PSY 748: Personal Reactions to
Concepts in Clinical Phenomenology

Joe Ferguson – July, 2004

At the outset I declare myself as a thoroughgoing scientist, a steadfast realist, and a committed naturalist. It is within this framework that I approach the application of phenomenology to clinical psychology, and on reflection I find no conflict whatsoever among these perspectives. In fact, I now recognize that the phenomenological perspective is a superset of both the scientific and the natural perspectives, and that it constitutes the proper basic psychotherapeutic posture *regardless of what other theoretical perspectives and techniques the clinician might embrace*. The phenomenological attitude and method expand the range of insight that is available to conscious reflection within the psychic hierarchies of both the clinician and the client, without limiting the range of other methods that can be engaged. Properly understood, clinical phenomenology embraces both the natural and scientific attitudes entirely. Such apperceptual flexibility facilitates both the clinician and the client, both diagnosis and treatment (McCall, 1983; Thévenaz, 1962).

The objects in the world exist within an ontological hierarchy, with epiphenomena of various kinds defining the boundaries among its many levels. To identify a thing as epiphenomenal detracts nothing from its substance or objective reality (Gell-Mann, 1994). In the hierarchy of physical phenomena the weird indeterminism of quantum mechanics yields elementary particle dynamics and then, progressively, the orderly regularity of chemistry, physiology, neurobiology, intelligence, and (I conjecture without evidence) subjective consciousness itself. Each of these levels in the ontological hierarchy is equally real in the sense that they manifest properties and effects that cannot be *meaningfully* reduced to the elements of which they are constituted. This same principle of hierarchical organization applies to the various psychic objects of cognition and experience as well.

> *"All conceptual structure and logical process can be seen as organized within a single hierarchical framework that defines the relationships between parts and wholes. This hierarchical framework is implicit in all cognition, and its characteristics account for many of the observed properties of cognitive and logical systems."*
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> Richard Feynman - (Feynman, 1965)

For example, the concept of phenomenology itself emerges from a broad array of subordinate constructs, including the ideas of philosophy and psychology, knowledge of a natural language in which phenomenological constructs can be formulated (English exclusively in this case, plus the wonderful must-be-Dutch word *"epoché"*), the nature of language itself, conceptions of ego, other minds, time, the intention to formulate or grasp the concept of phenomenology for some purpose, and many, many other constructs extending down to the level of elementary perceptual, motor, and psychological machinery. Constructs of personal identity, worth, purpose, appetite, affect, and circumstance are similarly constituted of subordinate elements; *but of elements to which their essences cannot be meaningfully reduced*.

The sum of all mental artifacts, of whatever sort, that constitute an individual's psychological/experiential space can be conceived as an evolving multi-dimensional matrix, structured within the "single hierarchical framework" that Feynman envisioned and which the phenomenological method both implies and explicitly recognizes. This matrix, or *hierarchically structured apperceptive mass*, is the domain of clinical psychology (as well as of *dasein*, the *life-world*) and it is the field of operations for both the clinician and her client. Their common task is to apprehend, supplement, refine, or transform some elements of this apperceptive mass in order to address the objectives of the clinical encounter, whatever those might happen to be.

Depending upon the circumstances, the clinician might draw the attention of her client "downward" to the muscular tension which constitutes one component of his apparent anxiety, or she might draw her attention "upward" toward the greater scope of his client's life in order to relieve an obsessive concentration on some particular circumstance. The appropriate shift in perspective can take any direction within the apperceptive hierarchy, according to the clinical intention at hand. In fact the effect of *any* clinical encounter can be interpreted as a shift in perspective within the client's apperceptive mass, and it is that perspective which defines the interpretation of his *life-world*, and which determines his behavior and personality.

It is in the nature of human cognition to scotomize as many elements as possible in the perceptual and experiential field, in order to focus on that which seems most relevant to whatever motivates a person (Minsky, 1986). Filtration of irrelevant elements from consciousness is essential to coherent and effective apperception, comprehension, analysis, action, and reaction. Much neural and psychological machinery is dedicated to the analysis, summary, and filtration of potentially conscious material (Kosslyn & Koenig, 1992). The overwhelming mass of William James' "*blooming, buzzing, confusion*" cannot be meaningfully digested raw; it must be pressed through the sieve of some apperceptual hierarchy and viewed from some perspective within that hierarchy (James, 1890). It is precisely the *fixed* perspective which can become a prison within the naïve natural attitude. It is precisely the flexibility of the phenomenological attitude to "shift away" from a fixed perspective within the hierarchically structured apperceptive mass, only sometimes in the direction of reduction, in order to explore and reflect upon various perspectives in a situation.

The natural attitude is marked by the absence of explicit interpretation. When driving an automobile we normally take for granted all of the physics, procedure, perception, and intention that are involved in driving, and we simply drive; whether we are paying attention to our driving or not. Usually such considerations are irrelevant to the motives of the driver. On the other hand, when the destination is novel, then the larger context of where the driver is going in her car must be held closer to consciousness and interpreted more explicitly. Similarly, driving to a regular destination or doing psychotherapy can sink below the threshold of explicit consciousness once it has been learned at a sufficient depth that it becomes intuitive or automatic. This distinction between explicit consciousness and the unreflective/naïve natural attitude certainly parallels, and may be literally isomorphic to, the distinction between explicit and implicit human memory systems, which appear to be subserved by relatively distinct neural mechanisms (Baars, 1997; Goldberg, 2001; Kosslyn & Koenig, 1992; Schore, 1994).

Strangely, it is *not* paradoxical that the phenomenological method combines the suspension of explicit analysis [bracketing] with the *explicit analysis of the implicit* material that naïvely presents itself to consciousness; by means of subsequent reflection upon the memory of that phenomenal experience. At least this is how I presently appreciate the clinical (and scientific) applications of the phenomenological method and perspective. The phenomenological attitude enables a certain mobility of psychic perspective, which automatically transforms the apperceptive mass of both client and therapist which, in turn, defines the manner in which the *life-world* is interpreted and understood which, in turn, determines affect and behavior.

I am tempted to assert that this same process may be involved in shifting the focus of consciousness toward *higher* level constructs within the apperceptual hierarchy (as from an obsession to its significance in a client's life), but the process of phenomenological *construction* may well rely more upon explicit and/or systematic analysis than does the deconstruction of phenomenological *reduction* (Heidegger, 1968; Hofstadter, 1989). At a minimum, the construction of higher level apperceptions (the shifting of attention "upward" in the apperceptive hierarchy) requires a detachment from a fixed perspective in the same way that such detachment is required in the phenomenological reduction.

Phenomenological shift in perspective can and does take place in every direction within the apperceptive hierarchy depending, in part, on the intentions of the phenomenologist or clinician. In the cases of Descartes, Husserl, and Heidegger the initial thrust was in the direction of phenomenological *reduction,* in order to locate an ontological or epistemological *foundation* of one sort or another, followed upon sufficient reflection by a "rebound" in the direction of the *reconstruction* of whatever conceptual or experiential edifice each particular foundation was supposed to support (McCall, 1983; Thévenaz, 1962). Descartes' ultimate intention was to reconstruct natural science on the foundation resulting from his reduction by radical doubt in the face of the Evil Genius, but his reduction succeeded only to the point of *cogito ergo sum* and failed to find any basis for scientific reconstruction. Husserl's initial intention was to apprehend the essence of his own transcendental consciousness, but he rebounded from *his* radical reduction to embrace the full range of human experience in the *life-world*, ultimately finding no consciousness outside of intentionality. broader conception of the human condition seems to have followed in the rebound to *dasein* from his own process of phenomenological and logical reduction in pursuit of the unshakeable foundation of ontology. Heidegger's broad perspective on the whole human situation provides a comprehensive framework for psychotherapy at any level.

Similarly, guided by whatever intentions the clinician and the client bring to their psychotherapeutic encounter, an analogous series of reductions, reflections, and reconstructions constitute the clinical interaction entirely. *This is true whether or not the clinician or the client realize that they are engaged in some form of the phenomenological method*, but they are each much more likely to be locked into some unfortunate perspective if they remain unaware of their own phenomenological flexibility, and that of their interlocutor, in the clinical discourse.

Like the Zen master who draws the attention of his pupil to her immediate situation by striking her with his staff (Kapleau, 1966), Will Kouw and Edmund Husserl are "*selling water by the river*". Phenomenological mobility is an inherent human faculty whether it is recognized and labeled or not. Properly and explicitly apprehended, however, it can be applied with much greater effect than is possible in the natural attitude.

The phenomenological psychologist's broad intention *for herself* in a clinical encounter is to garner a broad apperception of her client and his situation by iteratively:

1. Eliciting her own holistic experience of her client from various perspectives in her own apperceptive hierarchy.
2. Recognizing implicit insight into her client and his situation either by direct passive reflection upon her own immediate experience of him, or else by actively constructing such insights by means of explicit (and possibly formal) reflective analysis of her *memories* of such immediate experience.
3. Engaging her client in such a way as to encourage him to shift his own phenomenological perspective in directions that are indicated by the theoretical and practical perspective of the clinician, and by her intentions.

Clinical phenomenology is essentially a cognitive process. The essence of the phenomenological attitude is an attunement of consciousness to the holistic field of experience, as opposed to the specific elements of it. When employed intentionally in service of the phenomenological *method*, this attunement is refined by means of critical deconstruction and intentional de-emphasis [bracketing] of those epiphenomena that are accessible to explicit awareness upon reflection. The phenomenological method consists in the turning of attention toward the most automatic apperception of a given object that is accessible to consciousness. By bracketing every explicit psychic object in sight, attention is automatically shifted toward the implicit elements that constitute each bracketed object *in situ*, and away from the bracketed objects themselves.

This process provides informative access to ever more primitive (and more authentic?) intuitive apperceptions, which can then be interpreted and evaluated upon reflection in the natural or scientific attitudes (which are, of course, phenomenological in character themselves). The quest for ever more essential apperception ends at the point where its roots are no longer accessible to consciousness; where all of the psychic content is implicit. This end point may be defined by innate perceptual or psychological machinery, or it may be defined by more or less abstract learning and interpretation that has been integrated into the apperceptive mass to a depth where it appears as native and involuntary.

Awareness of the phenomenological attitude and methodology offers the clinical luxury of conscious accessibility to the broadest possible range of perspectives inherent within both the client and the clinician. All other psychotherapeutic technique is constrained and informed by such access.

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