Existential–Phenomenological Perspectives in Psychology

Exploring the Breadth of Human Experience

With a Special Section on Transpersonal Psychology

Edited by
Ronald S. Valle
John F. Kennedy University
Orinda, California

and

Steen Halling
Seattle University
Seattle, Washington

With a Foreword by James F. T. Bugental

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Psychotherapy and Human Experience

Donald Moss

Each human being entering the psychotherapist's office reveals a unique experience of the world, of self, and of other persons. In 1958, the landmark volume *Existence* (May, Angel, & Ellenberger, 1958) introduced the existential and phenomenological perspectives to American psychotherapists. Since then, the meaning of the patient's experience has been at the heart of new developments in the science and practice of psychotherapy. The present chapter takes as its theme psychotherapy and human experience, including but also reaching beyond the specific schools of existential and phenomenological psychotherapy, to encompass the broader family of experientially oriented psychotherapies. The chapter provides an integrative synthesis, from the standpoint of the psychotherapist, of the most useful strands within this broad psychotherapeutic tradition.

We include a number of authors who are not explicitly phenomenological or experiential in orientation but who nevertheless are masters of the art of psychotherapy and have contributed richly to understanding the significance of the patient's experience in the psychotherapeutic process (Bruch, 1974; Fromm-Reichmann, 1950; Jung, 1985; Sträpp, 1984).

This chapter is organized around the following topics: (a) Historical introduction to phenomenological and existential influences on psychotherapy, (b) fundamental principles in experientially oriented psychotherapy, (c) the therapeutic attitude, (d) helping oneself versus being helped, (e) the temporal structure of the human life, (f) the temporal process of psychotherapy in phenomenological perspective, and (g) modalities of therapeutic intervention.

**HISTORICAL INTRODUCTION TO PHENOMENOLOGICAL AND EXISTENTIAL INFLUENCES ON PSYCHOTHERAPY**

The terminology and names within the large family of existential and phenomenological psychology are often confusing, so we will begin with a brief identification of psychological and psychotherapeutic schools, accenting both their divergences and overlaps. For more detail on the history and conceptual frameworks of phenomenological and experientially oriented psychotherapy, the reader is referred to May, Ellenberger, and Angel (1958), Wyss (1973), May and Yalom (1984), Yalom (1980), Fischer and Fischer (1983), Bugental (1985, 1987), and Halling and Dearborn Nill (in press).

**Psychoanalysis**

Experientially oriented psychotherapy would be unjustifiable were it not to acknowledge its immense debt to Sigmund Freud and the subsequent psychoanalytic schools, especially the analytic psychology of Carl Jung, the will psychology of Otto Rank, and the individual psychology of Alfred Adler. The early existential and phenomenological psychiatrists showed that Freud's natural scientific orientation, with its emphasis on instincts and genetic causes, was inadequate to the understanding of human experience, yet these same critics in their practice of psychotherapy followed many of the lines of their psychoanalytic training. Many of the insights that set phe-
nomenological psychotherapy apart from psychoanalysis have also been formulated in parallel fashion by creative dissenters within the psychoanalytic tradition.

Psychoanalytic therapy encourages the patient to express whatever thought or feeling enters awareness. The purpose of psychoanalytic therapy is to: (a) bring unconscious conflicts and impulses to conscious, verbal expression, (b) transform impersonal, seemingly instinctual processes into personally "owned" motives and desires, and (c) identify and "work through" earlier traumatic experiences that contribute to present-day symptoms. The therapist relies on verbal interpretation, clarification, and confrontation of the patient's conflicts and defensive structure.

Existential

Existentialism traces its nineteenth-century roots to the Danish philosopher and theologian Søren Kierkegaard and the German philosopher Friedrich Nietzsche. In our century, existentialism influenced European psychiatry and psychotherapy dramatically after the 1927 publication of Martin Heidegger's philosophical work Being and Time (1962) and again after World War II under the influence of Jean Paul Sartre's (1956) Being and Nothingness. In psychotherapy, existential influences include the emphasis on the individual's freedom and responsibility for his or her own existence, the process of becoming an individual, the challenge to authenticity in existence, and the positive role of anxiety as a medium for change and growth.

Existential psychotherapy emphasizes the real relationship between the therapist and the patient, involving an authentic encounter in the present moment between two existing individuals. Existential psychotherapy recognizes psychiatric symptoms as meaningful expressions of a disharmony in the patient's existence, which are to be understood and not merely suppressed. It advocates an openness to the tragic dimension of human life, and not merely a naïve Pollyanna-like optimism.

Daseinsanalysis

The existential movement in European psychotherapy took various names—existential analysis, anthropological psychiatry, "onto-analysis," and the German name Daseinsanalysis. The early pillars of this movement were Ludwig Binswanger, Viktor von Geszten, Erwin Strans, Jurg Zutt, and Eugene Minkowski. After World War II, Medard Boss (in collaboration with Martin Heidegger) forged his own viewpoint of Daseinsanalysis, and Dieter Wyss formulated the approach of "anthropological integrative" psychotherapy. Several European refugees from the Nazis brought a knowledge of existential analysis with them to the United States in the 1940s, but the real Americanization of existential analysis began with the 1958 publication by Rollo May, Ernest Angel, and Henri Ellenberger of Existence, an anthology of works by European authors.

Most Daseinsanalysts or existential analysts remain psychoanalytic in their basic clinical procedure—often utilizing a couch, encouraging the patient to a free and uncensored expression of thoughts and feelings, and intervening with verbal interpretations, clarifications, and confrontations. However, the existential analyst abandons the biological, instinctually oriented concepts of Freudian analysis and adopts a more existential interpretation of the patient's experience. Prominent American existential analysts include Rollo May (1977), James Bugental (1987), and Irvin Yalom (1980).

Phenomenological

Phenomenology in philosophy was the creation of the German Edmund Husserl, who called for a "return to the things themselves" through a clearing away of assumptions and preconceptions. This methodological "fresh start" enables the phenomenologist to suspend his or her usual experience and interpretations of the world, in order to understand phenomena "as they present themselves." This philosophical new beginning immediately impressed European psychiatrists and psychologists, such as Binswanger, Karl Jaspers, and H. C. Rümke, who were seeking new theoretical foundations to understand the human being in his or her own nature, apart from the assumptions of science.

The concepts of phenomenology illuminate the experience of psychiatric patients and the process of psychotherapy in several ways: (a) human behavior and experience reveal a nature different from that of natural phenomena and require a distinct "human-science" approach if they are to be understood, (b) psychic phenomena, behavior, and experience can be understood through their "intentional" structure, that is, they are meaningfully directed toward a situation or object, and (c) in order to understand and to reach a patient, the psychotherapist must enter into a mutual experiencing of the patient's unique world of experience, with its own time, space, and interpersonal forms.

More recently, the Dutch psychiatrist van den Berg (1980) defined phenomenology in psychiatry as the "science of divergent thinking" about people and their world. In other words, phenomenological psychotherapy is never content with a simple change in behavior. Rather, the patient is invited to see his or her world in a different light, to discover a novel perspective on life and relationships, and to recapture and vital way of perceiving and interpretation of practical modification.

Gestalt

Gestalt psychotherapeutic patient's lively emotion now" (Perls, Heffer, and Thirst Polster & Polster relies heavily on the frequent experiences that part trauma or confidant issue in Gestalness, "as a preconc block effective life patient is invited to experience it differently or analysis: Gestalt therapy, and not on individualization, or an image a greater emotional The patient is invited her role in creating deeper ownership of the new Client-Centered

Carl Rogers' school of psychotherapy Rogers abandoned the patient's past. He nondirectively to the world of experience manner the patient's self-aware client-centered therapy or paraphrasing an emphasis on the feeling alone and abjection serves to acceptance of feeling, growth emerges spo tient's "real self," coping atmosphere...
tionships, and to recapture a sense of wonder in a fresh and vital way of perceiving. This transformed perception and interpretation of life events becomes the avenue for practical modifications in behavior and relationships.

**Gestalt**

Gestalt psychologists such as Fritz Perls radicalized psychotherapeutic technique by an emphasis on the patient's lively emotional experiencing in the "here-and-now" (Perls, Hefferline, & Goodman, 1951). Gestalt therapists have criticized "abstraction"—empty and unemotional talk about past events and distant situations, and invited patients to react intensively and in a fully physical fashion to the immediate situation with the therapist (Polster & Polster, 1973, p. 234). Gestalt therapy relies heavily on the therapeutic value of novel and divergent experiences that make no explicit connection with a past trauma or conflict. If the past emerges as an immediate issue in Gestalt therapy, it is as "unfinished business," as a preoccupation with old emotional issues that blocks effective living in the present. In this case, the patient is invited to reexperience or reenact that past so as to experience it differently and is discouraged from mere recitation or analysis of past events.

Gestalt therapy places emphasis on the process of therapy, and not on its content or issues. Role play, visualization, or an imagined reliving of an experience create a greater emotional intensity in the therapeutic session. The patient is invited to a broadened awareness of his or her role in creating life and relationships, invited to a deeper ownership of that role, and challenged to experiment now with new modes of behaving and relating.

**Client-Centered Therapy**

Carl Rogers originated the first truly American school of psychotherapy: client-centered psychotherapy. Rogers abandoned the exclusive preoccupation with the patient’s past. He encouraged the therapist to respond nondirectively to the patient, to understand the patient’s world of experience, and to reflect back in an affirming manner the patient’s own feelings, thus enhancing the patient’s self-awareness. The therapeutic procedure of client-centered therapy involves a continuous "reflection" or paraphrasing of the patient’s experiences, with an emphasis on the feeling dimension: "You seem to be feeling alone and abandoned." This nonjudgmental "reflection" serves to amplify the patient’s awareness and acceptance of feelings. Rogers (1951, 1959) believed that growth emerges spontaneously toward actualizing the patient’s "real self," once the therapist establishes an accepting atmosphere of "unconditional positive regard."

This concept of unconditional positive regard has broadened beyond an explicit approval of behaviors or statements to convey a deep respect for the person and for the "power of life" as it seeks its own way toward fullness and growth (Willis, 1985).

**Experiential**

Experiential psychotherapy is a specific school of therapy and should not be confused with the wider movement of experiential-oriented psychotherapies (Friedman, 1976). Experiential psychotherapy draws on elements from phenomenological, Rogerian, and Gestalt psychotherapy but transforms them from a general approach into a specific method of psychotherapy with procedures, steps, and interventions. Eugene Gendlin (1968) began with research on the process of client-centered therapy and what he called the "experiential response," a patient response that felt deeply, bodily, and immediately at an emotional level. He refined this element in the therapeutic process further into a teachable procedure called "focusing," which guides the individual to stay concentrated and attentive to the immediate flow of feelings about his or her total emotional situation (Gendlin, 1981). Gendlin (1973) and Alvin Mather (1983) have designed specific sequences of steps to enable the patient to enter an "experiential state," to enhance the formation of a "felt sense" of one's situation, and to allow this felt sense to move toward deeper experiencing, self-encountering, and closure.

**Humanistic**

Abraham Maslow founded humanistic psychology as a "third force" within American psychology in an effort to throw the doors and windows of psychology wide open (1962, pp. vii–ix). Humanistic psychology became an eclectic meeting ground for divergent influences including existentialism, the psychology of consciousness, the encounter and sensitivity group movements, and transpersonal psychology. Maslow introduced many of the key themes of humanistic psychology and psychotherapy: the pursuit of self-actualization, personal growth, and full humanness; an emphasis on both being and becoming; and a recognition of the place of values within psychological science. He also challenged the focus in psychology on the study of abnormal and dysfunctional behaviors and insisted that psychology must include in its vision the study of truly creative, outstanding, and fully functioning human beings.

We have summarized several overlapping movements contributing to the psychotherapy of experience. On the American scene, these movements have converged to a great degree, endowing many humanistic or
experientially oriented psychotherapists with a core of broadly shared beliefs about the psychotherapeutic process: (a) therapy must commence with an empathic sharing of the patient’s experience of a personal world, (b) the therapist must encounter the patient in his or her full historicity—as a being with roots in the past, a home in the present, and aspirations for the future, (c) therapy proceeds most effectively through a lively, emotional, and immediate reexperiencing and mastery of key personal issues, (d) novel positive experiencing in the encounter with the therapist has a corrective therapeutic value in and of itself, and (e) the individual spontaneously moves toward health, growth, and fulfillment in a therapeutic atmosphere of safety, acceptance, and awareness. The remainder of the chapter will enlarge upon these core beliefs.

FUNDAMENTAL PRINCIPLES IN EXPERIENTIALLY ORIENTED PSYCHOTHERAPY

Being with the Patient in His or Her World of Experience

The core of the phenomenological challenge to the psychotherapist is the invitation to enter into the world and story of the patient. The patient requesting help is isolated within personal suffering and troubles, and the essential curative factor of all experientially oriented psychotherapy is to stand with the patient and bridge that isolation. If the therapist is to succeed in entering into the patient’s concerns, then he or she must not only comprehend but also experience the patient’s own unique situation.

R. D. Laing, the British phenomenological psychiatrist, emphasized the importance of understanding each human being’s individual world of experience:

Each person not only is an object in the world of others but is a position in space and time from which he experiences, constitutes, and acts in his world. He is his own center with his own point of view, and it is precisely each person’s perspective on the situation that he shares with others that we wish to discover. (Laing & Esterson, 1964, p. 19)

The Dutch phenomenologist, Jan van den Berg, showed that we can only truly illuminate the abnormal behavior of the psychiatric patient through a shared perception of his or her world, with its unique unfolding of time, its individualized landscape, and its personal populace:

To be ill, even with just a trivial illness . . . means, above all, to experience things in a different way . . . to live in another, maybe hardly different, maybe completely different world . . . . The depressed patient speaks of a world gone gloomy and dark. The flowers have lost their color, the sun has lost its brightness, everything looks dull and dead. . . . The patient suffering from mania, on the other hand, finds things full of color and beauty, more beautiful than he ever saw before. The schizophrenic sees, hears, and smells indications of a world disaster. In objects, he observes the downfall of his existence. In the voices of people, in the blowing of the wind, he hears that a revolution is about to come. In the taste of his bread, he discerns evils penetrating the things of his world. . . . The patient is ill; this means that his world is ill, literally, that his objects are ill, however unusual this may sound. When the psychiatric patient tells what his world is like, he states, without detours and without mistakes, what he is like. (van den Berg, 1972, p. 46)

Even simple behavior change, when this is the patient’s goal in seeking treatment, is often impeded when the psychotherapist fails to understand the patient’s world. The first step toward change that seems so trivial to the therapist, may appear to the patient as a leap into a life-menacing chasm, and repeated goal setting and establishment of rewards or punishments will be ineffectual unless this experience is recognized. Aaron Beck has taken this into account in his cognitive-behavioral therapy, calling for the therapist to listen attentively to the patient’s perception of the world, before any behavioral interventions are attempted (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979).

The Meaningfulness of All Symptomatology

Implied in the challenge to see the patient’s situation as he or she sees it is the challenge to view the patient’s most abnormal behavior and painful symptoms as containing elements of self-actualization (Moss, 1984). In early discussions in the field of phenomenological psychopathology, both LudwigBinswanger and Medard Boss introduced this concept of self-actualization (Binswanger, 1931; Boss, 1949; Moss, 1978, 1981a). Their studies showed that even the most pathological and disturbed behaviors involve a desperate and last resort effort to come to terms with a difficult situation. Sexual perversions, according to Boss (1949), can be understood as disordered attempts, in the face of “insurmountable worldly barriers,” to achieve a “loving mode of being.” Faced with an unbridgeable distance and isolation, the sexual deviate turns to ever more desperate means of making contact with another human being.

Similarly, R. D. Laing showed in his studies of the schizophrenic family that the most psychotic and delusional behaviors display “intentionality,” that is, they are meaningfully directed as self-expression and genuine communication toward the family (Laing, 1959; Laing & Esterson, 1964). Otto Rank (1964, p. 4) formulated this same insight differently: A neurosis represents the individual’s creative behavior and forms upon his being in the context to develop and express. If the therapist has the patient’s efforts to do a problem, then it will seemingly negatively both liberating and meaningfulness of a psychotherapy disturbance, one behavior that is in so often seen as trigger deep self-confidence.

Diagnosis versus

The first level of the diagnostic process is diagnosis and categorizes it into schizophrenia, a r disorder. In diagnosis is established the patient’s illness with a known object for analysis. This relation as a put-down, a level abnormality, and abnormality of a self-diagnosis, and sells own behavior. Each encourages this kit its impact on the society. The diagnosis instance of psychopathological different re and depressive of a child in a pi vastly different f and helplessness of m history of affective back at a distinct course. The on stand the problem psychotic ad

Rigid adhesion, however, The therapist mutuality or of “person therapist and patients. This second
individual's creative but miscarried effort to impose a control and form upon his or her world and can only be understood in the context of the individual ego's ongoing effort to develop and express itself creatively.

If the therapist is to affirm and encourage the patient's efforts to discover new solutions to his or her dilemma, then it will be necessary to look more closely at seemingly negative and disturbed behavior. Further, it is both liberating and reassuring to the individual to have the meaningfulness of one's normal behavior illuminated in psychotherapy and to realize that, even in personal disturbance, one has been coming to terms with life. Behavior that is in some sense adaptive or purposive nevertheless often seems irrational to the individual and can trigger deep self-doubt.

Diagnosis versus Empathy

The first level of understanding in psychological science is diagnosis and judgment. The diagnostician recognizes symptoms and signs of a disorder or disease process and categorizes the patient's behavior as indicative of schizophrenia, a major affective disorder, or a character disorder. In doing so, an unequal interpersonal relationship is established. As diagnostician, one is the authority with knowledge and skills, looking down at an object for analysis and diagnosis.

This relationship is often experienced by the patient as a put-down, a further evidence of his or her inferiority and abnormality. In many instances, the patient also internalizes this same attitude as a kind of self-judging, self-diagnosis, and self-discounting attitude toward his or her own behavior. Frequently, professionals reinforce and encourage this kind of self-analysis, without recognizing its impact on the self-esteem and confidence of a patient.

The diagnostic attitude is medically invaluable. One instance of psychological distress may demand a qualitatively different response from the next. An experience of severe depression and hopelessness following the death of a child in a previously strong and healthy woman is vastly different from a similar experience of depression and hopelessness in a woman with three previous hospitalizations for major depressive episodes and a family history of affective disorders. To diagnose means to stand back at a distance, to focus symptoms, to delineate the onset and course of the problem, and to seek to understand the problem in biological, biographic, family, and psychopathological perspectives.

Rigid adherence to this diagnostic attitude is anti-theoretical, however, to the principles of psychotherapy. The therapist must reach the patient in his or her subjectivity or "personhood." For this to happen requires that therapist and patients also encounter one another as persons. This second level of understanding in psychological science is empathy. Although never throwing away my knowledge or expertise, as therapist I encounter and accept each patient as a person, on the same level with myself. I walk with my patients in their journey and imagine myself alongside them at the center of their world of experience.

When abnormal and even unacceptable behaviors emerge, it is not sufficient to revert to the diagnostic frame of mind, label the behavior as "schizophrenic" or manipulative, and mediate or otherwise subdue the behavior. Rather, even if such intervention is necessary, the therapist is challenged to understand first: How is the patient experiencing this moment, this place, and these persons, such that he or she acts in this fashion? Any intervention will then be informed by an empathic understanding of the person, which guides the behavior into more effective therapeutic channels. Further, empathy validates the patient as a person to be both understood and respected, even if the therapist forcefully restricts the patient's behavior.

The Hermeneutic or Contextual Approach

Seeking to make sense of a difficult text in the Bible or in literature, one usually explores its "context," that is, the textual passages that surround it, the historical place and events that influenced it, and the personality and style of the author. It is assumed in advance that the text means something, if only one can view it from the proper angle and in the proper setting. Interpretation out of context violates the integrity of the text and distorts the original meaning of the statements because one then interprets words, phrases, and events from one's own very different and distant perspective.

This same "hermeneutic" approach applies to the behavior of the psychotherapeutic patient. Research by humanistic and phenomenological psychologists has shown that many of the abnormal behaviors so troublesome to those around the mentally ill individual consist of meaningful responses to a difficult situation. The difficulty, however, may not be apparent to others, as it is a difficulty in "the situation as he or she perceives it." The patient's own world of experience is thus the proper context within which to interpret his/her actions, and our challenge is to illuminate this experience. This approach places a dramatic emphasis on the individual experience of the patient in psychotherapy.

THE THERAPEUTIC ATTITUDE

Phenomenologically and experientially oriented psychotherapy decrees neither a specific technical attitude nor specific treatment techniques. Rather, any
therapeutic modality or technique may be applied, as long as the principles of mutuality, intersubjectivity, and kinship with the patient are respected, that is, as long as the total human involvement of the therapist is not reduced to mere technique. Further, each therapeutic intervention reflects the therapist's own grounding in a philosophy and ethic of human existence, forming a therapeutic attitude that guides each encounter with the patient. What follows is a review of the perspectives of several European phenomenological psychotherapists.

Albert Zacher, of the Institute for Psychotherapy and Medical Psychology, in Würzburg, West Germany, examined the issue of therapeutic attitude in an article, which also serves as a useful introduction to the Würzburg school of "anthropological-integrative psychotherapy" (Moss, in press; Zacher, 1985). Zacher takes as his guiding hypothesis that:

The attitude of the psychotherapist toward his patient is shaped essentially by the theoretical concepts which he represents. The decisive influence theory thus lies not in its explicit instructions for a therapeutic posture, but rather in its image of the human being. This image can even bring about an attitude contradicting the explicit prescriptions of the theory. (Zacher, 1985, p. 149)

Zacher introduces the general concept of a therapeutic attitude, drawing especially on Jürg Zutt's existentially oriented discussion of the "inner attitude" of the therapist. Zacher reflects on critical themes in the anthropologically oriented image of the human being. At the base of an anthropologically oriented psychotherapy lie a few central concepts: (1) The unity of body and mind, implying the personal animation of the total living body—as von Weizsäcker (1947) has pointed out, there is as deep a bond between the mind and the cells of the liver as between mind and the ganglion cells of the brain. (2) The mutuality of self and other—the existence of each individual refers in its very structure to the existence of others, from the earliest phases of individualization in infancy. (3) The temporality of human existence—the human being is to the same degree one who has been, one who is in the process of becoming, and an inhabitant of the future. (4) The two domains of the ontic and the pathetic—the human being lives not only in the ontic, objective world of things and factual events but also in the pathetic realm of "I should," "I can," "I may," "I must," and "I desire." (5) Illness as a fundamental mode of human existence—being sick is not just a factual change in the physical body; rather, it involves fundamental transformations in one's "being-in-the-world," that is, one's experience of time, space, and other persons. This final concept unifies the other concepts because only when we can envision the totality of a vital human existence can we adequately comprehend its deficient forms in illness. Zacher relies here especially on Viktor von Weizsäcker (1956) and Dieter Wyss (1973).

The image of the human being in anthropological psychotherapy carries its corresponding therapeutic attitude articulated variously by the chief representatives of phenomenological and anthropological psychotherapy. Von Gebhardsdorff (1954) called for a "partnership with the patient." Von Weizsäcker (1956) emphasized mutuality as the "logic of interaction" between psychotherapist and patient; he also called this psychotherapeutic dialectic a "personal intercourse." Wyss (1982), in his anthropological reflections on psychotherapy, insists that the psychotherapist must bring himself as a fellow sufferer into the relationship with the patient.

Zacher (1985) summarizes another indispensable constituent in this therapeutic attitude: The therapist recognizes that he or she also lives in the field of tension of the irresolvable antinomies of human existence. The unfathomable processes of life does not stop for any person, nor are its tragedies and mysteries withheld from the expert psychotherapist. Accordingly, the therapist renounces any effort to oversimplify or reduce the problems of life to one-dimensional definitions and solutions. In other words, he or she recognizes the existence of a real relationship between therapist and patient as two human beings encountering each other in the present and does not interpret every interaction as a symptom of transference from childhood.

It is not only specifically phenomenological therapists who recognize this dialogal or dialectical quality in the therapeutic interaction. For example, see Greenson & Wexler, 1969, for a discussion of the "transference relationship" in psychoanalytic treatment. Carl Jung (1985) also insisted that, in the interest of enhancing the individuality of the patient, the therapist must in many cases abandon all preconceptions and techniques, in which case "the therapist is no longer the agent of treatment, but a fellow participant in a process of individual development" (p. 8).

Further, in the therapist's eyes, the illness of the patient is not merely a circumscribed pathological process but rather a transformation of the entire self and world organization of the patient. Jung (1985) has shown that the phenomenon symptom—illness—patient—world is indivisible, or as he puts it: "When the patient comes to us with a neurosis, he does not bring a part but the whole of his psyche and with it that fragment of world on which that psyche depends, and without which it can never be properly understood" (p. 95). The therapist encounters this world of the patient as something new and unfamiliar, he or she learns to perceive its horror and wonder but does not make him- or herself at home in it. Rather, by being present to the patient, the therapist communicates that this world of illness is ge...
world of illness is genuine but is not the only and true world and indeed that it is capable of transformation.

Zacher closes his essay with a passage from Viktor von Weizsacker, which in itself conveys something fundamental about the attitude of the phenomenological psychotherapist: "In order to treat the living, one must partake oneself in life" (cited by Zacher, 1985, p. 159). Thus it is not only concept and theory that form the therapeutic attitude, but, rather, the concept and attitude are reflections of a deeper existential posture of the person of the therapist. Similarly, Jung (1965) held that the therapist not only "has his own method—he is that method... the great healing factor in psychotherapy is the doctor's personality" (p. 88). If we could broadly characterize this existential bearing of the therapist as a person, it resembles the "Yes-saying" affirmation of life of Nietzsche's Zarathustra (Nietzsche, 1966). The psychotherapist affirms the broadest range of personal experiencing and living, confronts self-imposed barriers and restrictions, and challenges any surrender or avoidance. In contrast, von Gebhardt (1954) characterized the essence of psychopathology as a "no-saying self-constriction," that is, as the fundamental antithesis of what we are here calling the therapeutic attitude.

Self-Actualization versus Self-Transcendence

Other perspectives on the therapeutic attitude should be delineated as well. Viktor Frankl (1967, pp. 49-61), for instance, has criticized the excessive emphasis on self-actualization and self-expression in humanistic psychotherapy. These concepts, widespread today, emphasize that psychotherapy will assist the patient toward the fulfillment of the "greatest number of his or her own latent possibilities (cf., an article by Marcus & Nurius, 1986, on "possible selves"). This understanding of psychotherapy already marks substantial progress beyond Freud's initial strictly biological emphasis on the reduction of instinctual tensions. Yet Frankl points out that true psychological health at its upper limits is characterized by a transcendence of self-preoccupation and an orientation toward an objective world of other persons, meanings, and values, which surpass the compass of the individual person. In other words, Frankl challenges the humanistic idea that the "environment is no more than a means to the person's self-actualizing ends" (Maslow, 1954, p. 117) because this idea devalues the ultimate meaning of the world.

Frankl's criticism has many dimensions. Erik Eriksen (1968) saw the final and highest stage of human development as the challenge to transcend one's individual perspective in the face of death and to affirm the ultimate value of the earth and of being: This is my world, and I am of it. In a similar vein, Christopher Lasch (1979) has criticized humanistic psychology for reinforcing the prevailing narcissism of our day, pointing out that patriotism and civic virtues demand the individual sometimes sacrifice his or her own existence for the higher value of nation, of mankind, or of an ideal: "Give me liberty or give me death." Traditional religious viewpoints insist that the highest levels of human existence are realized when the individual surrenders to a meaning or value beyond oneself. Both Eastern and Western spirituality emphasize this transcending of the self as a necessary step toward higher development. Transpersonal psychology also finds the ultimate fulfillment of the human being to lie in the transpersonal, supra-human level, where strictly self-oriented needs, goals, and aspirations lose prominence.

On an immediate, practical basis, the process of therapy often involves the therapist's efforts to redirect the patient's debilitating and paralyzing self-focus, because neurosis especially is marked by an inward self-absorption. The neurotic parent, for instance, who agonizes endlessly about living for his or her children, is frequently insensitive to the actual feelings and needs of each child. Life is lived too uniformly from the focus of oneself; too often, the neurotic personalizes the acts of others and the indifferent blows of life as though they were "done to me." In this context, altruism, "going out to others," or a genuine experience of self-transcending love (or genuine religious devotion) mark a step beyond neurosis!

Self-actualization in the sense discussed by Maslow (1962) and Erwin Straus (1982) was never intended to include such neurotic self-absorption. Maslow studied the lives of outstanding or "fully functioning" individuals to illustrate the meaning of self-actualization: "These same people, the strongest egos ever described and the most definitely individual, were also precisely the ones who could be most ego-less, self-transcending, and problem centered" (Maslow, 1962, p. 140). Jung, too, intended individuation and self-actualization in a much broader sense, defining the "self" as a transcendence of the personal ego.

Yet Frankl's critique at least reminds us that the therapist must occasionally challenge the patient to look beyond his or her personal horizon to the well-being of a marital partner, the needs of a child, or the good of a community, when the patient conceives "self-actualization" in too narrowly personal a scope. Otherwise the jargon of self-actualization will only reinforce the narcissism and neuroticism of the day. Too often, the pop psychological slogans of "finding oneself," "doing what feels good," or "taking risks" are enframed at the expense of marriage, vocational commitments, or deepest personal beliefs and values. Already in 1930, in a
monograph resting heavily on the concept of "self-actualization," Erwin Straus showed the trivialization of experience and personhood when commitments and involvements become transitory and unbinding and when broader cultural values are overthrown in favor of momentary personal urges (cf., Straus, 1982, pp. 33-48; Moss, 1981a).

The Values of the Therapist—Openness, Acceptance, and Hope

Therapeutic technique and therapeutic attitude are inseparable. The Swiss existential analyst, Medard Boss, discusses the implicit wisdom in Freud's basic rule of psychoanalytic technique, which requires that the patient be absolutely open and truthful in revealing everything that passes through mind or heart without any exception. In Boss's (1963) opinion, this practical advice aims at "enabling the patient to unveil himself and to unfold into his utmost openness" (p. 2).

The significance of this basic rule will stand out more clearly if we consider the attitude that Boss attempts to evoke in his patients. Boss prescribes an attitude for the psychotherapeutic patient that the philosopher Heidegger (1966) called Gelassenheit ("letting be-ness"). This idea of Gelassenheit is centuries old. Two German Rhineland mystics of the late thirteenth and the fourteenth centuries, Meister Eckhart and Johannes Tauler, recognized that much of the malaise of the individual arises from the attempt to be something in particular—to force one's fate into a particular mold. The meaning of our destiny always exceeds in scope the efforts of the individual to keep it tight in hand, and such efforts to grasp and contain fate do violence to the spontaneous emergence of our future. Eckhart and Tauler guided the individual toward a deliberate, methodical cultivation of a willful passivity, toward facing the nothingness of one's own narrow intentions and projects, and toward surrendering one's whole life over to the mystery of being. They called this openness to the mystery beyond one's individuality Gelassenheit (Moss, 1981b, pp. 344-345).

Boss (1963) believes this same attitude to be beneficial for psychotherapy patients, who frequently suffer from a severe self-narrowing of their openness to the world. Boss conceptualizes much of psychopathology as a loss of "world openness." In attempting to refuse some potential invitation or challenge presented by the world, the patient eventually paralyzes his or her capacity to respond spontaneously. Conversely, in therapy, Boss advises the patient to surrender conventional roles and expectations, and to surrender to unknown experiences that might seem ominous and threatening and that conventional wisdom tells one are better left alone: experiences involving anxiety, anger, shame, despondency, and despair.

Many authors in existential and psychotherapeutic traditions have emphasized the value of fostering a similar "attitude to experience" as a fundamental value of client-centered therapy. Even behavioristically oriented researchers have advocated an attitude of "passive volition" or "letting go" as a means of releasing physical tensions and emotional constriction and allowing one's psychosomatic organismic balance to return. Less surprisingly, Gabriel Marcel, the French Christian existentialist, discussed a state of availability or receptiveness (Disponibilité) as the pathway to a life no longer empty and meaningless. Marcel was concerned that many existentially influenced authors, especially those guided by Jean Paul Sartre's works, emphasize an openness to anxiety as an authentic aspect of our humanness, yet fail to illuminate the path beyond anxiety. Marcel believed that a true receptivity, which is creative in its fidelity to what life presents, will ultimately transcend anxiety and issue forth into hope (Bollnow, 1984a; Marcel, 1964).

The poet Rilke (1962) also advocated that whatever uncomfortable and strange experience presented itself to one's life ought to be welcomed and nurtured, for these "are the moments when something new has entered into us, something unknown; our feelings grow mute in shy perplexity, everything in us withdraws, a stillness comes, and the new, which no one knows, stands in the midst of it and is silent" (p. 64). In his letters to a young poet, he provides a vivid image to advocate this Zarathustralian embrace of the possible: "For if we think of this existence of the individual as a larger or smaller room, it appears that most people learn to know only a small corner of their room, a place by the window, a strip of floor on which they walk up and down. Thus they have a certain security" (Rilke, 1962, p. 68). Outside this familiar zone of comfort and familiarity lies growth, and the guiding ethos of psychotherapy is to ease the individual's movement beyond this comfort zone.

HELPING ONESELF VERSUS BEING HELPED

The single greatest criteria on which the schools and types of psychotherapies diverge is the dichotomy between: (a) those approaches that in a nondirective fashion assist the patient to search through personal strengths, history, and knowledge for the means to proceed in life and (b) those that teach the patient a framework of skills and principles already designed to solve a particular problem. The first approach enhances the individual's awareness of inner resources, whereas the second pro-

vides prefabricated solutions.
vides prefabricated ideas and tools already tested by others. We might choose the examples of nondirective, psychoanalytic psychotherapy and directive, cognitive behavioral therapy as examples of the two extremes. Most experientially oriented psychotherapists identify more with the nondirective, inwardly oriented approach, yet it is too simplistic to conclude that there is no place for directive skills and techniques in the course of experientially oriented psychotherapy.

The Swiss daseinsanalyst, Medard Boss, portrayed the essence of the two extremes utilizing Martin Heidegger's (1962) concept of "intervening care" and "anticipatory care" as two modes of relating to the patient (Boss, 1963; Moss, 1978). In the first mode, we act for the other person. This other person waits passively, ready to accept the help that is offered, or to reject it. The action taken is accomplished by us; the patient stands by submissively. In psychiatry, a pill is dispensed, and the patient waits for its therapeutic effect. Many active and directive therapeutic interventions and many behavioral prescriptions, however powerful and effective they may be, run the risk of robbing the patient as an individual human being of initiation and responsibility.

In anticipatory care, however, we do not intervene for the other. Rather, we anticipate the patient in his or her "ability to be." We call attention to what we see as a possibility emerging for the patient. The work then remains in the patient's hands, not ours. No ready-made solution is bestowed, but, rather, a challenge is presented.

Psychotherapy, at its best, is based on the recognition of the meaning of anticipatory care. The therapist does not influence the patient by definitive maxims or dogmas, nor does the therapist eliminate the patient's sufferings by technical means. The therapist cannot determine the direction or the extent of the changes in the person. The therapist can only assist by confronting resistances or obstacles to change, thus freeing the person for a process of change that, once begun, pursues its own course.

Thus there are dangers of the directive approaches. Already, in 1919, Freud anticipated and accepted that economic and other practical needs would create pressure for directive, short-term, practical interventions on a large scale in public clinics, to treat large numbers of persons in short measure, yet he was concerned that such techniques would force psychotherapists to "alloy the pure gold of analysis with the copper of direct suggestion" (Freud, 1963a, pp. 189–190). Jung too cautioned that "giving advice" plays as small a part in psychotherapy as does surgery in general medicine. Interestingly, Jung was unconcerned about its harm because "it has so little effect" (1985, p. 173).

Yet we might better conceive of therapeutic approaches not in a dichotomy but as distributed on a continuum: from those that find the "whole answer" within the patient to those that provide the "whole answer" in technique. In practice, even those schools that cultivate a rich armamentarium of prefabricated solutions to be prescribed for specific problems, such as biofeedback, behavior therapy, and cognitive therapy, can be practiced in such a fashion as to enhance the patient's responsibility and freedom over illness and life.

The biofeedback concept of "self-regulation," for instance, which derives from cybernetics and general systems theory, is often utilized to encourage the patient in biofeedback to accept the responsibility not only to regulate physical tensions and states of emotional arousal but also to become self-directing in the events of life and to become an active participant in his or her own health, well-being, and quality of life (Moss, 1986). Experiencing a small resurgence of success and confidence as he or she learns to control muscle tension, the patient gradually builds a greater sense of confidence and "self-efficacy" in managing relationships, work, and life as well. The attitude of the therapist is decisive here and will determine the difference between a mere mechanical imposition of technique and the therapeutic use of behavioral techniques as tools to facilitate a deeper process of genuine personal change.

THE TEMPORAL STRUCTURE OF THE HUMAN LIFE

From a phenomenological perspective, human life is often compared to a story, with its major and minor characters and themes, its conflicts, with their resolutions and lack of resolution, and its characteristic flavor and atmosphere that set the tone for events that will follow. The reality of the human life is not like the reality of liquids and solids in physics; it is closer to the reality of metaphor and story in literature, rhetoric, and the humanities (cf. Romanyshyn, 1982; Smith, 1987). Or, as Bugental (1985) expressed it, the human universe "is made of stories, not atoms."

The story of psychotherapy intertwines with the story of the person's life. The individual is provoked to seek psychotherapy by some moment of crisis in the course of this life, by a sense of being stuck and not carrying forward the progress of his or her life. Both psychoanalytic and phenomenological authors have shown that psycho-pathology includes in its fundamental structure a variety of distortions in life's temporal organization and unfolding. Psychoanalytic authors speak of a fixation in development, a "frozen history" (W. Reich), or of a regres-
sion to an earlier developmental level. Phenomenologists have spoken of a vital inhibition of becoming, an arrested development ("vitale Werdenhemmung," von Gsebattel, 1954, p. 130), or a flight from self-actualization (Straus, 1982). In the absence of an inviting, future horizon, existence coagulates and flows with the sluggishness and inertness so common in depression (Straus, 1966; Minkowski, 1970). The sociopath, on the other hand, lives in an unending sequence of impulse driven "nows," forgetful of past lessons and unmoved by the future consequences of present actions. Anxiety disorders represent a different distortion of the temporalizing of life; in anxiety, the individual "possibilizes"—orienting him- or herself to the worst possible catastrophic outcome for present events. Experientially oriented psychotherapy takes seriously the individual's sense of stubbornness, dread, or being blocked, moves to facilitate the patient's search for a path toward the next-developmental level, and seeks to open the individual awareness for the fullness of time.

The temporalizing of each moment transpires within the larger context of the individual's total life cycle. Daniel Levinson, in his research on the course of adult development, introduces many rich and useful concepts: the life course, the "era," and the life structure (Levinson, 1986; Levinson, Darrow, Klein, Levinson, & McKee, 1978). The "life structure" is the overall pattern or design of a person's life at a given time, similar to Binswanger's (1973) "basic forms" or Boss's (1963) "world designs." The central roles or areas of life into which the individual pours time and energy and the key relationships between the individual and the world make up the life structure. Levinson shows that we can evaluate the "satisfactoriness" of an individual's current life structure, assessing both its viability for operating in the environment and its suitability for the self: "What aspects of the self can be lived out within this structure? What aspects must be neglected or suppressed? What are the benefits and costs of this structure for the self?" (Levinson, 1986, pp. 10–11).

The course of life shows recurrent phases of transition, alternating between structure building and structure changing, as the individual faces new inner or outer challenges that necessitate a transition in his or her basic approach to life (see Levinson, 1986, for a detailed schema of adult development). Many such changes resemble an organic ripening or unfolding where one pattern or era of life builds smoothly on the previous. Other phases show more the pattern of a crisis with a radical shattering of the person's life. O. F. Bollnow (1987), in his anthropologically oriented investigations of the meaning of the human life crisis, showed that it is inherent to the nature of human life that a person's life miscarries, goes astray, or is shattered, and, in such moments, the individual is challenged to take hold of life and find the way back to a new beginning. The human life does not merely unfold and ripen in a steady organic fashion. Rather, the individual moves forward through an effortful series of upheavals, reversals, and renewal.

Cummings (1979) writes of the "lost dream" or "lost hope": When psychotherapy can discover and reawaken such a lost dream, it serves as a powerful vehicle for mobilizing personal resources and overcoming such obstacles as addiction, negativism, and apathy. The lives of many persons entering psychotherapy are permeated by a deep and pervasive nostalgia, or sense of lost expectations; life continues in its seeming progress but seems empty of its former vigor. Hermann Hesse's (1961) Journey to the East is an allegory of this nostalgia, especially in the figure of the aging protagonist, H. H., who begins by remissimking and attempting to retrieve the essence of a youthful crusade. The protagonist describes at one point the sale of the violin with which he once had made such beautiful music for his companions on the journey. This becomes one of many symbols for the series of compromises he made with the practicalities of life, which led him farther and farther from the vision of his youth. Eventually, he is called before a tribunal for this betrayal of the "journey to the East" and for the "dreadful stupid, narrow, suicidal life which you have led" (Hesse, 1961, p. 109). Yet he is "acquitted" for this universally human loss of vision, something also familiar to each member of the tribunal, and challenged to pick up the thread of this lost dream and carry it forward within the context of his late adult life.

Otto Bollnow (1987), in reflecting on the search for new beginnings in the human life cycle, interpreted Hesse's allegory as an "outward depiction of the return of the human being to his essential origin" (p. 30). It is not an attempt to go back in space or in time but rather to find renewal in the present: "Inward youth is ... something given first of all as a task. It does not come to him as a gift from the gods, but rather must first be acquired" (1987, p. 42). Taking Hesse's story as an allegory of all spiritual searching, we can see in psychotherapy, too, a search for renewal and inward youth.

One male patient, for example, with a severe and recurrent depression accompanied by repetitive self-doubts, reported to me a deep disillusionment with his life and especially his career as a government accountant. As he related the story of his earlier life, the religious fervor of his youth was evident, as was the emphasis he placed on a life of "service." He had dreamed earlier of various ways of serving others, from forestry to the ministry. This ideal of service was still a dream capable of arousing his energy and enthusiasm, but the sense of being trapped in the comfortable but work robbed his life service to steer toward searching for the weight of need and the heart from this considered life to a discussion away.

THE TEMPSYS

PHENOMENON

The Opening Phase
Diagnostician view

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the comfortable but meaningless security of his current work robbed his life of vitality. With this bright star of service to steer toward, his therapy became a process of searching for the way to restore the balance between practical needs and the ideal of service in his life. Let us turn from this consideration of the time structure of the human life to a discussion of the temporal process of psychotherapy.

THE TEMPORAL PROCESS OF PSYCHOThERAPY IN PHENOMENOLOGICAL PERSPECTIVE

The Opening Phase of Therapy (Or, the Diagnostican versus the "Good Host")

Hilde Bruch (1974) titles her chapter on the opening phase of therapy "When Strangers Meet," and reminds us that the first visit in psychotherapy requires the same amenities of kindness, courtesy, and respect as any first social encounter but with the added dimension that this encounter is purposeful. "Something of positive value and constructive usefulness for the patient should come of it" (p. 5). It is in this first visit, and more generally in the opening phase of psychotherapy, that an initial sense of direction, a working alliance between patient and therapist, a sense of realistic mutual expectations, and a hope for renewal through self-discovery are created.

We discussed, previously, the impact of diagnosis on the psychotherapeutic relationship; it can create an unequal relationship of expert diagnostician and pathological specimen. The phenomenological contribution to the opening phase of psychotherapy is an approach that transcends diagnosis and enters into a deep empathic encounter with the patient.

Charles Maes (1972), in his Duquesne University seminars on phenomenological psychotherapy, introduced the useful concept of the "gift." He did so in part to counteract the myth of the "unmotivated patient"—the patient who requests psychotherapy but does not "work" in therapy in the usual energetic and clearly directed fashion. Maes insists that there is no unmotivated patient, that is, each individual is motivated; existence itself is movement. This movement is a gift that the individual patient presents to the therapist. The ethos of the gift demands receptivity and a gracious appreciation for what is given. The art and discipline of being a psychotherapist involves developing the grateful receptivity to hear, accept, and bring into illumination what kind of gift each patient brings to the consultation room.

Contemporary psychiatry has developed a rich understanding of personality structure and personality disorders to describe the "stuckness" of many patients who repeat the same self-defeating patterns in relationships, jobs, and life in general over and over through adult life, and manifest these same patterns in their relationships with frustrated psychotherapists. Unfortunately, the so-called personality disordered patient is especially likely to be labeled as unmotivated. The most infamous patient now is probably the patient diagnosed with "borderline" personality, a pattern that brings together many features of other personality disorders along with a lack of consistent personality structure: histrionic appeals for nurturance and attention, dramatic swings in mood, impulsive and often self-destructive behaviors, a sensitivity to abandonment, personal experiences of emptiness and fragmentation, and a chameleonic disposition to take on the psychological coloring of any new surrounding. This diagnosis may send a team of therapists into tremors of apprehension, as each clinician recalls some classic case of a "borderline" patient appealing for assistance and then rejecting the action taken, pitting one professional against another, or plunging from lucid sanity to seeming psychosis because of a rescheduled appointment. There is a great temptation for the psychotherapist to immediately label such patients in some such stigmatizing fashion and dismiss their "disordered" behavior simply as part of the diagnostic picture—as "to be expected of such a case." Yet humanistic and experiential psychology have shown that the most self-defeating patterns are nevertheless, in some sense, adaptive and purposeful, if only we can decipher the proper context toward which the patient directs his/her behavior.

Abraham Maslow originated a pyramid schema displaying the hierarchy of human needs, asserting that all human behavior tends ultimately toward the higher needs of self-actualization, individuation, and becoming fully human. However, he also showed that at the lower levels of the pyramid, behavior is dominated by deficiencies and the drive to complete them. The biological need for food to survive is more "prepotent" than the need for safety and security; the latter is more prepotent than the need for love or nurturance; the latter more so than the need for self-esteem, and so on. This scheme shows that whether or not the individual himself perceives this in his or her striving, gratification and resolution of a lower need open consciousness to domination by another higher need. The personality disorders are instances of an individual trapped developmentally in the grips of some lower, basic, deficiency-oriented need: "So far as he is concerned, the absolute, ultimate value, synonymous with life itself, is whichever need in the hierarchy he is dominated by during a particular period" (Maslow, 1962, pp. 153–154).

One of my patients, a 34-year-old woman named Ellen, who reported both childhood physical abuse and
sexual molestation, was frequently diagnosed as "borderline personality." She spent a total of 18 years in therapy with seven separate therapists repeating the same basic scenario: desperate appeals for her therapist to love, nurture, and tend her unconditionally, to be her sun, moon, and stars, and to withstand every provocation and test she could put that love to. When declarations of suicidal despair and shrieks of helplessness failed to win special after-hours attention, she performed rather childlike and ineffective gestures at suicide and self-mutilation in the therapeutic sessions to display the immensity of her need. (In my first session with her, she attempted to strangle herself with a belt of thin yarn.) When she could not elicit enough "good" nurturing mothering, she blamed her own "evilness"; she then attempted to provoke punitive, "bad" mothering—pushing the therapist to "give me what I deserve." Appeals for attention to reality-based goals of social adjustment or self-actualization fell on deaf ears.

Ellen was living perpetually in the immediate fear of imminent abandonment by the one person she needed most to survive in this world. Harsh confrontation only exacerbated her feelings of abandonment and endangerment; she responded best to a consistent but gentle reinstatement of limits. Unless psychotherapy could encounter her at the level where she was living, it was fruitless. Only after years of empathic affirmation and encouragement for the person she already was, did she begin to transcend this blocked need for basic nurturance, and display a willingness for personal rebuilding. In effect, Ellen remained suspended for years in the opening phase of psychotherapy, hungering to engage the therapist in a relationship but never solidifying that bond. (We will discuss later phases of Ellen's treatment later in the chapter.)

Another patient, Lucy, had never experienced basic trust and security; she spent day after day in a vigilant scanning of the environment for potential aggressors and dangers. Session after session, Lucy searched my every utterance and behavior for a sign that I too was a menace. By merely labeling Lucy as a paranoid personality, one would miss the meaning and purposiveness of her behavior and miss Lucy the person in her immediate lived engagement with a menacing world. The contextual meaning of her behavior is to establish a sense of basic security in an existence that has never experienced anything but endangerment.

Anthony Barton (1985), an American phenomenological psychologist, has endeavored to understand the therapeutic attitude in the first phase of therapy concretely, as a disciplined and systematic transformation of everyday modes of being with other persons. Barton points out that, unlike the ordinary citizen, the therapist characteristically "stays with" the person, world, and story of the patient, attentively, interestedly, and with a willingness to bear the problems of the patient. Where others would pull away from the patient, the therapist stays with the patient. At the point where the family member or friend may chide the patient for oddness and peculiarity and convey some variant of "come be normal like me," the therapist, in contrast, finds a way to join with and stay with the patient's individual experience. One's work as therapist begins with this joining and staying, and the therapist continues to be "at work" illuminating the patient's peculiarity, suffering, and personal story.

This persistence in being "at work" is also a fundamental constituent in the therapeutic attitude. The tools of the therapist's work are the therapeutic techniques for joining with the patient; they involve the therapist's "co-participation in creating a common field of discourse, meaning, interaction, and language focused on the patient's life" (Barton, 1985, pp. 2-3). Once these initial moves have taken place and successfully created a "common field of presence with the patient," a second set of moves commence, "in which the therapist alters, transforms, or otherwise intervenes in the unfolding of the suffering life of the patient" (Barton, 1985, p. 5). Barton believes that the greatest contribution of phenomenological psychotherapy is the "initial moves" of joining and staying with the patient; the rich variety of techniques from the most diverse therapeutic schools can all be successful in the second stage. "As long as the staying-with and joining-with is being done sufficiently and well, any or all of these modalities of intervention will work helpfully in assisting the patient to a life of decreased misery, increased self and other understanding" (Barton, 1985, p. 5).

The Central Phase of Psychotherapy

According to Martin Heidegger (1962), the German phenomenological philosopher, one of the essential characteristics of human existence is that individuals are "thrown" into the world. They always find themselves already immersed in a situation, a history, and a network of relationships not originally chosen. This is the "facticity" or destiny of life that the strongest individual cannot erase. Psychotherapy challenges the individual to take this "thrownness" and make it in some way "my own," to take the facts and particularities and create of them a new life that is uniquely an expression of oneself.

Jean Paul Sartre (1956), on the other hand, emphasizes the freedom and responsibility of each individual for his or her entire existence. Each individual is, in some sense, the creator of his or her own situation. Sartre denies any and all limitations on the freedom of human existence and confron the blame others or outsider content or suffering. away from an aware individual relates therapist's role then i patient, to confront or the patient toward a "his life is based." (H)

Many individual experiences, come in their "thrownness"—either perceived as background for the social context or toward a new life in histronic and manic spy "living beyond d and extravagant man life, while ignoring th and, spiritual being."

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The psychotherapist practices his or her art in the tension between the attitudes of Heidegger and Sartre, between a form of fatalism and an absolute idealism. On the one hand, the therapist challenges the individual to "make peace" with and appropriate as one's own the particularities of this one and only life cycle. Whether the past includes incest, the war in Vietnam, or a perfectionistic family environment, this is the individual's one and only existence, beginning point, and fund of experience. Simply to appropriate this set of facts and own it as one's personal history is already liberating. There is also a coming to terms with fate and the unchangeable. To quote the final words of Sophocles' Oedipus at Colonus, the patient is challenged to accept and affirm this threnows: "Cease now and never more lift up these lamentations, for all this is determined."

On the other hand, the psychotherapist also challenges the individual to own his or her life as an eternal product of personal choices and actions, taking responsibility for the consequences of past actions, and responsibly steering a course now toward a future only dimly seen. Like Isak Dinesen's (1961, p. 77) characters in "The Deluge at Norderney," the patient is invited to imagine that one's entire life and world is a creation of one's own imagination and is compell to ask the question, "Are we pleased with it, proud of it then?" Emotion itself is reinterpreted not merely as a passive reaction to events but as a powerful form of acting upon the world and others, as a form of personal conjuring that colors the atmosphere of one's existence and evokes a selected palette of responses from one's companions. In this Sartrean view, emotion is a form of "magical pseudo-action, a substitute for genuine action in situations which impose limitations on our freedom" (Halling & Dearborn Nill, in press).

Once the individual has attained a belief that this life is one's own and can become an active and freely directed creation, the individual can begin to regain access to a lost capacity for action. This sets in motion a process in psychotherapy that James Bugental (1985) has called "searching." The therapeutic dialogue at this point seeks new avenues for change, beyond the patient's current awareness. The full story of the patient's life becomes material sifted through in a search for hidden resources and potential. There is no shortcut either, to avoid the sometimes circuitous searching in this phase of personal renewal. We might think of the scene in Rodgers and Hammerstein's The Sound of Music, where the Abbess advises the young novice Maria, who is so confused about her own life directions. She advises Maria to "climb every mountain, search high and low, follow every by- way, every path you know. Climb every mountain, ford every stream, follow every rainbow, till you find your dream" ( Rodgers & Hammerstein, 1959).

The Termination or Concluding Phase of Psychotherapy

Martin Heidegger (1962) writes that human exist- ence realizes its greatest wholeness or consummation in man's "being toward his own death." It is in this orienta- tion toward the fact of one's own death that the limitations and finitude of one's existence becomes most clear. Sigmund Freud (1939) expressed himself similarly, with a Latin maxim that "Si vis vitam, para mortem"—If you would endure life, then prepare for death (p. 133). The medieval Christian church taught each individual the lesson of memento mori (remember death) as a means of placing limited and mortal goals in an eternal perspective.

These philosophical and religious lessons have implica- tions for a confrontation with twentieth-century psychopathology. Neurotic experiencing often includes among its manifestations a loss of time perspective, with a kind of vague floating awareness that one's life is out of balance, that I will act on that problem "someday," when the time seems right. Days turn into years, and one's life slips by with a kind of unreality. The individual's loss of this time sense carries with it a loss of appreciation for the gravity and urgency of one's actions and choices. For example, while in psychotherapy, a 40- year-old divorced mother arranged for her teen-age daughter to stay with a family member for "a couple of weeks" while the mother confronted her alcohol problem, her depression, and a number of self-defeating patterns in her living. Six months later, when confronted about the time that continued to pass with the daughter...
out of the house, she insisted she needed at least "a couple of months" to set her work, life, and relationships in better order, so she would be free to work on the right conditions for the daughter’s return.

Psychotherapy can exaggerate this sense of living outside of time, with its atmosphere of unconditional empathy and acceptance. Many patients lose a sense of how long they have been in psychotherapy, why they requested treatment in the first place, and what they want to accomplish in order to complete the process. One’s lack of progress or initiative is ignored with the rationale that one is "in therapy," as though that fact alone will accomplish the desired end. The psychotherapist is equally responsible in this regard, for failing to maintain a clear awareness of direction, the passage of time, and the ultimate end point of therapy.

Psychotherapy has multiple means of reminding the patient of limits and everyday reality, however, because it, too, is temporally structured. Each session has a beginning, a middle, and an end point fixed in advance. Although many have criticized the rigidity of the traditional 50-minute hour, it nevertheless remains true that the fixed time conveys a limit to the patient. The psychotherapist accepts the responsibility to assist the patient toward his/her goals for this fixed time; then the patient must continue with the direction and responsibility of his/her life beyond this time and place. Payment of money is also expected in return for the sessions, and money in our society represents reality and "business." The therapist is not the patient’s selfless mother or caretaker but rather a professional exchanging services for money. A patient who seeks to stay on at the close of the session and does not make the agreed-upon payments is revealing something about his/her fundamental attitude toward life and interactions with other persons that is of immediate relevance to the purpose of psychotherapy. The psychotherapist ignores such clues only at great cost to both himself or herself and the patient.

The fact that therapy is a temporary assist to life, and is not the process of life itself, must be kept in mind by both therapist and patient from the first session, for example, through a periodic review of progress toward goals, time in therapy, and remaining work to be done. The most decisive reminder of the finite scope of therapy involves the setting of a target date for therapy to cease. The advocates of short-term, time-limited psychotherapy argue that the end date should be set in advance of the first session, so that the sense of reality, urgency, and limit is present in the therapeutic relationship from the first moment (Strupp & Binder, 1984). James Mann (1973) expresses profoundly the existential dimensions of the patient’s time experience in time-limited psychotherapy:

Any psychotherapy which is limited in time brings fresh flame to the enduring presence in all persons of the con-

flict between timelessness, infinite time, immortality, and the omnipotent phantasies of childhood on the one hand, and time, finite time, reality and death on the other hand." (p. 10)

Mann articulates this conflict in psychodynamic terms, as one between child time and adult time within each individual.

The "termination phase" is the stage of therapy when even those patients who have struggled against facing the limitations of their life or the realities of the psychotherapeutic situation are confronted directly with a heavy dose of reality. Patients’ dreams and fantasies at this stage often show that the patient equates losing access to the therapist with "losing everything." Dreams of death, disaster, or world collapse are common during the termination phase.

Ellen, a patient I mentioned earlier, reported a series of vivid and disquieting dreams during this termination phase of therapy: Frequently she searched in her dreams for me—the therapist—only to find that my name was changed, or I was somewhere else, and no one would tell her where. In other dreams, she destroyed and dismembered with violent actions; acts of love and violence alternated, and my face and the faces of several past male therapists kept fading one into another. Only when she accepted and made peace with the scheduled reduction (and eventual termination) of therapeutic sessions did she begin to relate to the therapist as an actual person apart from her prescribed melodrama, a melodrama that seemed so monotonous to those around her. Only in this termination phase did she make more visible progress toward the personal transformations sought in therapy; we describe this progress in the following section.

MODALITIES OF THERAPEUTIC INTERVENTION

In the early days of psychoanalysis, Freud called his treatment the "talking cure." Language has held the focal point in much of the debate over psychotherapeutic technique since Freud, yet the full range of therapeutic experiences also relies on visual imagery and the full range of our sensory modalities, behavioral enactment of situations, and the nonverbal, affective, and personal encounter of therapist and patient.

The Place of Language in the Process of Psychotherapy

Phenomenological philosophy and psychology have deepened our understanding for the place of language in human experiencing. In the phenomenological perspective, the structure of language and reality, especially human reality, are deeply intertwined: "Language is the
house of being. In its abode dwells man" (Heidegger, 1947, p. 49). Similarly, the German philosopher Humboldt showed that our language already contains a specific view of the world (Spranger, 1909). O. F. Bollnow (1980) expressed this in the following way: "Our whole feeling, volition and thinking have always been channeled, that is guided, by an understanding of the world and of life, indicated for us in advance by the language we speak" (p. 187). This is true not only at the general level of cultures, with their specific languages, but of personal languages, where the language of the patient betrays the structure of a world that discloses no hope, a world with no words for emotion, or a world in which things happen to a powerless, passive individual. Bringing a new realm of experience into language or assisting the individual to linguistically define self and world differently thus have a deeply transformative power.

The anthropologist Levy-Bruhl expressed this viewpoint as follows: "We perform a magical act when words are spoken" (cited by Bollnow, 1980, p. 188). Bollnow (1980) has shown that naming in itself is a form of appropriation:

By giving things names we incorporate them into our world, we make them identifiable for ourselves and thereby make them for the first time accessible to ourselves. What the name is, is in the first instance irrelevant—the main thing is that the object has a name of its own. (p. 189)

In this sense, therapeutic speaking is a direct hermeneutics of experience. It is not simply a matter of copying an experience already existing—for example, in the "unconscious"—but rather of an original and creative articulation of something previously only latent (Bollnow, 1984b). In other words, there is not one true interpretation of the client's experience or behavior, awaiting our accurate discovery. Rather, interpretation and therapy is a constructive process in which the therapist contributes a significant amount of his or her own creativity and ingenuity: in selecting elements from the client's remarks for attention, in selecting how to phrase and rephrase the client's experience, and in choosing a "proper narrative frame" (Messer, 1986, p. 1267; Spence, 1984, p. 86).

Barton (1974) illustrated this principle by following the same hypothetical client through dialogues with a Freudian, Jungian, and Rogerian psychotherapist and showing how each therapist, given his or her own theoretical predilections and personal perspective, assists the client to constitute or construct a unique and different version of self-understanding. Therapists' interpretations are, in this sense, useful fictions of value in assisting the patient toward self-understanding and not objective facts in a scientific discovery process (Meichenbaum & Gilmore, 1984; see also Messer, 1986). From the phenomenological point of view, this makes psychotherapeutic dialogue a hermeneutic process because, like the latter-day interpreter of ancient scriptural passages, understanding for the present day can only be arrived at through a constructive recreation that gives form to meaning only latent in the original. Gergen and Davis (1985) have elaborated a comprehensive theory of the person, based on a similar, social constructivist viewpoint.

Messer (1986) has reformulated the therapeutic purpose as follows:

The therapist from this perspective, must lead clients to a vision of themselves and events that is different from their current view. Narrative truth emerges from the dialogue between therapist and client which provides an organizing influence in the client's life. There are clearly multiple avenues for constructing and interpreting such a narrative. (p. 1269)

Cognitive-Behavioral Approaches

In the 1920s and 1930s phenomenological psychiatry pioneered in showing the importance of the patient's unique "language," interpretation, and perception of the world, in producing psychiatric disturbance (see Strauss, 1982). However, phenomenology is no longer alone in investigating the place of language and cognition in therapeutic experience. Cognitive-behavioral psychotherapy and the social psychological fields of attribution theory and self-efficacy theory have also demonstrated the empirical relevance of the individual's words, names, and attributions. Aaron Beck, Albert Ellis, Fritz Heider, and Albert Bandura are key among the theorists who have made contributions in this area.

Cognitive-behavioral authors have taken the general recognition of the importance of the patient's experiencing and founded upon it an empirically based technology for modifying the patient's modes of experiencing. As a group, the cognitive behavioralists are more interested in efficient techniques for change than in understanding the complexity of human experience. As a result, they frequently reduce the relationships between experience and action, cognition and emotion, or individual and environment to a simplistic cause-and-effect sequence. Nevertheless, the cognitive-behavioral school can teach us much, for example, about the experience of depression.

Ellis (1975), Beck et al. (1979), and Meichenbaum (1977) have shown how automatic negative thoughts, negative self-attributions, and pessimistic interpretations of daily events play a major role in depressive mood and low self-esteem. Aaron Beck describes a "negative cognitive triad" in depression, of negative thoughts about oneself, the world, and one's future. He says of his depressed patients:

They regard themselves as deprived, defeated, or diseased, their worlds as full of roadblocks to their obtaining
even minimal satisfaction, and *their futures* as devoid of any hope of gratification and promising only pain and frustration. (Holton & Beck, 1979, p. 154)

In spite of the myriad of ways in which a person might interpret life events, the depressed individual will repeatedly perceive life in a stereotyped, monotonously dark fashion, assuming that a pebble in the road will block movement for life, that any setback must be his or her own fault, and that any behavior by another is evidence that "once again no one respects or loves me."

Similarly, attribution theory shows that the qualities a person attributes to him- or herself influence that person's own thoughts, feelings, and behaviors, as well as others' reactions toward that person. Attribution of unwanted, negative qualities by others plays a role in the erosion of self-esteem, stigmatization of an individual, and exclusion of him or her from social acceptance, and the onset of depressive, affective experiencing (see Forsterling, 1986, and Heider, 1958, for further details).

The therapeutic remedy, according to both cognitive-behavioral and attribution theories, is not simply to substitute a positive and equally unwarranted attribution of qualities to the individual, but, rather, to retrain the individual to engage in realistic self-attribution. That is, the therapist teaches and models a realistic appraisal of events, realistic appraisal of self, and realistic appraisal of environment. The ultimate goal has been articulated by H.H. Kelly (1971) in the context of his discussion of attribution theory, "The attributor is not simply an attributor, a seeker after knowledge. His latent goal is that of effective management of himself and his environment" (p. 22).

The cognitively oriented social psychologist, Albert Bandura (1982, 1986), has pioneered research on the sense of self-efficacy, which seems to be a critical element in overcoming habitual behaviors and problems. "Self-efficacy" is a person's belief in his or her own ability to cope with a situation. When an individual comes to believe that he or she can do nothing to change a problem, that individual will feel helpless and behave passively. The individual's fear is not merely of the feared situation but also of personal inadequacy in dealing with it. Even when given constructive suggestions to overcome the problem, such persons will implement the instructions ineffectually, expecting and bringing about their own failure.

Those persons who believe that past failures are due to their own personal defects are more likely to give up or merely "go through the motions" for change. Thus it is absolutely critical how an individual cognitively accounts for his or her failures, especially whether they are attributed to internal or external causes. To quote Bandura: "If people are not convinced of their own efficacy, they rapidly abandon the skills they have been taught when they fail to get quick results or experience some reverses" (Bandura, cited by McLeod, 1986, p. 49).

Bandura, Beck, Ellis, and others are thus developing through psychological research something that existential philosophers and psychiatrists have been exploring since the early decades of our century. Sartre (1956, 1962), the French existential philosopher, emphasizes the human need for a sense of agency, freedom, or choice, in his writings about human existence. To paraphrase the findings of both attribution theory and self-efficacy theory in the service of psychotherapy, we can "empower" or restore hope and confidence to a powerless and helpless patient, by assisting the patient to reappraise negative self-attributions, to experience self-efficacy, and to perceive the world more realistically and openly. Mahoney has succinctly formulated the overall cognitive approach as one of teaching the patient to be a personal scientist: "We should model and teach an intimate empiricism replete with skills' training in problem analysis, hypothesis generation, evaluative experimentation and so on" (Mahoney, 1974, p. 274).

The phenomenologically or experientially oriented therapist typically places a greater emphasis than cognitive psychologists on emotional experiencing, immediate encounter with the patient, and a deeper exploration of the anchoring experiences early in the patient's history. However, cognitive-behavioral authors have recently placed greater emphasis on the need to give therapeutic attention to emotions independent of cognition and thus made more room in their theory and practice for the irrational dimension of affective experiencing (Rachman, 1980, 1981; Zajonc, 1984). Lazarus (1977) has also emphasized the power of imagery and the realm of the imagination in personal transformation. Finally, the cognitive-behaviorists' introduction of a practical reality-oriented approach to life can be helpful to many patients in experimentally oriented psychotherapy.

**The Transformative Power of the Linguistic-Visual Self-Image**

The deepest task for cognitive transformation is to accomplish a radical transformation of one's experience of "self"—in its full cognitive, affective, and interpersonal dimensions. In order to illustrate the powerful personal impact of the self-image each individual constructs out of words and mental pictures, consider my client, Ellen.

Although Ellen had been variously diagnosed as borderline personality and schizophrenic, she also showed some of the characteristic profile of a multiple personality. Ellen believed that at the core of her personality was "the evil one"—which she named Corrie (for the core).
Ellen saw Corrie as all-powerful and believed that all other aspects of her personality were too weak and powerless to combat Corrie. Ellen attributed most of her self-destructive acting out and fantasies of violence toward herself and others to Corrie, and many of her own constructive goals were stifled when she would announce that "Corrie doesn't like that idea," or "Corrie would punish me if I did that." In the termination phase, when frequency of therapy was reduced gradually from twice a week to every 3 weeks, Ellen reported a dream in which a disembodied set of hands began to slash at her and me with a razor. She admitted to owning an art razor and commented that "someday Corrie will come here with the razor."

This set the stage for one of the most crucial interventions in Ellen's years of therapy; I directly confronted Ellen with the suggestion that "Corrie" was merely an interpretation Ellen was making of her own personality, that, in fact, her anger and rage were not the core of her being, that her own core was not evil and dangerous at all. I suggested to her that we might apply the Biblical guideline "By their fruits ye shall know them" and look at Ellen's own behavior that showed a repeated caring, sympathetic, and gentle attitude toward her son, toward other patients she had come into contact with, and with her mother's physical suffering. I also traced the angry and hateful reactions, which Ellen had exhibited, one after the other as secondary reactions when Ellen felt hurt, betrayed, and endangered by others. In summary, I suggested to her that those feelings and impulses she called Corrie were not her core at all, but merely a secondary reaction, and her own core was one of goodness and tenderness.

Ellen's initial response was to strike out at me with her fists to prove that "Corrie is real," that Corrie is "evil inside me." Yet, as she argued that she was evil, she also burst into tears and held my hand, wanting to believe that her core was not evil and dangerous.

This seemingly simple revision in her image of herself also upset Ellen's entire view of life and reality. Ellen remarked, "It would be a whole different way of looking at everything." In succeeding weeks, this revision in her viewpoint became extremely powerful for Ellen, as she was able to be less fearful of Corrie's retaliation and came to interpret the Corrie aspects of herself not as evil but rather as the reactions of an immature and very frightened child within her, the childlike aspect of herself that needed to be guided and limited rather than exercised or snuffed out. She also began to refuse to surrender to her other "personifications" (she began to call them by this term and give less credence to their independent reality). Here we have a complex linguistic and visual image that Ellen had constructed of her own personality and we can see its consequences in her behavior and experiencing. Further, the consequences when she began to challenge and revise that image were quite dramatic, ranging from the altered cognitive self-definition, to weight loss and a new more feminine hair style, to increased contact with what she called "normal" people.

Modalities of Experiencing

The work of Milton Erickson (Erickson & Rossi, 1979) has contributed a heightened awareness of the diverse modalities of individual experiencing. Each individual in psychotherapy responds to the therapeutic dialogue in a manner heightened by his or her own preferred sensory and perceptual modalities. It is helpful for the therapist to pick up on clues in the patient's language that show that he or she "gets a feeling" of the problem, "sees the solution," or "hears and understands." These verbal clues show us the client's dominant sensory-perceptual modality, and by couching our response in the same modality, the pathway to empathy is shortened. This same approach can enable the patient to free up latent but blocked veins of experience.

For example, a woman undergoing evaluation for chronic pain had emphasized the factual, objective, and medical nature of her complaints and minimized any accompanying emotional experiencing. Later she mentioned an episode of physical therapy where she was lying down and then unable to get up and walk again because of severe muscle spasms. She remarked matter of factly, "I felt humiliated by the pain." I simply repeated her remark with an emphasis on the word felt, and again she remarked, "Yes, I felt defeated by it." Again, I simply mirrored her response but now in the present tense, "You feel defeated by it." At this moment, tears came over her and she said, "Yes and I feel angry, too. I'm angry at myself that I don't know what to do. I feel inadequate, and I'll be going through it over and over the doctor says." At this point, the simple repetition of her own remarks, with an emphasis on the word feeling and the present tense, amplified her experience to such an extent that she volunteered an outburst of emotions, related feelings of helplessness at being unable to control her own muscles and limbs, fears of where these spasms might attack her, and how helpless she might be to prevent herself from falling to the floor, falling in the bathtub, or drowning in a swimming pool. Both a deep sense of vulnerability and a profound terror of the spasms emerged in a woman who, up until this point, showed very little emotionality. The therapeutic dialogue here follows the guidelines of a Rogerian client-centered reflection of the patient's feelings. The Ericksonian school shows, however, that feeling is only one modality of experience and...
that the therapist can respond to various patients with the same kind of amplification of thought, of sensing, of seeing, because this is the client’s preferred modality.

It is naive to expect that each therapist's personal favored modalities of experiencing will automatically fit with those of each patient seen in psychotherapy, but a therapist can attune further through body posture, tone of voice, facial expression, and choice of cognitive and sensory vocabulary to accommodate the patient’s preferred modes of perceiving. There is already a sensitive, pre-reflective dance taking place between the therapist and patient, and whenever empathy deepens, this dance automatically attunes our experiencing to one another. We can heighten and accelerate this attuning process by deliberately choosing visually oriented remarks with a visualizing client or cognitive remarks with an intellectualizing client. Further, there are moments when we may want to go against the patient’s own overinvested modality, challenging a feeling-dominated patient to think, a cognitively dominated patient to feel, and so on.

Behavioral Enactment and Therapeutic Experiencing

It is not only our words and tone of voice that attune us to the client’s experiencing. Actual behavioral enactment of a situation lends greater reality and immediacy to the patient’s experiencing. Another case example shows how active, directive therapeutic intervention, involving behavioral rehearsal, role play, or psychodrama, can heighten the intensity of experiencing for a client. A 15-year-old girl, Candace, revealed more in a 3-minute role play than in four previous exploratory sessions. Candace, a bright, artistic girl, with a low opinion of herself, complained of being trapped in an unwilling relationship with an older, domineering, lesbian friend, June. She was unable to convey what specific fears blocked her breaking with the friend, other than a fear of being alone. However, when I asked her to become June in a role play, while I, as Candace, declined the relationship at an end, the situation was greatly illuminated. In rapid-fire succession, June threatened suicide if Candace broke off and threatened to tell her parents everything—including sexual activity, secret contact when Candace’s parents had forbidden her to see June, and gifts Candace had given June to keep her attention. She also threatened to “come out of the closet” with Candace’s friends so no one else would accept Candace either. This burst of dialogue disclosed the full extent of the manipulative, coercive, and exploitative aspects of the older woman’s behavior, as well as Candace’s own ambivalent attachment and involvement with June.

Further, Candace was empowered by the role play to a degree neither she nor I anticipated. She reported the following week that she had stood her ground with June, refused to leave school with her, and brushed off June’s threats by repeating some of the words I had used when I played Candace.

Interpersonal Encounter

The interpersonal encounter is also ever present in psychotherapy. Frequently, the interaction between therapist and patient reproduces in immediate form, the most crucial, interpersonal, and intrapersonal conflicts in the patient’s life. I will illustrate this with another case example, this one from the initial evaluation interview with a 15-year-old girl. Like Ellen, Melissa also splits off (or “dissociates”) most of the anger and oppositionalism that she feels onto a personality fragment that she calls “Her.” She explained that “sometimes I feel like I have two people in me. I call the other person ‘Her.’ When I’m upset, ‘Her’ comes out. I blame ‘Her,’ and I feel better about me, but I fight with ‘Her’ and soon she’ll be dead.”

At this point, the therapist intervened and suggested that “Her” might be an important part of Melissa, and Melissa might want to listen to Her and take seriously those feelings and urges that Her expresses. Melissa’s immediate retort was, “I don’t like to be angry.” The therapist then challenged her more firmly, saying that she was trying to kill a part of herself that might be very important in her life, especially in becoming an adult, strong, independent woman. At this point, the therapist suspected that he was opposing Melissa vehemently enough to arouse some kind of anger or oppositional reaction and inquired whether his remarks were already stirring “Her” up. At this point, Melissa admitted that yes, she could already feel “Her” getting stronger in her throat.

In this fashion, Melissa could already see, in the first session, that the therapeutic interaction would recreate Melissa’s battle with “Her” and enable Melissa to deal with “Her” in an immediate, direct fashion. Later in the session, when the therapist solicited specific goals for therapy, she stated that she wanted to learn to deal better with anger and especially to learn how to channel “Her and her feelings” more positively.

We will now turn from the example of Melissa to review the overall picture of experientially oriented psychotherapy.

Conclusion

Experientially oriented psychotherapy has entered the mainstream in American psychology and psychiatry. The present chapter began with a review of the contribu-
tions of each school within the broad family of experientially oriented psychotherapies. Next we introduced the basic principles shared by these therapeutic schools, especially their emphasis on "being with" the patient in his or her world of experience, the meaningfulness of all symptomatology, the priority of empathy over diagnosis, and the contextual, hermeneutic approach. We also highlighted the therapeutic attitude of the experientially oriented psychotherapist, which includes the principle of mutuality in the therapeutic partnership with the patient; the dual emphasis on self-actualization and self-transcendence; the therapeutic values of openness, acceptance, and hope; and the priority placed on the patient's helping him- or herself through inner, personal resources.

The human life, in phenomenological perspective, is a story unfolding in time. As such, it is susceptible to arrest, reversal, and stagnation; to upheaval, shattering, and crisis; it presents a challenge to each individual for renewal in each new era of life. It is this problematic course of each personal story that propels the individual human being to become a "patient" and to seek assistance in questioning his or her own existence.

Just as the human life is articulated in time, the course of psychotherapy unfolds in time as well. The initial challenge to the therapist is to join with and stay with the patient's experience, receiving and affirming what each patient presents as a "gift." Next the therapist and patient thread their way together between the twin challenges of accepting one's life and world as they present themselves, in all factual reality, and owning this life and world as the product of one's own choices, beyond all fact or accident. Finally, in the "termination phase," the therapist and patient face the limitations of time and situation so central to both life and psychotherapy. Accepting these limitations gives time in therapy a greater seriousness and compels the creativity of the therapeutic partners.

Psychotherapy—the "talking cure"—unfolds within a world of language and cognition, but the dimensions of embodiment, nonverbal attunement, action, and encounter have equal significance in the process of psychotherapy. We closed the chapter with the examples of Ellen, Candace, and Melissa, which bring together the therapeutic modalities of language, image, and relationship. All self-cognitions and self-images take on their deepest import for us from their most significant relationship contexts. The child's early experience of self is formed in the shadow of the parent-child relationship (Merleau-Ponty, 1964). The therapeutic relationship is the milieu within which the patient can learn to experience both life and self in a more fundamentally positive light. Experientially oriented psychotherapy is thus never a mechanical process of substituting a healthy cognition or behavior for a diseased one. Rather it is, in the deepest sense, a "corrective emotional experience," unfolding within an authentic personal encounter between two fully human individuals. Therapeutic technique lends a practical effectiveness to therapeutic intervention but only when it serves the process of reawakening a human being to the broader horizons of his or her own world and life.

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