CHAPTER 7 - THE IMPLICATIONS OF THE PHENOMENOLOGICAL APPROACH ON PSYCHOTHERAPY

Having stated the basic principles of the phenomenological approach, it is now possible to discuss the implications and usefulness of these on psychotherapy and the healing of the patient.

Phenomenology is not a school of psychotherapy but an attitude to human beings. As phenomenology describes rather than explains, psychotherapy is not viewed as a technique but an approach which brings us back to the basic human experience of being-in-the-world. May strongly believes that "therapy must be based on a human model, a science of man" (p. 33) that takes into account the uniqueness of man (Smith, 1979). Phenomenological psychotherapy is viewed as a "situation in which one human being (therapist) is available to other human beings (clients) as fellow human being in the attitude of Gelassenheit or let-be-ness which is a special and active rather than passive participation in the unfolding beingness of the other person aimed at grasping those relational meaning coherences of the world that are specifically the client's, so as to facilitate his taking upon himself that existence which is his own" (Kruger, 1988, p. 190). However, the therapist participates in the life of the patient for only a period in time and is not involved in the ongoing process of his daily life (Moss, 1989).

Psychotherapy is thus not something the therapist does and the patient receives but a mutual encounter between two people in which there is an attempt to understand how the patient is being-in-the-world. May (1964) states that the psychotherapeutic "encounter" is "our most useful medium of understanding the patient as well as our most efficacious instrument for helping him open himself to the possibility of change" (p. 31). Phenomenology provides a broader framework which allows a wider range of behaviours to be interpreted as it takes the patient's whole world into account (Corin & Lauzon, 1994). It also broadens the focus from the individual in isolation to a human being relating in and to the world. Laing (1969) states that psychotherapy is an activity in which the patient's relatedness to others is used for psychotherapeutic means. As human existence is interpersonal to the core, it is only in relationship that people can be healed, develop and grow. "For phenomenology, ongoing, direct contact is the basis out of which understanding unfolds" (Halling, Kunz & Rowe, 1994, p. 126).

May (1958) submits that the phenomenological approach emerged as a result of "a protest against the tendency to see the patient in forms tailored to our own preconceptions or to make him over into the image of our predilections" (p. 8). He also states that different patients may require different approaches and that one cannot stick rigidly to one specific theory. The willingness to dialogue and allow someone to be who he is without judgement cuts across all theoretical boundaries. So, as Kruger (1988) states, the phenomenological approach is "quite indifferent to techniques to the extent that one may be practising the method of psychoanalysis..." (p. 190) through different styles to behaviour therapy as long as one is grounded in the phenomenological principles.

THE MEANING OF SYMPTOMS AND BEHAVIOUR:

Man can only be understood in terms of his whole existence and not merely within the framework that makes a distinction between healthy and sick. Boisen (1962) states that observable behaviour cannot be studied without understanding the meaning of the behaviour to the patient as well as its relevance to his goals. In order to understand the person and the meaning his experience has for him, one must study him in the context of his being-in-the world which includes the patient's interpersonal sphere, the network of social relationships, significant others, social support links, the sense of integration into family life and his relationship to social norms.

This is very different from the scientific world where facts have always been explored rather than the pathic moment or immediate communication with the phenomena (Straus, 1962). Science has also taught us that it is easier to interpret and analyse specific phenomena in a more systematic manner than to explore the whole experience. Boelen (1963) describes how the scientist is involved in only a segment of the human being's world which reduces the individual to the ultimate 'It' where he is studied as an object. Thus lived experience tends to be ignored in favour of factual specifics. However, man exists in interaction as a whole so it is necessary to move from the Cartesian split to an understanding of the person's whole world. Everything man experiences is in the lived moment which includes spatiality and time, where there is only continuity and "no gap between observer and observed" (Krishnamurti, 1968, p. 32). So, despite the difficulties inherent in the phenomenological approach of exploring the underlying experience as a whole, it is vital to do so in order to understand the patient as a whole human being.

Phenomenologically informed psychotherapy focuses on the meaning of the symptoms rather than simply exploring the causes of the behaviour. The patient's experience, the strategies he uses to face or avoid challenges and suffering, how he inter-relates with others and the world is of more importance. Thus, the primary focus is on what the meaning of a particular mode of reacting and functioning has for the individual. As stated, people operate in relation to objects in the world which have a particular significance and value for them according to the world they live in. The fabric of the patient's world is woven from what the individual chooses out of the whole to be conscious of and what has meaning and reality for him (Jaspers, 1963). As one explores how the patient lives and he gains a sense of wholeness, the symptoms recede as they are no longer necessary modes of functioning and being.

The phenomenological approach advocates suspending explanatory theory and presuppositions whilst experiencing the patient's world with him. According to Merleau-Ponty (1967), Husserl's view of reductionism is to suspend any or all reality judgements concerning the person's description in order to concentrate on the meaning of this experience for the individual. What is valid and has meaning for this unique person in his experiencing of the world is what is of value and explored. Merleau-Ponty speaks of Husserl's view that the world is what we perceive it to be and "the world is not what I think, but what I live through" (p. xvi - xvii). This shifts the focus from the symptoms to the phenomena which are always experienced within the broader context of being-in-the-world (Corin & Lauzon, 1994).

Merleau-Ponty (1967) believes that phenomenology's greatest contribution is in uniting "extreme subjectivism and extreme objectivism in its notion of the world or of rationality" (p. xix). He states that rationality is "measured by the experiences in which it is disclosed" (p. xix) and views rationality as a result of perceptions confirming one another which allows meaning to emerge. This indicates that the foundation for rationality is in the world and in communication with the world. He describes the world as the individual's and others' experiences of meeting and engaging. But there is also a shared reality that provides some solid foundation for people to live with and move from.

As Kruger (1988) emphasises, the focus of exploring is based on a subject-subject relationship rather than a subject-object one. He points out that phenomenological research cannot be reproduced in scientific terms for comparability in other studies but has themes which may be explored to assess the reliability of the work. As phenomenology stresses that phenomena are not measured, it is not the facts that are studied, but how they are experienced and grounded in the patient's living and experiencing. For example, understanding that one has certain feelings is insufficient for change. There must be an experiencing of these feelings before the understanding is integrated (Gendlin, 1964). Lang (1939), a schizophrenic who writes of his own hallucinatory episodes, supports the belief that the form of the experience is more relevant than the content.

Man is grounded in his world but lives the meaning of his disturbance through the body. How the body manifests problems provides clues as to the dysfunctional manner in which the individual is living. When there is a distortion of the sense of self and the body in eating disorders, this is displayed by a mind/body split in the patient's perceptions of her body and how she relates to it. For example, the anorexic has a delusionary self-image of her body and believes herself to be immensely overweight (Moss, 1989). Physical symptomatology must be addressed in relation to the messages it is providing. By viewing man as a unity of mind and body living actively in a world of dialogue and relationship, the value of the patient's experiences, which have all too often been missed in narrower theories, becomes recognised. The uniqueness of each person's experience is recognised rather than the simplistic, mechanistic, logical manner of knowing people through convergent thought. Convergent thought tends to reach only the most rational result which fails to recognise the unique, richness of each individual.

THE INFLUENCE OF THE THERAPIST:

The phenomenological approach has enormous implications for psychological theory and practice. It is a challenge to researchers and theorists to acknowledge that there does not have to be a specific way to heal. It is a call for the therapist to leave stereotypes behind and instead search for meaning in wholeness and uniqueness. Van den Berg (1972) advises the therapist to leave "his convergent weapons where they are ... on the shelves of his bookcase" and work to return the patient to "an everyday, healthy .... equally divergent life" (p. 32). The primary aim becomes to observe, comprehend and make the experience explicit in order to understand its meaning. The phenomenological approach has shifted the emphasis away from the Cartesian view to meeting the human being in his entirety. To step from the clinical, neat, ordered

safety of diagnosis and specific ways of working in therapy is to step into a world rich in diversity and possibilities for exploration. However, as Van den Berg explains, there is also dilemma, uncertainty, confusion and emotion due to the broader, deeper perspective. The therapist must resist the temptation to avoid this confusion and anxiety by only sticking to simple and safe techniques. This does not rule out the value of theories but suggests that the foundation should be man in his lived existence.

May (1992) discusses how the goals of psychotherapy have changed drastically over the century as the Western world has moved to focus on the individual. This has resulted in losing the element of surprise and wonder in psychotherapy as therapists are viewed as a guide to individual gain. May (1992) warns of the danger of losing "our sensitivity ... We take refuge in definitions, putting aside our awareness that every moment in therapy is distinctive and needs to be seen as new" (p. xxvii). Smith (1979) queries the goals of psychotherapy. Are the goals to remove symptoms, reorganise the personality or adjust to the norms of society and culture ? The last goal is a dangerous one as it is not necessarily in the best interests of the patient's integrated being to serve society's norms. Smith states that there is a difficulty in defining goals when there are no universally agreed models of what constitutes health and normality. The phenomenological goal of psychotherapy is that the patient "experiences his existence as real" (May et al., 1959, p. 85) and that he understands the phenomena and their meaning and value as they are currently lived and experienced in the world. The aim is thus to assist the patient to see his world in a different light, to heal sufficiently to live in relationship with more authenticity and not just experience behavioural change. The cure of symptoms is only a by-product of the patient's changed relationship to the world.

The therapist plays an important role in this mutual encounter and task of helping the patient heal. May (1958) states that "the central task and responsibility of the therapist is to seek to understand the patient as a being and as being-in-his world" (p. 77). Giorgi (1970) believes the description of the patient's world and the meaning it has for him should be allowed to unfold in an unbiased manner. Van den Berg (1972) supports this with his statement that the "investigator remains true to the facts as they are happening" (p. 64). To allow the patient's story to be revealed, Binswanger states that the therapist must communicate with the patient as one human being to another (May et al., 1958). There must be commitment from both sides to gain the real experiencing of existence. One can only be open to insight and knowledge as one grows and connects with oneself. For example, if the patient is unable to express his felt-sense of an experience, the therapist's ability to express feeling becomes a critical factor in assisting the patient to re-connect with his experiences and relate to the world (Gendlin, 1964). As this process unfolds, there is change in the content of the experiencing as well as the feelings and interpretations attached to the event. Thus, contrary to the usual belief that understanding follows from using the correct technique, May (1958) stresses that "technique follows understanding" (p. 77).

The core of the challenge for the therapist is to enter the world and story of the patient. By entering the patient's world the therapist indicates to the patient that his disturbed behaviour and world is real and genuine but is not the only experience and reality which means change is possible (Moss, 1989).

The therapist starts working with the basic description of the patient's world. Many phenomenological clinicians caution the therapist to beware of the question "why ?" as this cuts short the descriptive quality of the patient's experiencing and can result in therapists rushing in with interpretations. Asking the question "what?" encourages the patient to provide a fuller description of his experience. As Fischer (1989) states, "Once we know the whatness, the 'why ?' question disappears. The therapist is required to bracket his own assumptions, especially those provided by the diagnostic understanding of mental illness and his own cultural values and attend closely to the description unfolding. Listening and encouraging the patient to describe his experiences allows the phenomena to emerge with increasing richness and variety (Margulies, 1984). However, therapists should keep in mind that they can never have a clear, objective understanding of the patient's experience (Leonard, 1989). Meaning is interpreted by the therapist so every attempt at understanding is an interpretation of the patient's interpretation. When interpretation is utilised wisely, Fessler, 1978 (as cited in Smith, 1979) describes it as a "mutual sculpting" (p. 44) of the meaning in the psychotherapeutic relationship. This signifies a relationship in which both therapist and patient are focused on understanding the meaning of the patient's world. However, when the therapist makes inappropriate interpretations, especially with patients suffering from a fragmented sense of self, the result is often a very literal or concrete interpretation on the part of the patient. The therapist must be aware of the dangers of misinterpreting the patient's experiences as this can damage the relationship and result in the patient acting out what he perceives as literal instructions or advice. For example, the therapist may suggest that the patient perform a mental exercise of imagining what it might be like to be feeling the way his partner is the next time they argue in order to better understand the partner's viewpoint. The patient may take this suggestion literally and give his partner instructions as to how they should perform this exercise during the next argument. This can result in further confusion, anger and hurt feelings.

The call is thus for the therapist and patient to move together in a dance of mutual encounter which requires the therapist to be connected in a real, human relationship. The therapist is required to be more open, flexible and to constantly fight not to be caught up in the familiar, known, set theory. This is difficult as the therapist can become anxious when uncertain what to do and the pull to know and do is a powerful one. Given that there is this strong desire for knowledge in the midst of anxiety, it is critical that the therapist resists the pressure to find a quick fix and instead moves at the patient's pace. The patient is blinkered and cannot see the peripheral view so it is the therapist's role to assist in broadening the horizon to allow the patient to perceive a different reality and allow the unknown to become the known. The therapist forms a link to connect these two levels of awareness and this can only be achieved by inviting the patient to talk of his world (Van den Berg, 1972). When the therapist shares his insights with the patient, the patient may begin to perceive and know how and why he is interacting in the world as he is. In gaining knowledge and insight he is brought from darkness into light with new meaning. May (1958) distinguishes between a knowing within and a knowing about something. He views knowledge as important but states that genuine knowledge is always grounded in the actual existence of the human being. Thus, May believes that the intrinsic element of man is self-consciousness. Man must be aware of and responsible for himself if he is to live an authentic existence.

The therapist can also become lost in the process of living the experience with the patient. Lawner (1981) speaks of the need for therapists to "allow ourselves to be still ... stay close to our partners in the dark" (p. 306). The therapist must tolerate feelings of confusion and helplessness and use the value of waiting as he helps patients learn to stay with being lost in the dark. There is frequently a demand and pressure on the therapist to provide control in the chaos. However, therapists are not controllers but guides, and techniques and strategies do not "run to the heart of a person's deepest concerns" (p. 309). The therapist can thus only get to the core of the problem by sacrificing control and prediction in favour of unpredictability and lack of control in order to allow the meaning to unfold "in an accepting, unintrusive relationship" (p. 309).

Lawner (1981) queries how much of the bizarre and psychotic behaviour is within the patient's control. How much is the result of 'thrownness' and a frailty of personality and the patient's distortions ? The therapist's challenge is to stay open to hear and not diagnose - prediction and control yield unpredictable effects and prevent the story from unfolding and being heard in a true manner. Control can be used as a tool for gaining power or a means of controlling the therapist's fear rather than caring and thus being open to the patient. However, sometimes theory and knowledge provide a framework for the therapist to prevent him from being overwhelmed and wanting to remove himself from the psychotherapeutic relationship. There is a danger of being-in-the-patient's-world without keeping a boundary for oneself. This balance can be difficult to achieve and the therapist must strive for a position of tension between the known and the unknown. But, Lawner states that therapists move predominantly in the unknown and must not fall into the trap of thinking they are "directors or creators of the therapeutic process, rather than its servants" (p. 312). The therapist should have the ability to meander down the pathway of the patient's experience, in the ambiguity of the unknown, as it unfolds rather than attempt to order its direction.

To understand the meaning, especially at pre-reflective levels, the therapist must provide a sound, safe and trusting relationship in which the patient is able to be open and free to speak of his being-in-the-world. Communication and dialogue are essential and the therapist will not know the patient's world until he listens and allows himself to enter it (Leonard, 1989). The therapist is required to give full attention to what the patient is experiencing as a felt-sense and not necessarily to do anything. This also focuses the patient on his feelings in a lived, connected way deepening the therapist's understanding of the experiences and how this is being lived within the interactions and connectedness of the relationships of this person in his world.

The values of the therapist must include openness, acceptance and hope so that the patient can discover and reconnect with some sense of hope for his life and future. Halling and Dearborn Nill (1989) state that the therapist should have an empathic, disciplined, imaginative and receptive stance. Gendlin (1986 - 87) stresses what this author views to be the most basic quality necessary in a psychotherapeutic relationship, that is, respect. In his work with schizophrenics he speaks of there always being a positive way to respond to even the most difficult of patients. He advises us to look beyond the self-defeating behaviour which is so successful at alienating the patient from others and see the patient's positive attempt to reach others, to live and to be real. This necessitates reaching into the patient's experience past all the negativity to the

core of the patient with respect. It is important when doing this that the therapist differentiate between his own feelings and the patient's in order to truly hear and meet the patient in his space. By doing this and allowing himself to separate the other from his own fears for himself and the need to be the good-enough therapist, it is possible to meet the patient as a separate human being one cares for. Linked to this is the quality of empathy which Margulies (1984) views as "a complex empathic state" which is "at once both a passive, echoing experience and an active imagining of the unknowable of the other" (p. 1032).

The self of the therapist becomes the instrument through which healing in the relationship occurs. The profound connectedness in the psychotherapeutic relationship is the most difficult form of relating and requires the "most skill, the most self-knowledge and the greatest care because its potential for careless or destructive use is so great" (Clarkson, 1990, p. 155). If one has the attitude that the patient is struggling with aspects of himself and his world, the therapist can hear the patient's reality without necessarily approving of his behaviour.

Van den Berg (1972) succinctly summarises the patient's world of experiencing in the title of his book A Different Existence. He says the patient's world is as real to him as our world is to us but reminds us that what seems real to the patient does not exist in our view. The patient's relationship to the world has changed and it is in his world that the neurosis has developed. This means his perceptions of the world and the meaning they have for him have changed. Thus, the therapist must focus differently. It makes little sense to explain to the patient that what he is experiencing is not real - he is, after all, living the experience daily in a felt-sense manner. So, the therapist would be incorrect in telling the patient that he is deluding himself or that he is mistaken about his condition. The point is that the patient differs from others in recalling his past and he has a different opinion about the reality of his childhood. There is no use in confronting the patient with contradictions which he has heard before and will, therefore, make him feel unheard and unmet. This would not help the patient to get better.

It is thus critical for the therapist to accept the patient's experiences as real for him and not to avoid his reality. This is especially true for psychotic experiences where the therapist may fear that the patient will plunge into psychosis again or because the patient's reality is so obviously bizarre to the therapist. Prouty (1994) advises the therapist to be empathic and understanding of any increases in delusional and hallucinatory experiences. For Prouty this means being "empathic to the lived experience of the psychosis" (p. 50). He has done valuable work with schizophrenics suffering from psychotic episodes without the use of medication simply by meeting the patient in his world. Prouty describes four stages of hallucinatory experiencing: 1) the self-indicating stage where the therapist focuses on the image itself to make it more accessible to both the therapist and patient; 2) the self-emotive stage in which the focus is on the image and the feelings required to maintain the unity of process; 3) the self-processing stage where there is a shift from the symbolic image to experiencing the feelings; 4) the final stage where the feeling "shifts from the hallucinatory image to the person's own sense of self, and is integrated, owned and experienced as self" (p. 81). In this way the hallucination is connected to the self and integrated so that it gradually becomes part of the self-sense of experiencing.

Prouty's work emphasises the need to move at a pace that is comfortable for the patient who would regress if the therapist met him too quickly. Laing (1969) discusses the feared loss of identity for the ontologically insecure patient when the therapist makes correct interpretations that expose the patient too quickly. This risks making the patient feel engulfed because, despite the need to be understood, the isolation protects the self. Thus, patience and much time, even years, is needed to reach and shift people who are deeply damaged and fragmented. Chessik (1986) reinforces Heidegger's view that a person will only be able to live authentically when he is connected to other humans in a common world. This state of being can only be achieved if the patient allows himself a quiet space in which to reflect and contemplate. Learning how to be re-connected starts in the psychotherapeutic relationship. Each meeting is a unique encounter so only the therapist and patient can ascertain what is effective for the psychotherapy in that relationship. This can differ from patient to patient and what works for one is not necessarily going to work for another. But the basic respect for and meeting of the other as unique and special does not change.

THE IMPLICATIONS OF THE PHENOMENOLOGICAL VIEW OF TIME ON PSYCHOTHERAPY:

With the phenomenological understanding of time in terms of the concept of temporality, views of psychopathology are altered. Psychopathology is viewed as a variety of distortions in the way an individual is conceptualising his past, present and future (Moss, 1989). The difference between neurosis and health is that the past has been chaotic/traumatic for the neurotic and thus makes the future inaccessible, for an "accessible future means a well-ordered past" (Van den Berg, 1972, p. 92). Thus, Van den Berg states that for the healthy person, the past has a value it should retain but, for the neurotic, it is important to view the past and deal with it because it can and will affect the present and future negatively. Anxiety and depression affect the perception of time. For example, anxiety results in the person experiencing the future as threatening. On the other hand, to be depressed means that the person anticipates what has not yet occurred as being like the past and is, therefore, not able to experience the future as a possibility. Moss describes the immobility of depression where "in the absence of an inviting, future horizon, existence coagulates and flows with ... sluggishness and inertness" (Moss, 1989, p. 202). Thus, the challenge is for the therapist to help the patient gradually speak about his past and to anticipate the future as a possibility. This can occur in the context of the psychotherapy enabling the patient to develop a different relationship to the present and future.

However, as stated, the past is frequently the major stumbling block cluttering the pathway to growth. Patients often grapple with working in the past because they feel they cannot go back to resolve something already completed. Some have difficulty in recalling past events which are forgotten because the present will not allow the past to appear as it is too much of a distracting factor. This prevents the future from becoming accessible. Kruger (1988) maintains that "the past that meets us out of the future is the past that can be recalled, because such a past already holds within itself the possibilities for the future" (p. 115).

The past has particular meaning for the patient due to the specific circumstances and interpretations he has imbued it with. This is relevant as it requires the patient to deal with the trauma and chaos and fulfil the task that the past has set. Much of the difficulty

of working with the past is many patients' perception of it. The facts recalled are often inaccurate and distorted as experiences can deeply affect the perception of events and, as one is unable to return to childhood in a literal sense, one has to deal with the patient's perception as truth. There is also frequently a fear of repeating the past in the future. "Nothing can be done about the past as it really happened" so the patient can only "alter the roles of the people of his childhood" and "do something with his time" (Kruger, 1988, p. 101) in order to change past perceptions.

Our past and recollections of it have a motive or task which affects how the past is perceived and how one will move into the future. Our lives are often strongly dictated to by the future and yet traditional approaches of psychology have tended to ignore the value and significance of the future. Maybe because, as Van den Berg (1972) states, neurotics are often more focused on the past. This means that therapists often become preoccupied with the past because that is what the patient primarily talks about. It is also likely that the therapist will be more focused on the past and its causes because the emphasis, in many therapist's training, has been on finding causes/origins for behaviour. Also, traditionally, past memory or perception has been viewed as real events that have already occurred and are more easily workable with whereas the future is not fixed and is viewed as being out of our control to a large degree. However, our action and behaviour is directed at the future and no action is determined solely by the past.

The task of the psychologist is to assist the patient in connecting the various time periods of his life-history in order to liberate him to find meaning and to be and become in the fullest possible sense. Jager (1990) views the therapist as someone offering support which allows the patient to explore and fulfil his role and reach his potential. By understanding and healing, the past and the present are opened up, revealing possibilities for the future. The phenomenological approach allows the patient to explore and discover what his capabilities are and what he may achieve in the future and what he is unlikely to. The future is so real that it can largely determine people's behaviour, that is, our behaviour is so interlinked that the future (already influenced by the past) is enveloped by the present. Just as the past is past NOW, so is the future NOW as everything is experienced in the present. An important point for psychotherapy is that just as the past has a task, so does the future have a function. How an individual tackles his life in the future will be affected by the past experience of that same situation. So, although the past is behind and the future ahead, both have value as they powerfully influence experiences in the present. However, too much focus on either the past or the future negates the experience of being in the present (Van den Berg, 1972).

As a therapist one, therefore, becomes less engaged in clearing up the source of the problem but on liberating the patient by focusing more on unfolding possibilities for the future. If, as Kruger (1988) says, "the future is a very present phenomenon" (p. 203) in this approach, it allows both patient and therapist a wider range of freedom and a less constricting way of working. He states that people do "tend to repeat self-defeating patterns" (p. 203) and thus no-one ever totally "leaves his family of origin" (p. 204). Therefore, there is a need to explore the past, but the phenomenological approach allows for a three dimensional way of working and thinking, not only of temporality, but

as the therapist and, for the patient, in attaining the goal of a fuller, richer sense of self.

The implication of the above views is that by exploring the patient's relationship to his current situation and the things around him, one helps him focus and think about his relationships, actions and emotions and how they are inter-connected. This will assist him to gain insight and knowledge to function in a more meaningful manner and in a more realistic sense. It will also provide him with the ability to begin to interact in a fuller manner with the therapist initially and, as he progresses, with the people involved in his world. Corin and Lauzon (1994) stress the need to then broaden the therapist's focus from the alteration of the patient's experiencing to include how he uses this growth to change relationships in the everyday world. The patient can not only understand, be heard and exist as the burgeoning butterfly in the psychotherapeutic encounter but has to live and work in a real world on a daily basis. It is critical for him to grow and gain insight in a manner that will be effective for his daily living. This allows healing through the meeting of dialogue in a continuous shift of knowing and not knowing and of helping create awareness so that the patient can focus, explore and gain increasing control of his own world.

The phenomenological approach thus calls the therapist to give of his whole self in the psychotherapeutic relationship. Foulkes (1982) speaks of the effects that a therapist's training has on his style of working. The suggestion is that the training becomes internalised and this may lead to problematic blind spots which could limit the therapist. This will affect the type of interventions made and possibly the outcome. Thus, techniques may be maintained but, once one adopts a phenomenological attitude one's whole centre as a psychologist has to shift as one could limit psychotherapeutic success by staying in a particular mould of technique. One has to broaden both in growth as a therapist and also in the style of psychotherapy with which one works and change in attitude will affect change in technique to a greater or lesser degree.

The phenomenological view assists heal the schism appearing in aspects of psychotherapy, not only in the concept of Cartesian dualism, but in the tendency to view man as made up of separate parts of his own life-history and existence. If this is the case, this viewpoint offers hope for people whose problems have frequently been viewed as hopeless.

The field of psychotherapy is very fragmented as indicated by the fact that there are over 400 different psychotherapy approaches in existence today (Arkowitz, 1992). May (1992) forewarns of the dangers in the Western world in that psychotherapy is becoming a self-concern, a "new cult, a method in which we have someone to act as a guide to our success and happiness" (p. xxv). Phenomenology offers a deeper, more respectful approach to healing the patient as a whole. Despite the enormous implications and possibilities for healing, phenomenology is still not sufficiently recognised in the psychological field. For example, in the "History of Psychotherapy - A Century of Change" (Freedheim (ed), 1992), the schools of psychoanalysis, object relations theory, behaviour therapy, cognitive therapy and the humanistic approaches are discussed. Under the humanistic approaches there is only a brief mention of phenomenology which does not even do justice to the basic tenets of the approach.

This author believes that if one makes the phenomenological-dialogal attitude the basic foundation of being-with-the-patient before one even thinks of a theoretical approach, a sound, healthy base for healing will already have been established. One must hope that the approach will become better known and incorporated into psychotherapy since phenomenology brings with it a deep respect for human experience and thus has much to contribute to growth and healing.