher, 1999, p. 145)

What was successful about Mosher's approach – and R.D. Laing's – was that they did not ignore or deny the patient's experience. They did not 'treat' the patient, or 'do' things to them. The phenomenological method consists of 'being' with the patient in 'their world' and trying to see the world through 'their eyes'. This is where psychiatry falls down. By separating the 'doctor' and the 'patient' into 'well' and 'sick', a divide is created that prevents healing. The Soteria and Kingsley Hall communities did not create such a divide: they affirmed the person's experience and 'normalized' the person's 'treatment'.

Varghese (1988) examines the psychotherapeutic implications of Husserl's method within the epistemological framework of Kuhn, Piaget, and Popper's work, which provides a model for both psychopathology and the change process in psychotherapy. He concludes that psychotherapeutic change results basically from the experience of the therapeutic relationship (which is born out by research) and that this significantly contradicts most prior psychopathological paradigms. The phenomenological approach enhances this process of change. However, this perspective of phenomenology in psychotherapy has been critiqued, particularly with respect to a phenomenology of empathy:

> *In an important paper in this journal, F. T. Varghese demonstrated the clinical benefit of the phenomenological method, and showed that this benefit is effectuated in and through the empathic field. However, Varghese's formulations are in crucial respects incorrect and in need of reformulation if there is to be significant progress in bringing forth a credible theory of psychotherapy based on Husserlian phenomenology. The purpose of this paper is to make the needed corrections in Varghese's work and at the same time begin to develop a phenomenology of empathy.* (Nissim-Sabat, 1995; Abstract)

First an allegorical example: a psychiatrist and a priest both get to see a patient who reports hearing voices: the psychiatrist thinks it is a disease and prescribes a treatment that lasts for many years. When the patient doesn't hear voices any longer, the treatment stops and the patient starts to hear the voices again. Whereas the priest thinks the person is listening to angels or to God.

Often, when we (or other people) hear voices, our own "stuff", or other peoples' "stuff", gets in the way, and thus we don't hear them so clearly, a little like a badly tuned radio. I wrote of a similar example in another article (Young, 2010), where an elderly lady in Texas rang up a Spiritual Emergencies referral service in California some time ago and said, *"Can you help me? Last Christmas, God came and sat in my head."* When asked what she meant by that, she said, *"I seem to know things that are going to happen before they happen and I get messages telling me what to do and what is happening with other people. I know what people are thinking. ... Now, my Minister says that I am of the Devil and my women's group at the Church say that I am a witch, and my husband, well, he just doesn't want to know anything about this at all. So can you help me?"* This is a clash between her phenomenological perspective and other peoples' belief systems.

There is another perspective that should be mentioned: within psychotherapy in recent years, there has been an increase of interest in the findings of neuroscience and particularly psycho-neuro-immunology. Whilst much of this is absolutely fascinating, and potentially very relevant to our work as psychotherapists, it is also potentially a distraction. It is not questioned that different neurological pathways and biochemical reactions are involved in the ability of the mind to interpret and affect physical states. However, this facility exists within:

> *... a philosophical and social dimension that matches an understanding of the interactions between the individual and the outside world. It is not enough for the individual to feel connected to the collective organism of society itself, called upon as it is to meet threats to human welfare and, indeed, to human survival. No individual may have it within his or her power to overcome or expunge the malaises and misfortunes of society. But everyone has something important to contribute to the whole, and the radiating effects of that contribution are sometimes beyond calculation. ... It addresses itself squarely to the greatest need of our time, which is to shatter tour feelings of helplessness about challenges that are personal or impersonal, in the immediate community or the outside world. For it is not enough to be told that we possess powers far beyond our conscious awareness; it is important to know the nature and reach of those powers and how to activate them.* (Frank & Frank, 1993)

There has been a big debate in psychotherapy between the "(bio)medical" model and the more psychotherapeutic (psychodynamic, systemic, person-centered or process-oriented) models. If we address the medical-model patients first: *Who ever told you that you were ill?* The first thing to do perhaps is actually to 'step away' from the medical model. Most of the people who come for psychotherapy are not sick or ill; there is nothing actually 'wrong' with them, or their minds; they are not 'patients'; and we need to de-role ourselves from the 'medical' part of a profession that involves such 'diagnosis' and 'treatment'. The patients (sorry) - the people - who come to see us –

see themselves differently. They don't feel 'themselves' - their 'usual' selves, so there *"must be something wrong"* (with them). They often feel lost, scared, confused, and upset.

So, we may need to listen to them very carefully; we may need to help them to understand what is happening to them; maybe reassure them, that from one perspective anyway, there is nothing wrong with them at all; perhaps we may need to 'assess' their needs; or maybe help them to determine a 'good enough' course of action for themselves; they often do not need (or want) a lot of psychological 'stuff'; they just want some clarity, to use our knowledge and experience, and to see what we, as professionals, can offer them, depending on our background, training and experience. They often want some simple pragmatic suggestions – to go away and 'do' this or that. As professionals, we need to ensure that 'this' or 'that' suggestion is suitable and appropriate to what they seem to be wanting.

So we need to 'tailor' our methods and skills and interventions more towards their needs, and not assume that – just because we are professionals – we have the right methods and know the answers and what is 'right' for them. Psychotherapy is not really designed for the 'diagnosis' and 'treatment' model. As psychotherapists, we are generally much more concerned with the person's process; their unfolding and changing experiences and needs; the richness and complexities of their feelings, and what underlies all these dynamics; what they can change and what aspects of their process they have difficulty with, and for what reasons. This is actually quite phenomenological – and we need to walk with them, at least alongside them if not actually in their shoes.

There are only two domains in psychiatry: the pathological and the normal. By way of contrast, there are three main domains in psychotherapy: (i) the intra-personal, in which we investigate what is inside of us; (ii) the inter-personal where we communicate with those people around us; and (iii) the trans-personal, where we identify what is common to all of us, despite all of our differences. But the central point of psychotherapy lies within the person – or the personality. When their world falls apart, or they discover that things are not working for them, then they come for help with these sufferings and needs. We cannot provide them with everything they want; we can only help them to understand themselves a little more functionally, use different ways to describe what they are experiencing, help them make connections between these aspects and those events, and so forth. They describe what they experience, and we – because of our training, knowledge, skills and experience – despite the modality we have been trained in – can describe what we see and hear as aspects of their process and feed this back to them. We help them (hopefully) link the inter-personal with the intra-personal and the transpersonal.

A psychiatrist will understand and interpret someone who is 'seeing things' or 'hearing voices' as delusions, possibly with a biological cause, but almost definitely needing psychological and often pharmacological treatment; we may hear this as a manifestation of their unconscious, or maybe even accept that they believe that they are seeing things – and that acceptance is crucial and affirming to them. and to their development. We are helping them perhaps more with psychological hygiene than with mental illness. An EAP colleague wrote:

> *From which position do I ask my question? As a psychotherapist, I speak to the person as a subject; on the other hand, as a psychiatrist, I will tend to look at them as an object." "What do I do with the person? Psychiatry tries to cure the symptoms. Psychotherapy tries to help the person alleviate the cause or the affect of the problems. The psychiatrist's field (of expertise) is disease: the psychotherapist's is the alleviation of suffering.*
> *Existentially, we can and do all suffer. All we can do is to help the person alleviate some of their suffering. This is closer to existentialism than it is to mental health: a philosophy rather than a treatment; a new way of being, rather than a cure.* (Alexander Filz: personal communication: February 2010)

Whilst we mostly live <u>in</u> the conscious world, we are largely lived <u>by</u> our Unconscious, and we usually live <u>for</u> something even bigger or higher than that. This is not a very popular concept in traditional phenomenology. Nevertheless, a large part of our experience is viewed through transpersonal, spiritual or religious 'spectacles', which 'frame' our experiences of life. These are often taken as a 'given', but vary considerably with each person's different perspective. So, what is not communicated? Or what is informed by our dreams, or by our "structures of meaning"? Maybe we need another disc-like layer (as in Fig. 1), which would be that of 'Belief Systems'.

Human existence can therefore be seen from many different perspectives and in many different terms, especially like that of improving our capabilities: there is a wider form of thinking when we consider concepts of unfolding and blossoming as a whole person; or becoming more 'whole'; or facing the 'Dark Side' (as in the tradition of Sartre's Existential Psychoanalysis[6]), and so this is where I begin to diverge from the standard phenomenological aspects of psychotherapy, towards more aspirational aspects, or even perhaps towards transpersonal psychotherapy. We can start to use teleological forms of thinking as we experiment with a better system of 'being'; we can study the causes of why and how we have become who we are at this moment in time – and what this implies for the future; we can examine our motives in the light of a wider system of ethics – and seek to change these; and we can direct our current activities towards more beneficial goals.

We can heal our psychic wounds: not by taking in some chemical substance, nor by having this or that 'treatment', but essentially by accepting how these wounds have shaped us; why they might have been necessary to our survival (once upon a time); how we survived with them, or

despite them; and even how and what we can learn from them now. But we also have to not only accept them, but also to be able to step outside them and look at them clearly. This involves a degree of freedom of thought, or width of vision, that Hesserl was trying to attempt with his "radical certitude". This is something of what psychotherapy can do – and, limited by the biomedical model, the current state of psychiatry cannot do.

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Endnotes:

[1] Society for Existential Analysis: www.existentialanalysis.co.uk/

[2] Wikipedia: http://e.wikipedia.org/wiki/Existential_therapy

[3] Society for Existential analytical therapists: SEA: www.existentialanalysis.co.uk

[4] Digby Tantum & Emmy van Deurzen: http://www.existentialpsychotherapy.net (accessed 16/04/2010)

[5] Constitutive: definition = forming part of; essential to; formed continuously with; establishing.

[6] **Existential psychotherapy** is a method of therapy that operates on the belief that inner conflict within a person is due to that individual's confrontation with the givens of existence. These givens … are: the inevitability of death, freedom and its attendant responsibility, existential isolation (referring to phenomenology), and finally meaninglessness. (Wikipedia: accessed 16/05/2010: http://en.wikipedia.org/wiki/Existential_therapy)