The Phenomenological Use of Self in Integrative Psychotherapy: Applying Philosophy to Practice

Linda Finlay

Abstract

Phenomenology is an umbrella term encompassing a philosophical movement and also a range of approaches applied to research and therapy. It is a way of seeing how things appear to us through experience, and it demands an open way of being—one that examines taken-for-granted human situations as they are experienced in everyday life. In this article, the author applies ideas from phenomenological philosophy to show how they are enacted in practice in our moment-to-moment therapeutic use of self. Several case illustrations of therapeutic dialogues are offered along with philosophers' original words to show the richness and potential of phenomenologically oriented relational integrative psychotherapy.

Keywords

Phenomenological philosophy, therapeutic use of self, integrative psychotherapy, phenomenological inquiry, existentialism, dialogic practice

Phenomenological inquiry is often seen as a foundational touchstone for integrative psychotherapy. This is particularly the case for those therapists who embrace Erskine's model (e.g. Erskine, 2015, 2020a; Moursund & Erskine, 2003/2004; Erskine & Trautmann, 1996), which draws on transactional analysis, behaviorism, gestalt, systems theory, intersubjective psychoanalysis, and developmental attachment theory.

The concept of phenomenological inquiry comes directly from phenomenological philosophy and involves a special kind of stance: one that is open, respectful, empathetic, compassionate, curious, and nonjudgmental and in which the practitioner is relationally present and attuned. Such inquiry goes beyond asking questions; it involves a profound way of being, one that philosophers have been trying to articulate for over a century. In this article, I explore some of the complexities of this phenomenological inquiry and consider how therapists might embody and apply it in practice.

Three specific challenges confront us when we consider the use of phenomenological philosophy in integrative psychotherapy. First, practicing therapists are rarely philosophers, and few have studied philosophy in any depth. When we try to read primary sources—written in philosophers' own words—we are likely to find the language dense, baffling, abstruse, and inaccessible. Second, philosophers are given to articulating a dazzling range of ideas, including those that are ambiguous or even contradictory. The philosopher Merleau-Ponty (1945/1962) recognized this when he declared phenomenology to be a "problem to be solved and a hope to be realized" (p. viii). Third, it is important to remember that the philosophers who first came up with particular ideas or concepts were grappling with purely philosophical questions, far removed from the world of therapy. It has been left to successive generations of scholarly therapists to work out what these complex, and sometimes mystifying, ideas mean and how they might be applied in practice.

Mindful of these challenges and the need to tread gingerly, I invite you to accompany me on a trek through some phenomenological philosophy. Following a brief orientation, I guide you along my favored route using five key markers to help us as we seek to unite philosophy with practice. The five markers are: phenomenological inquiry, the phenomenological attitude, phenomenological description, dialogic relationality, and existentialism.

As well as providing a map through this philosophical territory, I seek to apply the philosophical ideas we encounter and show how they are enacted in practice in our moment-to-moment relating. To this end, I offer several case illustrations of therapeutic dialogues. Philosophers' own words (especially those of Merleau-Ponty, as I am particularly drawn to his writings) accompany our journey. They add poetic resonance to our discoveries while giving us a taste of philosophers' individual voices.

Philosophical Foundations

Phenomenology calls for a special, open way of being and invites us to explore those aspects of experience that often go unquestioned. As a philosophical movement, phenomenology has spanned more than a century and has embraced many different ideas and theories. This is a rich tradition, involving many different strands, which have been applied to both research and therapy.

Writing in early 20th century Germany, Edmund Husserl (1913/1962, 1936/1970)—often seen as the "father" of the movement—spelled out the phenomenological method as an attempt to look at the world with fresh eyes (Finlay, 2013). He advanced phenomenology as the reflective study of the essential structures of consciousness, highlighting how acts of consciousness (perceiving, willing, thinking, remembering) arise prereflectively out of our self/world relationship. He sought to capture the essences and meanings of such phenomena.

> What is in question is not the world as it actually is but the particular world which is valid for the person. … The question is how they, as persons, comport themselves in action and passion—how they are motivated to their specifically personal acts of perception, of remembering, of thinking, of valuing. (Husserl, 1936/1970, p. 317)

Husserl wrote and revised his ideas over many years. His work is often quite dense and hard to read. Merleau-Ponty (1945/1962) explained it poetically: "Husserl's essences are destined to bring back all the living relationships of experience, as the fisherman's net draws up from the depths of the ocean quivering fish and seaweed" (p. xv).

Martin Heidegger (1927/1962), Husserl's student, took phenomenology off into existential, ontological (about being and existence) and hermeneutic (interpretive) realms in order to explore the nature and totality of "being-in-the-world" or "to-be-there" (what he called *Dasein*). He drew attention to the way Being involves engaging in everyday activities and dwelling in a network of social relations embedded in a specific historical context. The basic structure of Being is saturated

by the world while the world is soaked through with meaning. Arguably, Heidegger's biggest contribution was (and remains) his radical interpretive questioning of Cartesian dualism (the split of mind from body and subject from object). He moved us to conceive of our existence as a field of openness into which things and the world reveal themselves.

Hans-Georg Gadamer (1960/1989) went further into the hermeneutic realm while arguing for dialogue to promote understanding instead of method. He identified the nature of the *hermeneutic circle* in which all meanings of texts need to be seen in their social, cultural, historical, and linguistic context.

The work of the French philosopher Maurice Merleau-Ponty (1945/1962) also built on Husserl's ideas by focusing on the nature of embodiment and emphasizing principles of nonduality (e.g., the intertwining of mind/body, person/world). Merleau-Ponty (1964/1968) described the process of phenomenological reflection as trying to find the meaning of our (and others') embodied worldly existence:

> Reflection must suspend the faith in the world only so as to see it, only so as to read in it the route it has followed in becoming a world for us; it must seek in the world itself the secret of our perceptual bond with it. … It must question the world, it must enter into the forest of references that our interrogation arouses in it, it must make it say, finally, what in its silence it means to say. (pp. 38–39)

Merleau-Ponty's French contemporaries Jean-Paul Sartre (1943/1969) and Simone de Beauvoir (1949/1984) explored existential dimensions through their artful writing (both fiction and nonfiction), with de Beauvoir adding a feminist perspective.

Two Jewish survivors of the Holocaust also journeyed deep into the nature of ethical relationships. Martin Buber (1923/1958) is best known for his work on the dialogic I-Thou relationship, based on presence and inclusion, while Emmanuel Levinas (1961/1969) highlighted our responsibility to respect others by not reducing them to labels and categories.

More recently, philosophers have made specific contributions to psychotherapy practice, notably Eugene Gendlin (1962/1970), who highlighted the wisdom of bodily felt sense and his use of what he called *Focusing*. Paul Ricoeur (1976) foregrounded the importance of language/discourse, interpretation, and narrative,

contrasting the hermeneutics of suspicion (for instance, as seen in psychoanalytic interpretation) with the hermeneutics of empathy (descriptive versions of the interpretation of phenomenological meanings).

What links all of these philosophers is their profound curiosity and desire to describe the nature of prereflective, lived, intersubjective experience in its fullest, most holistic sense, uncontaminated by predetermining theories and explanations of behavior. They endeavored to view our “being-in-the-world” in ways that eschew dualisms and polarities: for example, individual-social, person-world, mind-body, self-other, inside-outside, and so on. Since Descartes, we have been conditioned to split mind from body (at least in the Western world). Phenomenology offers a radical challenge to this perspective by arguing for the interpenetration of mind, body, self, and world. As Merleau-Ponty (1964/1968) argued with reference to the nature of being (which he called “flesh”):

> Where are we to put the limit between the body and the world since the world is flesh? … The world seen is not “in” my body, and my body is not “in” the visible world. … [It is] a participation in and kinship with the visible. … There is a reciprocal insertion and intertwining of one in the other. (p. 138)

Phenomenological Inquiry

Phenomenological practitioners (be they philosophers, researchers, or therapists) generally agree that our central concern is to return to embodied, experiential meanings of the world as it is directly experienced. We ask, “What is this kind of experience like?” “How does the lived world present itself to me/my client?” The aim in psychotherapy when using phenomenological inquiry is to ask questions that enable clients to make their own choices and find their own way through their specific life situation. In a real sense, this form of inquiry is geared to self-discovery.

Richard Erskine et al. (1999) have asserted that phenomenological inquiry, an essential component of full interpersonal contact, begins with the assumption that “the therapist knows nothing about the client’s experience” (p. 19). None of our past experiences, understandings, theories, or even our observations tell us enough about what it is like to live in another person’s skin (Erskine, 2001). Here therapists “exercise an expertise in asking questions from a position of ‘not

knowing' rather than asking questions that are informed by method and that demand specific answers" (Anderson & Goolishian, 1992, p. 28). It is about constantly focusing on the client's experience rather than on their observable behavior alone. It is about seeing them as a person in their life context rather than as a problem to be solved.

To engage in phenomenological inquiry, Erskine has recommended using questions or statements that focus on the client's experience. The inquiry can focus on a range of dimensions: bodily ones ("What's happening in your body just now?"), cognitive ones ("What sense do you make of that?"), affective ones ("What are you feeling?"), and/or relational ones ("What's it like to be sitting here telling me that story?").

With relationally orientated phenomenological inquiry, Erskine (2021) suggested asking explicitly about the client's experience of the therapist's tone of voice or what it is like when the therapist reacts a certain way or draws attention to the client's behavior. In another version of relational inquiry, Spinelli (2007) explicitly invited clients to recognize similarities and differences between the here-and-now therapy relationship and what happens outside in "real life." Through such inquiry, the client becomes more aware of their needs and more choiceful about their actions while taking in the relational nourishment being offered.

The aim, always, is to raise the client's awareness of their experience, meanings, needs (current and archaic), and issues—all aspects that may have been pushed down or defensively disowned. Affect, thoughts, fantasy, memories, hopes, core beliefs and values, and bodily experience (movement, posture, tensions) that have all been kept from full awareness are opened up through the relational dialogic process. Through the therapist's respectful questioning and listening, the client can develop self-curiosity and gain new insights, the first step toward self-acceptance and growth.

Žvelc and Žvelc (2021, pp. 139–140) showed this engaged witnessing in the following dialogue:

Client: My father was like a Nazi; we were all terrified of him. I remember that I was strange already back then. I started to avoid social contacts and had my own world. … In my world everything was fine.

Therapist: You were strange?

Client: Yes, I felt different from others. I didn't tell you about my inner world; for a long time I felt that you would think I am crazy and will put me in a psychiatric hospital.

Therapist: So you were very afraid of your father, who was often drunk and violent. And at that time you started to live on the other side where everything was ok. So this "other world" in which everything was fine helped you to survive and keep you sane in the "insane world."

The therapist acknowledges and validates the client's coping mechanisms, which promotes the client's awareness and acceptance.

Client: Yes, it helped me to survive, definitely.

Therapist: (with a kind and compassionate voice) Let's appreciate this strategy of a five-year old that helped you to survive.

Another validation, which helps the client to experience self-compassion.

Client: I feel touched, I never thought about this in this way …

Therapist: Maybe this strategy was the most clever strategy to survive in a family where there was no one to hold on to … (short pause)[.] What do you feel now?

The therapist conveys the normalisation of the client's past coping strategy.

Client: I feel like I would embrace this younger part of me … telling him I love him and care for him.

Therapist: Just do this, take your time.

Client: (crying) I feel sad for what I have gone through … (pause)[.] Now I understand that having my own world actually saved my life[.] … I also understand that I am not there anymore, I am safe now.

In this dialogue, the therapist draws on the work of Erskine et al. (1999). They explained the way inquiry, attunement, and involvement are facets of the overall empathic frame within which the client's growth is nurtured. The therapist demonstrates "contact-in-relationship" by taking a compassionate approach that encourages the client to connect with a younger part of themselves (Žvelc & Žvelc, 2021). At the start, the pace is slow: The therapist listens, attunes, and validates the client's experience and offers time for reflection (attunement). This enables the client to make contact with their grief and acknowledge the value of their own coping mechanisms. By compassionately asking about the client's way of coping and surviving (inquiry), the therapist is modeling acceptance and being present to the grief. This, in turn, encourages the client to honor (or even let go of) their protective mechanisms (involvement). By normalizing what has happened, the therapist helps the client appreciate and embrace the defensive strategies that have helped them cope.

Such phenomenological inquiry (combined with attunement and involvement) requires the therapist's genuine interest, curiosity, and care. It forms the core of the therapist's use of themselves in relational integrative psychotherapy, even as other therapeutic techniques may be employed. "Our use of self is not something we *do* to the client. Instead, it emerges within the specific relationship and evolves as we adapt—over time—to the client's needs and the relational context while they adapt to us" (Finlay, 2022, p. 9).

Central to the practice of phenomenological inquiry is the fundamental stance or attitude we adopt. That is the focus of the next section.

Phenomenological Attitude

The key to practicing the phenomenological attitude (in therapy, in research, or in life) is to adopt a particular open, nonjudgmental approach—one filled with wonder and curiosity about the world—while simultaneously holding at bay prior assumptions and knowledge. The immediate challenge for a therapist entering a

therapeutic encounter is to remain open to new understandings, to be both present and empathically open to the client in order to go beyond what is already known or assumed (Finlay, 2008, 2016a, 2016b).

Engaging with a phenomenological attitude, we strive to leave our worlds behind and enter into our clients' worlds in order to reflect on their meanings and experience. This attitude involves a special attentiveness and presence, an ability to dwell with the situations the client describes, to listen with an ear attuned to detail, nuance, and turns of phrase. This involves separating ourselves as far as possible from value judgments and theoretical constructs. We try instead to focus on the meaning of the situation purely as it presents to our client (Wertz, 2005).

Commonly, the term *bracketing* is used as shorthand for the broader way of being that forms the phenomenological attitude. A concept from phenomenological philosophy, it means putting previous understandings/assumptions into metaphorical brackets that can be held aside—reflexively, in awareness. Husserl, the philosopher who is particularly associated with the term, was a mathematician, and he saw the brackets like mathematical brackets where things are put aside but held—as a whole—in awareness. He developed these ideas with reference to what he called the *epoché* (pronounced "eepokay"), which can be translated as "suspension of judgment." Applied in practice, the process of bracketing is often misunderstood and misused. Some make the mistake of seeing bracketing as simply putting aside their subjectivity in an attempt to be unbiased or objective. But subjectivity can never be renounced or hived off in this fashion. Rather, the challenge for therapists is to recognize the impact of their subjectivity. It is our very (inter)subjectivity that we must engage.

Taking its cue from phenomenological philosophy, bracketing is best understood as nonjudgmental, focused openness in which we try to see clients and their lives with "fresh eyes" (Finlay, 2008, p. 29, 2016a, 2016b). We bracket in order to be open to the other (the client). In this sense, "bracketing is enacted alongside a genuine, mindful sense of curiosity and compassion. As therapists, we strive to maintain a genuinely unknowing stance in which we remain modest about our claims to understanding" (Finlay, 2022, p. 47). We try to bracket what we might know or assume to be present to what is emerging in the here and now. We bracket to engage in genuine phenomenological inquiry. After all, what is the point of asking the questions if we feel we already know the answers (Finlay, 2022)?

There is much that we bracket in practice. Bracketing is an ongoing, continuous process that occurs moment to moment as we become aware of a new thought, understanding, or emotion that bubbles up. Specifically, we bracket:

- **Our knowing**. By not jumping to conclusions and by holding lightly to interpretations or judgments about someone's mental state.
- **The truth (or otherwise) of what a client is saying**. For instance, if a client tells us their dream, we do not say, "It was only a dream, it wasn't real." Instead, we acknowledge that the dream was experientially real for that person, so we attend to it as we would to any recounting of experience in so-called "real" life.
- **Our feelings/needs**. Foregrounding clients' interests, we try to avoid unduly leaking our emotions (or at least minimize their negative impact), so as not to drown out our clients. It is destructive, exploitive and unethical for therapists to use the client's therapy for their own support.
- **Cultural assumptions and values**. If a person says they want to engage in … [certain behaviors and] practices outside of our beliefs or cultural norms, we respect their preference and bracket our own values. (Finlay, 2022, p. 46)

Whereas bracketing is explicitly practiced by integrative psychotherapists who lean toward existential-phenomenological practice, it also is enacted in other ways when different theoretical frameworks are employed as part of the integrative work. For instance, psychoanalyst Wilfred Bion (2005) argued that therapists should work without desire or memory and with a quiet mind open to making contact with clients' unconscious communications:

> "Forget" what you know and "forget" what you want, get rid of your desires, anticipations and also your memories so that there will be a chance of hearing these very faint sounds that are buried in this mass of noise. (p. 17)

Winnicott (1971) agreed when he advocated a "not knowing" stance:

> The patient's creativity can be only too easily stolen by a therapist who knows too much. It does not really matter, of course, how much the therapist knows provided he can hide this knowledge, or refrain from advertising what he knows. (p. 67)

Whatever psychotherapy theory is adopted as part of an integrative framework, what is called for is an especially attentive attitude of nonjudgmental, curious receptivity. There is an emptying of the self while being present in the moment in order to be filled by the other and what is occurring between the clinician and the client. “Although it is not easy to let go and enter this space, the results can be rewarding” (Finlay, 2022, p. 48).

In practice, therapists often have to keep adapting. They catch themselves when they fall into undue knowing or start pushing forward their own agenda. Methodically suspending our commonsense assumptions about the shared world, wrote Fuchs et al. (2019), “enables psychotherapists to transpose themselves … into fundamentally different ways of finding oneself in the world” (p. 63).

To understand this process in action, it is helpful to turn to Erskine’s touching story about his work with Violet, a 52-year-old woman with a schizoid process. When she started therapy, Violet seemed depressed. She would spend her sessions going into great detail about her day-to-day life while avoiding talking about her feelings. Erskine (the therapist) felt talked “at” rather than “to”:

> I realized that I was not making full interpersonal contact with Violet. Just like her, I was not fully present. I was confused by her. I did not understand how she functioned. No wonder I periodically felt drowsy or found my mind wandering to other situations. It was evident to me that in the absence of any emotional connection between the two of us, I compensated by becoming more and more behavioral in my interventions. Eventually I became aware of a parallel process: My focus on behavior change mirrored both her mother’s and her husband's attempts to control her behavior. My countertransference was in my wanting something to happen … so I focused on expressive methods, cognitive understanding, and behavioral change to ward off my worry about not being an effective psychotherapist. (Erskine, 2020b, p. 16)

Erskine (2020b) realized that he needed to change his approach. After some months of working with Violet, he began to understand there was a need to respect and be with her in her “quiet place”—a space involving long periods of silence during which she self-stabilized and self-regulated. Erskine recognized her need for him to be less invasive by gently reflecting back and describing her internal experience:

> I invited Violet to withdraw to her safe bed. There were about 15 minutes of silence during which I watched over her in the same way that I watched over my children as I sat by their bed at night when they were sick. I watched Violet's labored breathing and the tension in her clenched hands. I said, "You must be so scared. … It is important to have a safe hiding place." She again nodded her head. After another 2 minutes of silence, I offered, "It is so important to hide in your quiet place, particularly when you are sad." She again nodded, her breathing returned to normal, she unclenched her hands.
>
> When Violet opened her eyes, she said my description of her internal experience was important because it meant that I understood her and that she was not all alone. … We discussed how my description of her internal sensations was different from her mother's and her husband's criticizing definitions of her. She described my voice as "tentative" and my tone soft, "not a definite, authoritarian voice" like those she was used to in her family. (p. 24)

Phenomenological Description

Instead of explanation, theorizing, or interpretation, phenomenologists value and prioritize description. Merleau-Ponty (1960/1964) explained phenomenological description as needing to "stick close to experience, and yet not limit itself to the empirical but restore to each experience the ontological cipher which marks it internally" (p. 157).

Phenomenological research typically involves the participant describing their lived experience of, for instance, a particular trauma or disability. Together, participant and researcher dialogue and try to make sense of the phenomenon as seen from the participant's point of view. Similarly, in therapy the aim is to invite the client to simply describe their experience, to put words to their feelings. If words are hard to find, perhaps the person can find a metaphor or say what color or texture the experience has. If the client struggles to describe the experience, the therapist can go slower with the phenomenological inquiry. The point is to stay with the manifest material in active, curious ways rather than passively reflecting it back. By this means clients can edge forward to making or finding their own meanings rather than being fed the therapist's meanings or interpretations.

For example, we might ask a client to describe an experience as it happened in real time: “Can you describe this experience as it happened?” Some prompts to help return the client to the specific scene may be helpful: “Put yourself in that place and look around. What do you see/hear/smell?” Often when a person recalls an experience in detail, it can be vividly evoked, almost reexperienced. Then it becomes about staying with this: standing with the client, encouraging more description, and not foreclosing too quickly (for example, avoiding interpretations or assuming a clear understanding). This is an opportunity to go deeper, to ask for more textured description: “As you’re now feeling a little of how it was for you, how are you experiencing it in your body?” “Stay with that body feeling. What is it saying?” Inviting more metaphorical description is also a possibility: “What would its color/sound be if it had one?” (Spinelli, 2007).

The process of describing involves us slowing down. When seeking to describe, we focus in an attempt to uncover sediments of meaning or reveal nuance and texture. Wertz (1985) described it well: “When we stop and linger with something, it secretes its sense, and its full significance becomes … amplified” (p. 174). This attitude, he said, involves an

> extreme form of care that savors the situations described in a slow, meditative way and attends to, even magnifies, all the details. This attitude is free of value judgments … and instead focuses on the meaning of the situation purely as it is given in the participant’s experience. (p. 172)

This process is illustrated in the following verbatim dialogue between a client and existential psychotherapist Ernesto Spinelli (2007, p. 161):

> *Client*: When he finally told me that he didn’t want to stay in the marriage and that he’d found a new life-partner, I just felt so sick and angry. I hated my self more than I hated him.
>
> *Therapist*: Can you say a bit more about what it was like for you to hear him say these things? How was that sense of feeling sick and angry, for instance?
>
> *Client*: I can just feel it, you know? It’s hard to put words to it.
>
> *Therapist*: [accessing his own experiences of being rejected and the feelings that arise in him regarding this] Would it be OK for me to try to speak the words?

Client: Yeah …

Therapist: Now, I'm just guessing here. So anything I say that feels wrong to you, that's fine. You let me know. OK, so what I'm imagining when I put myself in your experience is: I get an overwhelming dizziness; a tightness in my gut; a restriction in my throat so that I can't even reply to him; I see flashes of all sorts of earlier moments in our life together: happy moments, sad ones, silly ones, private ones; and as I see them I hear his voice saying over and over: "It's finished. This is the end." I feel a rage that is almost murderous directed toward him, but oddly it's also directed toward my self. How's that so far? Is it at all close to your experience?

Client: Yes, a lot of it is. But as you were talking, what mainly came up for me was a sense of failure. That was the main thing. "I've failed and I'm not worthy."

Therapist: OK. So let's stay with that. "A lot of those statements Ernesto made are correct and they've provoked my overwhelming sense of failure." Are you feeling it now?

Client: Yes.

Therapist: So what's it like to feel it right here with me present?

Client: It's like I felt with Harry when he told me he was leaving me.

Therapist: OK. So that feeling with Harry is right here in the room with us. Can you access any words for that feeling?

As this exploratory dialogue reveals, the phenomenological description of lived experience takes priority over focusing on pathological symptoms, analyzing unconscious motivations, or attempting to explain and modify behavior. Rather than seeking to educate, repair, change, analyze, or explain, phenomenologically oriented therapists celebrate the value of simply describing (Finlay, 2016a).

> Bringing one's world into focus, and dwelling there, often alters one's being itself. As new awareness arises, subtle shifts occur. Along with other existential phenomenologists, I believe that I just have to be there *with* the client, perhaps in their dark place, for the combined power of the relational context and the process of description to reveal its transformative potential. (p. 178)

Dialogic Relationality

Contemporary dialogic and relational approaches to therapy place the focus on the therapeutic relationship rather than simply on the individual client. The therapist tries to be present in the moment to both the client and to their own feelings (which, through countertransference, may offer important clues about the client's experience). Therapists are encouraged to foster a client's sense of self by maintaining an affirming, holding, relationally responsive presence (Finlay, 2016b). There is a growing emphasis on the mutuality of the therapeutic relationship.

But how we bring this relational dimension into therapy varies according to perspective and context (Paul & Charura, 2015). A key debate revolves around the extent to which we emphasize the here-and-now intersubjective relationship rather than the intrasubjective one, where past developmental relationships are accessed transferentially.

In the field of integrative psychotherapy, the work of Erskine and his colleagues has engaged a process that involves simultaneously attending to client and self (in terms of being emotionally available and self-aware). The therapist decenters from their own needs, making the client's process the primary focus. The therapist is mindful of the client's experience, watching every gesture, listening to each word, and/or being with the client's silence. At the same time, the therapist's history, relational needs and sensitivities, theoretical stance, and professional experience all enter into building therapeutic presence (Erskine, 2011; Moursund & Erskine, 2003/2004).

Similarly, with reference to dialogic gestalt therapy, Yontef and Jacobs (2005) wrote that contactful dialogue is the basis of the therapeutic relationship: "In dialogue, the therapist practices inclusion, empathic engagement, and personal presence (for example, self-disclosure). The therapist imagines the reality of the patient's experience and, in so doing, confirms the existence and potential of the patient" (p. 362).

Hycner (2017) also talked of the "artistry" involved in maintaining a three-way attuned focus: on what the client needs, on our own needs, and on the needs of the relationship. Immersed in the relationship, therapists engage in an intricate dance, one that involves being present to all three dimensions while also being curious, attentive, open, and able to step back and think. In the fluid moments

between intimacy and distance, the nature of our holding as clinicians shifts, as do our points of focus. In one moment, we might be deeply immersed in holding a client's story or literally holding them; in the next, we might be holding on to ourselves, struggling to anchor ourselves by stepping back reflectively to avoid being caught up in a relational maelstrom.

Some gestalt therapists have built on the significant work of the phenomenological philosopher Martin Buber (1923/1958, 1951/1965) and his ideas about I-Thou versus I-It relationships. In I-Thou, the therapist surrenders an instrumental desire for control or validation and eschews habitual ways of interacting that are found in instrumental I-It relationships. The I-Thou relationship is "free from judgment, narcissism, demands, possessiveness, objectification, greed, and anticipation" (Finlay, 2016a, p. 127; see also Hycner, 1991/1993). In the authentic, open relationship of I-Thou, each person gives of themself without manipulating the other or controlling the impression being created. The direct experience of such presence with another is comforting (by showing us we are not alone) and threatening (by challenging us to be more). Treating another as a "Thou" rather than an "It" has important ramifications: Buber (1923/1958, 1951/1965) saw the Holocaust as a particularly horrendous example of the ethical consequences of seeing others as "Its." Ultimately, the I-Thou relationship is mutually revealing (Hycner, 1991/1993). Recognizing the value of the other's personhood helps us renew our own personhood (Finlay, 2019).

Buber's dialogic philosophy also guides therapists to embrace both presence and inclusion. Presence is the capacity to be present emotionally and bodily; inclusion is the capacity to put oneself into the experience of the other with attuned empathy while holding on to oneself and one's own presence (i.e., not getting lost in confluence) (Finlay, 2016b). When we have the courage to be fully present, we are met and affirmed by the other through what Hycner called an "embrace of gazes" (Hycner & Jacobs, 1995, p. 9).

Another key idea in Buber's philosophy is what he called the *interhuman,* that is, the deep contact that can be found in the relational between:

> Where the dialogue is fulfilled in its being, between partners who have turned to one another in truth … there is brought into being a memorable common fruitfulness. … The world arises in a substantial way between men [sic] who have been seized in their depths and opened out by the dynamic of an

> elemental togetherness. The interhuman opens out what otherwise remains unopened. (Buber, 1951/1965, p. 86)

In relational-dialogic work, decisions about interventions—such as whether to make an interpretation or to confront and challenge the client—necessarily take into account the client, the therapist, and the context. For example, a therapist would not just start to hold (either metaphorically or physically) a client. The client needs to be receptive; they need to accept and take in that holding and feel held. The question becomes, what level of holding can the client tolerate? And, in turn, the therapist needs to be alert to when the client is accepting (or resisting) being held. How does that impact the therapist and how do they respond back to the client? (Finlay, 2019). Therapists need to factor in their own needs and readiness. If the therapist is uncomfortable using touch yet still pushes ahead with it, this may have negative implications for the relationship. If you are feeling pulled to physically hold a client, it might be useful to ask yourself why: "Am I intuiting the client's needs? Or does this feeling have something to do with my own needs? Could it be something that is emerging from the relationship? In whose interest is this holding?" (Finlay, 2019, p. 115).

In the dialogue below, the therapist (Ken Evans, an integrative psychotherapist) holds on to his presence while containing his client's rage. For instance, rather than reacting in anger when feeling "wiped out," Evans used his awareness of his own experience and what seems to be happening between him and the client to attune to his client's experience. He also showed the impact the client's experience was having on him.

> Therapist: "tell me some more about what that was like for you Phillip, to witness your brother get beaten?" … "it must have been really tough for you."…
>
> At this point there is a dramatic physical change in Phillip's presence, from a sad slumped body posture to an erect and rigid position and with a face contorted with rage and disdain ... "You haven't a fucking clue what it was like for me."… I imagine I experience something of what it must have been like for him as a child – sarcasm, dismissal, humiliation and a deep sense of being "wiped out."…
>
> Therapist: "Phillip, I was listening intently to you talk about your father beating up on your brother, and feeling a lot of compassion[.] I reached out to you in

> your obvious distress. I then experienced you responding to me with sarcasm and angry disdain, which impacted me deeply. I experienced being dismissed by you and feel unseen, fearful and angry. I want to ask you 'Who did this to you?' "
>
> Phillips's posture instantly deflated, as did his seething anger, and with eyes filled with tears he replied sorrowfully, "That's just how it was for me." (Evans & Gilbert, 2005, pp. 118–119)

Here, Evans attempted to be attentive to the client's experience, his own, and what was happening between them. He made himself both present and transparent to Phillip, inviting him to recognize his projections. Although some therapist self-disclosure was involved (he owns feeling dismissed, unseen, fearful, and angry), we can also see how he contained his personal reactive responses. His hurt/anger/shame was not the issue; it was about being in the process and being alert to the source and meanings of those emotions (Finlay, 2016a).

Gestaltist Lynne Jacobs (1989) provided another example that involved reflexively adjusting her approach:

> The patient was argumentative and critical. She claimed to be desperate for help, but disparaged my attempts to understand her and to be helpful. I tended to react with unaware defensiveness by taking a particularly superior, authoritative stance toward her. The meeting—the momentary I-Thou—occurred after I realized that I was defensive, and decided to be more attentive to my own defensiveness. The next hour, I found myself again reacting defensively. I began to "disclose" this to the patient, while still operating from my defensive authoritative stance. Suddenly I realized that at that moment I was still protecting myself by pushing against the patient. I brightened and exclaimed, "See! Oh my, I'm doing it right now! Damn it, E—, you are just too good. I give up!" I began laughing at my own absurd attempts to coerce the patient. The patient, surprised, also laughed heartily. She admitted she was very good at what she was doing, and enjoyed it, although she always left feeling bitter and dissatisfied. What ensued was our first authentically cooperative exchange of ideas. Both of us had gained a renewed respect for the anxieties that had driven us into defensive styles at the expense of presence with each other. (pp. 3–4)

Existentialism

Existentialism is concerned with questions about human experience and existence. It addresses shared human concerns relating to authentic being and becoming, meaningfulness and meaninglessness, belonging and needs, free will/choice and autonomy versus oppression and constraints, and so on. Importantly, existentialism calls us to face the fact of our death in order to make us focus on our life. Paraphrasing Heidegger's often-cited words: If I take death into my life, acknowledge it, and face it squarely, I will free myself from the anxiety of death and the pettiness of life—and only then will I be free to become myself.

These questions can become the focus of therapy as the client is encouraged to become aware of what it means to be alive, to own one's choices, and to embrace the special capacity of humans to be reflexive (self-aware) about our identity and relationships with others. Existentially oriented therapy aims to examine ways in which each (unique) individual comes to claim their way of being. The focus is on questions such as: "Who am I?" "What gives my life meaning?" and/or "How do I want to live my life?" (Deurzen, 2014).

A central existential concept philosophers have written about is authenticity. Heidegger (1927/1962) referred to inauthenticity as "forgetting" to take ownership of one's life/world. The inauthentic being is "tranquillized" and "flees," for instance, into bingeing on TV, food, online gaming, consumer products, and so on. Heidegger pointed to our daily experience of being-at-home where we are tranquillized and "fall into" the taken-for-granted certainties and familiarities of the anonymous "They" (*das Man*). With these ideas brought to the fore, the key aim of existential psychotherapy is to claim one's authentic being and become more self-aware, to embrace one's possibilities and limits, and to be present to one's existential anxieties while facing the horizon of our death squarely (Yalom, 1980).

Another existential phenomenological concept, which was highlighted originally by Husserl (1936/1970), is the notion of *lifeworld* (*Lebenswelt*) as the taken-for-granted world that is experienced. It is our meaningful subjectivity in relation to the experienced world—not the material world out there but the humanly relational lived world of being. We all have a lifeworld, one that is both unique and also somewhat shared with others (for instance, through our use of language/discourse and culture).

Different interlinking existential “fragments” (Ashworth, 2003) of the lifeworld can be identified as universal themes (van Manen, 2014):

- First, we all have a sense of embodiment. Rather than being about our biological body, it is about our experiencing, lived body, which we may be attuned to or disconnected from. It is always there, whether we feel slothful and flabby or energized and potent, and so on. Applied to therapy, for instance, we might invite a client to tune into their bodily sense of feeling “hollow,” perhaps opening up a dialogue about what the body in its wisdom is saying about what it needs.
- Second, our lifeworld is constituted by our lived relationships with others. Here, we might embody our loving “motherly” presence or be a passive-aggressive “stroppy teenager,” or we might set out to please and charm, or we might even withdraw from contact and close down.
- Our lived world also involves a sense of lived time and space (temporality and spatiality). Lived time is not clock time but our experience of time, perhaps as creeping slowly when we are bored and rushing ahead when we are stimulated. Lived space similarly involves our experience of spaces: for instance, whether they feel safe or threatening, oppressive or free, large or confined, and so on.

Therapy is geared to exploring the person’s lifeworld. As part of this, existential feelings (Ratcliffe, 2008) can be explored: for instance, when we feel fulfilled or safe and secure or distant and outside a group or have a sense of depersonalization. Existential feelings are more than emotions we direct somewhere (such as the anger we might feel toward a particular person). They are more like background orientations involving our bodily relationship with the world. Describing the experience of a mental health disorder, for instance, the psychiatrist van den Berg (1972) talked of how a person’s world can “collapse” or feel “unbalanced”: “The depressed patient speaks of a world gone gloomy and dark. The flowers have lost their color. … The patient is ill; this means that his world is ill” (pp. 25–26).

The notion of the lifeworld is rooted in nondualism. As Merleau-Ponty (1945/1962) famously said, “There is no inner man. Man is in the world and only in the world does he know himself” (p. xi). Body and world are intertwined; people need to be understood in the context of their world and their meanings. Our lifeworlds (individual and shared) are endowed with particular meanings and

emotional tones. In Heidegger's (1927/1962) terms, we can speak about *mooded disposedness* or *affectivity* (*Befindlichkeit*), which discloses what matters to us, and the brute facticity of Dasein's there-ness. In other words, feelings are not located inside of us but involve a felt sense of ourselves in a situation. Heidegger's Befindlichkeit discloses how we are always already delivered over to a situation. Applied to developmental trauma, for instance, the child feels unbearable pain in a context in which there is an absence of relational attunement.

Engaging the body more specifically and explicitly, Madison (2014) argued for *palpable existentialism*—a term for a model of experiential-existential therapy that draws on Gendlin's Focusing practice. This practice works through the therapeutic relationship and phenomenological description, prioritizing the client's bodily experiencing over therapeutic technique or inference. Rather than necessarily addressing the manifest content of what is being said, the therapist responds in a way that brings into awareness the embodied feeling process that is there in the moment for the client.

> The forward movement of bodily process feels right. It comes through the person-in-relation; not arbitrarily constructed by the person from their pre-existing biases. It comes with a deep breath, the release of tears, laughter … some bodily indication of relief and expansion, even if what was realised was an unpleasant fact. Acknowledging our existential reality usually feels better, even if it's not what we would wish for. (p. 29)

Applying all of these existential ideas to psychotherapy practice, we can say that phenomenology is a holistic approach that "captures human existence in all its dimensions, from self-awareness and embodiment (including their prereflexive and 'unconscious' forms), to spatiality, temporality, narrativity and intersubjectivity" (Fuchs et al., 2019, p. 64).

Existentially focused therapy puts the human condition front and center, engaging with all its complexity, ambivalence, paradox, tragedy, and wonder. It recognizes this human experience as inseparable from our being-in-the-world. Such an approach reminds us to engage the individual's experience of their wider life-as-lived and relationships with others, not just restrict ourselves to exploring what is happening internally. For Dahlberg et al. (2009), "lifeworld-led care" should be applied beyond therapy to health care in general, replacing consumerist patient-led, client-centered, or medical-model-driven care.

An Integration

The process of phenomenologically orientated integrative psychotherapy is experiential, with an embodied, relational, here-and-now focus. It turns away from reductionist diagnostic labels and cognitive approaches that categorize and explain the person simply in terms of their thinking/behavior, which thereby locates the "problem" in the individual. There is also a turn away from psychoanalytic "archaeological" and inferential explorations of the unconscious and early life. The focus, instead, is on the implicit past that structures the individual's current phenomenal field of self-other relating (Fuchs et al., 2019).

In this article, I have offered a map of how phenomenological philosophy is, or might be, applied in integrative psychotherapy. Each of the landmarks discussed (phenomenological inquiry, attitude, description, dialogic relationality, and existentialism) has been presented as a distinct process. In practice, however, these processes intertwine and blur into one another.

The following case illustration shows something of that holistic intertwining (NB: The bolded terms are not in the original passage, but I include them here to highlight the five markers of phenomenological work discussed in this paper.)

> I had been seeing Gillian (aged 28) weekly for a couple of months. She had come for help with anxiety and panic attacks, specifically relating to swimming in deep water. …
>
> Then, one session she mentioned her uncle. … His presence had brightened the family home one summer when she was about 10 years old. He took on the responsibility of reading to her at night and tucking her in. Gillian described his attentions as making her "feel special" [**description**]. She started to say something more and then went quiet.
>
> … The silence between us stretched out. Gillian seemed frozen in a nowhere land as she gazed sightlessly out of the window, and I felt her withdrawal [**dialogic relationality**]. I tried to reach out by asking what was happening to her [**phenomenological inquiry**]. She replied that she didn't know and just felt "empty." At that point I, too, lost my words and joined her in feeling blank. …

> I sensed a large blockage in my throat. … Was this mine or did it belong somehow to Gillian's experience? Could it be that my body was vibrating to something occurring between us? [**existentialism**] …
>
> I shared with Gillian my sense that my throat felt blocked and how I was feeling the opposite of her emptiness, being choked up with unshed tears [**dialogic relationality**]. She turned to me in surprise saying that her throat too was feeling like it had a "fist-size blob in it." ...
>
> I invited Gillian to focus on her throat sensation, utilising the technique of Focusing (Gendlin, 1996). "What might your blob throat be saying?" I asked [**existentialism, phenomenological inquiry**]. …
>
> "Get out … [pause] I don't want it," she eventually whispered. She tried to clear her throat and then said, "It's not, it's not … cc … coming out." She started to get tearful and began to look visibly anxious. "I don't want to speak anymore. Stop this." At this point I did not know whether she was still talking from her throat or expressing her own desire to not explore further or pleading with me to stop her pain somehow… [**phenomenological attitude**].
>
> It took two more sessions for her story of being sexually molested to emerge more fully. Together [**dialogic relationality**], we came to understand Gillian's sense of her blobby throat as partly representing the *re-membered* experience of the oral sex and partly her own fearful pushing down of her desperate emotions relating to that unspeakable experience. (Finlay, 2015, pp. 347–348)

The art of therapy comes in those exquisitely delicate moments of contact when we make clinical judgments about when and how to intervene. It surfaces as we move in and out of varying levels of support/challenge, separation/distance, connection/intimacy, self-containment/self-disclosure, nondirectiveness/directiveness, silence/active presence, and more (Finlay, 2022). Therapy involves responding in the moment and going with relational flow and the client's readiness to explore (Moursund & Erskine, 2003/2004). Together, client and therapist then find themselves immersed in a duet of cocreated music.

Such moments of connection can feel magical. Even so, our craft skills and phenomenological dialogic practices can be reflected on, observed, and learned (Finlay, 2022). And, if we listen to the original teachers, philosophy can be our guide.

References

Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25–39). Sage.

Ashworth, P. D. (2003). An approach to phenomenological psychology: The contingencies of the lifeworld. *Journal of Phenomenological Psychology, 34*, 145–156.

Bion, W. R. (2005). *The Tavistock seminars 1976-1979.* Karnac.

Buber, M. (1958). *I and thou* (R. G. Smith, Trans.). Charles Scribner's Sons. (Original work published 1923)

Buber, M. (1965). *The knowledge of man: A philosophy of the interhuman* (M. S. Friedman & R. G. Smith, Trans.) Harper & Row. (Original work published 1951)

Dahlberg, K., Todres, L., & Galvin, K. T. (2009). Lifeworld-led healthcare is more than patient-led care: An existential view of well-being. *Medicine, Health Care and Philosophy, 12*, 265–271.

de Beauvoir, S. (1984). *The second sex* (H. M. Parshley, Trans.). Penguin. (Original work published 1949)

Deurzen, E. (2014). *Existential psychotherapy and counselling in practice* (3rd ed.). Sage.

Erskine, R. E. (2001). The psychotherapist's myths, dreams, and realities. *International Journal of Psychotherapy, 6*(2), 133–140. https://www.integrativetherapy.com/en/articles.php?id=33

Erskine, R. G. (2011). *Attachment, relational-needs, and psychotherapeutic presence*. https://www.integrativetherapy.com/en/articles.php?id=73

Erskine, R. G. (2015). *Relational patterns, therapeutic presence: Concepts and practice of integrative psychotherapy*. Karnac.

Erskine, R. G. (2020a). Compassion, hope, and forgiveness in the therapeutic dialogue. *International Journal of Integrative Psychotherapy, 11*, 1–13.

Erskine, R. G. (2020b). Relational withdrawal, attunement to silence: Psychotherapy of the schizoid process. *International Journal of Integrative Psychotherapy, 11*, 14–29.

Erskine, R. G. (2021). *A healing relationship: Commentary on therapeutic dialogues*. Phoenix.

Erskine, R. G., Moursund, J. P., & Trautmann, R. L. (1999). *Beyond empathy: A therapy of contact-in-relationship*. Brunner/Mazel.

Erskine, R. G., & Trautmann, R. L. (1996). Methods of an integrative psychotherapy. *Transactional Analysis Journal, 26*(4), 316–328. https://doi.org/10.1177/036215379602600410 www.integrativetherapy.com/en/articles.php?id=63

Evans, K. R., & Gilbert, M. (2005). *An introduction to integrative psychotherapy*. Palgrave Macmillan.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the “phenomenological attitude.” *Journal of Phenomenological Psychology, 39*, 1–32.

Finlay, L. (2013). Unfolding the phenomenological research process: Iterative stages of “seeing afresh.” *Journal of Humanistic Psychology, 53*(2), 172–201.

Finlay, L. (2015). Sensing and making sense: Embodying metaphor in relational-centered psychotherapy. *The Humanistic Psychologist, 43*(4), 338–353.

Finlay, L. (2016a). *Relational integrative psychotherapy: Engaging process and theory in practice*. Wiley.

Finlay, L. (2016b). ‘Therapeutic presence’ as embodied, relational ‘being.’ *International Journal of Psychotherapy, 20*(2), 17–30.

Finlay, L. (2019). *Practical ethics in counselling and psychotherapy: A relational approach*. Sage.

Finlay, L. (2022). *The therapeutic use of self in counselling and psychotherapy*. Sage.

Fuchs, T., Messas, G. P., & Stanghellini, G. (2019). More than just description: Phenomenology and psychotherapy [Editorial]. *Psychopathology, 52*, 63–66.

Gadamer, H. G. (1989). *Truth and method* (2nd ed. rev.) (J. Weinsheimer & D. G. Marshall, Trans.). Sheed and Ward. (Original work published 1960)

Gendlin, E. T. (1970). *Experiencing and the creation of meaning: A philosophical and psychological approach to the subjective*. Free Press of Glencoe. (Original work published 1962)

Gendlin, E. T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method*. Guilford.

Heidegger, M. (1962). *Being and time* (J. Macquarrie, & E. Robinson, Trans.). Blackwell. (Original work published 1927)

Husserl, E. (1962). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. Book one: General introduction to pure phenomenology* (W. R. B. Gibson, Trans.). Nijhoff. (Original work published 1913)

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology*. Northwestern University Press. (Original work published 1936)

Hycner, R. (1993). *Between person and person: Toward a dialogical psychotherapy*. Gestalt Journal Press. (Original work published 1991)

Hycner, R. (2017, 8 September). *What does it mean to be a relational psychotherapist?* [Lecture]. Scarborough Counselling and Psychotherapy Institute, Scarborough, United Kingdom.

Hycner, R., & Jacobs, L. (1995). *The healing relationship*. Gestalt Journal Press.

Jacobs, L. (1989). *Dialogue in gestalt theory and therapy*. http://www.gestaltpsychotherapie.de/jacobs1.pdf

Levinas, E. (1969). *Totality and infinity* (A. Lingis, Trans.). Duquesne University Press. (Original work published 1961)

Madison, G. (2014). The palpable in existential counselling psychology. *Counselling Psychology Review, 29*(2), 25–33. https://gregmadison.net/documents/CRRMadison.pdf

Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). Routledge & Kegan Paul. (Original work published 1945)

Merleau-Ponty, M. (1964). *Signs* (R. C. McCleary, Trans.). Northwestern University Press. (Original work published 1960)

Merleau-Ponty, M. (1968). *The visible and the invisible* (A. Lingis, Trans.). Northwestern University Press. (Original work published 1964)

Moursund, J. P., & Erskine, R. G. (2004). *Integrative psychotherapy: The art and science of relationship*. Brooks/Cole-Thomson Learning. (Original work published 2003)

Paul, S., & Charura, D. (2015). *An introduction to the therapeutic relationship in counselling and psychotherapy*. Sage.

Ratcliffe, M. (2008). *Feelings of being: Phenomenology, psychiatry and the sense of reality*. Oxford University Press.

Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Christian University Press.

Sartre, J-P. (1969). *Being and nothingness* (H. Barnes, Trans.). Routledge. (Original work published 1943)

Spinelli, E. (2007). *Practising existential therapy: The relational world*. Sage.

van den Berg, J. H. (1972). *A different existence: Principles of phenomenological psychopathology*. Duquesne University Press.

van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Left Coast Press.

Wertz, F. J. (1985). Methods and findings in an empirical analysis of "being criminally victimized." In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 155–216). Duquesne University Press.

Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167–177. https://doi.org/10.1037/0022-0167.52.2.167

Winnicott, D. W. (1971). *Playing and reality*. Pelican Books.

Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.

Yontef, G., & Jacobs, L. (2005). Gestalt therapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (pp. 342–382). Brooks/Cole-Thompson Learning.

Žvelc, G., & Žvelc, M. (2021). *Integrative psychotherapy: A mindfulness and compassion-oriented approach*. Routledge.