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Cultivating the Therapeutic Moment: From Planning to Receptivity in Therapeutic Practice

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Abstract

A popular model of psychotherapy as a rational, linear, and instrumental treatment that can be mastered and planned by the therapist is critiqued as an idealized fantasy. This model, which often underpins cognitive behavioral therapy and a medical approach to therapy, is contrasted with an alternative model based on attentiveness to the therapeutic process defined as an emergent and unpredictable thirdness between therapist and client. Three principles of a process-oriented therapy are described and illustrated through case vignettes. Each of these principles is shown to contradict the assumptions of a rational/planning approach to therapy and therefore to undermine the rational endeavor to "plan" treatment. A process-oriented model of therapy is argued to be a more ethical choice due to the fact that it avoids the moralism and authoritarianism of the rational/planning approach to therapy and has a more radical therapeutic aim that circumvents conventional definitions of what good outcome is or should be.

Keywords

process, psychotherapy, treatment planning, rationality, ethics

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In this essay, I would like to compare two alternative approaches to psychotherapy and the "treatment" of psychological distress. The first approach is what I refer to as the rational/planning approach to therapy. It is exemplified by the medical model of therapy and cognitive behavior therapy (CBT). Both these approaches find common ground in the assumption that therapy can be implemented as a rational solution to a clearly defined problem. The second approach is what I call a process-oriented approach. In this approach, the therapy is itself the means by which a client is able to arrive at an understanding of the problem and find out what he really wants in life. Therapy can here not be thought of as solving a problem but must be thought of as helping the client discover what the problem actually is. Nor can therapy be planned out in advance, since both therapist and client are here coming together to learn and discover who the client is from out of an initial uncertainty and ambiguity about this question. The therapist in this latter approach is not devoid of rationality but deploys a different kind of rationality than the rationality of the therapist in the former approach. Rather than planning the entire course of therapy on the basis of an initial assessment, he remains in dialogue with the therapeutic situation and continuously revises both his understanding and his interventions on the basis of ongoing feedback and responsiveness to what emerges in the "now."

In today's therapeutic environment, the therapist is often forced into a conflict between these two approaches. On the one hand, insurance companies, licensing boards, and mental health agencies increasingly want the therapist to document that he is doing therapy in a rational and orderly fashion and show that he is following a "plan." On the other hand, the very principles that this rational orderly approach presupposes tend to clash with the much more messy and unpredictable process of the actual therapeutic experience.

In the work with a particular client by one of the interns I am supervising at the counseling center at University of Houston, it was interesting to observe how the intern, having been taught to define the problem up front according to the ideals of rational/planning, found himself in a struggle with a process of therapy that did not lend itself to such a rational first step. The starting point of their encounter was one of confusion and lack of clarity about the issue to work on. Although the client was unhappy with her life and demanded change, she did not know exactly what was "wrong" with her and did not know exactly what she needed from her therapist. Although the therapist felt a pressure to define a problem so he could adhere to a treatment plan, he felt mostly confused about the client's concerns and could not fit the client into a neat category of pathology. Both therapist and client therefore hit an impasse: Each was relying on clues from the other for further work to take place. As a

result, a battle ensued about who should take responsibility for the therapeutic work. The client, for example, was none too happy with the therapist's lack of answers. She wanted her suffering to be externalized in a concrete problem that could be solved much like one can solve a math problem or fix a broken car. Hence, as the therapist deferred definition of the problem in the interest of learning, the timber of the client's voice became increasingly more nervous, and the plea to be saved ever more desperate. "I like structure," she said, "I like for people to tell me what to do." And as answers still were not forthcoming, she became more accusatory, "I don't even think therapy is working!" "I feel better when I am not in therapy!" "I don't even know why I am coming here!"

Even though the therapist showed great foresight and resilience at times, by refusing to collude with the client's immediate demand for answers, definitions, and direction, the client also managed to make a strong appeal to the part of him that believed good therapy involves a clearly defined "goal." If the client did not know how to set goals for herself the therapist therefore finally declared, next time they would focus on goal-setting strategies.

With this declaration, an uncomfortable situation had finally been resolved. At long last the unwieldiness of the therapeutic process had been tamed and brought under control. With order restored, therapy could now proceed as "planned."

And yet one could make the argument that in reaching this final agreement, both therapist and client had in fact missed the problem altogether. For the problem here was not a task to be solved but an initial "mystery"[1] (Heidegger (1930/1993a) implying something about the person that demands to be further unraveled and understood. The client's anxiety in the face of uncertainty, her appeal to the therapist to be a strong authority who could tell her what to do, and her preference for abnegating her own subjective responsibility for her situation are not just pleas to be accommodated but signs of an underlying attitude toward life that reveal something about the client, which is itself problematic. This problem, however, is not a problem to be solved but a question to be further pursued through curiosity and inquiry. Its resolution is not achieved through practical advice but through a further pursuit of what is not yet understood. By siding with a definition of the client's problem as a concrete issue in need of a specific solution (goal-setting difficulties), the client may gain valuable skills, but she will be robbed of an understanding of herself and will likely continue to seek solutions from others in many interactions to come. Such is the dilemma often faced by the modern-day psychotherapist: She often has to make a choice between the short-term achievement of specific goals and the longer term pursuit of self-understanding. In the first situation, the therapist is told to define the problem up front so she can plan

specific interventions intended to bring about a solution. In the second case, the goal of the therapy is first of all to discover what the problem *really* is, which is never an easy task.

What I would like to show in the following is that the rational/planning approach to therapy, which is rapidly becoming the standard of practice, is based on a number of philosophical assumptions that are themselves highly distortive of therapeutic reality and can easily be criticized:

1. The first assumption is that we can define a client's problem ahead of time, through a diagnostic interview, psychological testing, or a rational collaborative discussion with the client.
2. The second assumption is that therapy is a linear process in which goals can be determined in advance and will remain steady throughout the course of therapy.
3. The third assumption is that the therapist is in control of the therapeutic process and is able to direct treatment in a rational and goal-oriented manner.

In contrast to these assumptions, a process-oriented approach to therapy claims the following:

1. The objective of therapy is to discover what the problem is rather than to provide a solution to a problem that has been defined at the beginning of therapy.
2. The process of therapy transforms goals rather than leads to their realization in some progressive and linear way.
3. The therapist is most therapeutic, not when he plans out and administers universal interventions, but when he responds to what emerges in the moment in a contextual and well-timed manner.

By comparing the assumptions made by each of the two approaches, the ethical stance I am adopting and the argument I wish to make is that *therapy should not just be a technology used to bring about predefined goals but a process of discovery through which one discovers who one is and what one wants.*

Against Rationality, Linearity, and Planning in Therapy

My own experience with a rational/planning approach to therapy came from my postdoctoral experience in a community mental health agency, where for

the first time, I was forced to reconceptualize my therapeutic work with clients to accommodate the requirements of a "paper reality" where what looks reasonable on paper is assumed to *be* reasonable in actuality. Foremost in the hierarchy of this reality was the diagnosis provided by a medical doctor. This diagnosis, which defined the client's distress as a "mental illness," could be broken down into problem areas or symptomatic thoughts, feelings, and behaviors. It was then the therapist's job to target these problem areas and to devise a structured plan for how to bring about changes in the problems through specific interventions. Most of the time between five and eight problem areas were defined following the initial diagnostic interview. Goals were then devised that corresponded to each problem. The more specific they were the better. Hence, if someone was diagnosed with depression, a goal could be to decrease periods of sadness from three times daily to two times weekly. Next, to reach the goal, a series of interventions aiming at the realization of the goal had to be devised. The client had to be able to achieve the end goal through the progressive accomplishment of specific tasks, challenges, or assignments devised by the therapist. Hence, if you were depressed, subgoals such as identifying three possible aspects of your life that contribute to your sadness, or identifying at least one daily pleasurable activity to engage in, might be listed as steps in the treatment plan. Once the first subgoal had been achieved, you could then move on to the next, and once all challenges had been mastered, you would presumably have achieved the overarching goal of a decrease in sadness. Obviously, this degree of rational planning, favored approaches to therapy that were interventionist, targeted specific symptoms, used specific techniques, and aimed at specific effects. This meant that cognitive and behavioral approaches to therapy were largely favored since these approaches align the best with the underlying philosophical principles presupposed by the rational/planning approach to treatment. Only cognitive and behavioral techniques, broken down, as they could be, into specific interventions targeted at specific symptoms and aimed at specific results, translated well into the paper-reality of means-end rationality. Interventions such as active listening, responding intuitively based on feelings in the room, getting clients to speak freely and without inhibition, and letting the unfolding process of therapy teach both client and therapist something, did not pass the test. They were therefore relegated to the role of invisible context and either explicitly or de facto denigrated as unscientific, superfluous, or even irrational. It is thus no surprise that the concept of empirically supported treatments has become the gold standard in many treatment setting and that almost all these are cognitive behavioral in orientation (see, e.g., Wachtel, 2010, or APA Division 12's list of empirically supported treatments). Hence, the medical

model, the cognitive behavioral approach to therapy, and the general societal preference for means-end rationality are rapidly merging into a hegemonic triangle that I refer to as the rational/planning approach to treatment. This approach designates a philosophy of practice, much more than an actual theoretical approach. I am therefore not specifically critiquing CBT as a theory of psychotherapy but more broadly the underlying philosophy of rational/planning that leads to a certain instrumental way of practicing CBT.[2]

Because scientific means-end rationality has such a strong grip on the society in which we live, it is very easy to agree with the rational/planning approach to treatment, for *who would not prefer a definite result over an indeterminate outcome? Are clients not consumers entitled to a product? And, should we as therapists, not dedicate our profession to finding empirically proven ways to provide consumers with the products they ask for?* The argument sounds so rational and intuitive that it is hard to see how one could even question it. And, in fact, one is only able to, once one realizes that the philosophical foundation of the rational/planning approach to therapy is itself what is flawed. It is therefore important that we as clinicians not just rush to distort our approaches to therapy to make them align with the rules of the game but examine the foundation on which the rules of the game are made to ascertain if the playing ground is itself justifiably constructed.

My argument in this article is that the choice between a rational/planning approach and a process-oriented approach to therapy is not just an empirical and pragmatic issue but a larger ethical and philosophical issue about what "good" therapy is really about. The broader question we must ask is: *What are we really aiming for when we invite someone to undergo a therapeutic experience?*

From a rational/planning perspective, the good outcome can always only be defined in relation to what we already know. This kind of therapy is confined in scope by the doctrines that are already in place, either as the sociocultural common sense adopted by clients as their own opinions of what they want or the authoritarian knowledge of a medical or therapy profession that defines people's problems for them. In contrast to this approach, a process-oriented therapy seeks as far as possible to dispense with readymade assumptions promulgated either by the client or the therapist. Here, what is prioritized is the uncertainty of the unfolding process, which will itself teach therapist and client something that none had up till then known. In this way, a process-oriented approach to therapy becomes a more ethical choice since it has its origin not in conventional social morality or socially constructed knowledge but in the void or happening out of which everything valued and everything known first becomes a question. Hence, process-oriented therapy might very

well shatter people's long-held beliefs about themselves and what they want and might very well shatter the therapist's expectations and preconceived knowledge. It is precisely this possibility that accounts for its full transformative potential.

Before a discussion of the "good" in good outcome is even possible, we need to first question the assumptions of the rational/planning approach to therapy that would have us settle the question through a mere demand for empirical proof. This appeal to proof as the final arbiter in the debate is itself only reasonable if we adopt the assumptions of the rational/planning approach in which good outcomes can be predefined through outcomes that are relatively fixed. And yet this view of the good is itself a philosophical and value-based position and thus part of an ethical–philosophical rather than empirical debate, for as Karl Jaspers (1997/1913) has pointed out, "Theory lurks in every fact" (p. 15).

To make space for a way of thinking about therapy that is not confined to the supposed value-neutrality of the rational/planning approach, we therefore need to examine its assumptions from a philosophical/ethical perspective. In the remainder of this article, I will aim to do so, by showing how each of the three principles of the rational/planning approach, as previously defined, can be critiqued from a process-oriented philosophy of therapy.

Critique of Defining the Problem Ahead of the Therapy Itself

The rational/planning model of therapy turns actual reality on its head by suggesting that the problem of a person's suffering or unhappiness must be known first for actual therapy to subsequently take place.

In practice, this usually happens through a diagnostic interview in which the client's problem is summed up as a diagnostic category, or through a belief that client and therapist can mutually agree on goals through a simple rational discussion of presenting concerns.

This way of thinking sounds right if we envision that therapy is the process of helping clients solve a problem of which they are already aware or which can be authoritatively defined by the expert knowledge of the therapist.

Initially, as we have seen, however, a problem is often not what it seems, and attempts to quickly define it are therefore necessarily premature. At the heart of every human being's approach to life, our supposed values, and our reasons for doing things lies something obscure: a mystery. We live in partial darkness about who we are, and we often do not really understand ourselves

despite what we may think. This means that the starting point of any therapeutic situation is often one of "not knowing" and one of complexity that defies quick comprehension. As Karl Jaspers (1997/1913) has argued,

> There can be no final analysis of human beings as such, since the more we reduce them to what is typical and normative the more we realize there is something hidden in every human being which defies recognition. We have to be content with partial knowledge of an infinity which we cannot exhaust. (p. 1)

This initial complexity or mystery at the heart of every presenting concern is what our supervisee was experiencing in his encounter with his pleading client. His adherence to the tenets of the rational/planning approach to therapy, however, quickly let him to abandon the initial ambiguity in favor of categorical knowledge that allowed him to define his client's problem as a case of "problem-solving difficulties."

This leap from the process into categorical knowledge is one of the hallmarks of the rational/planning approach. The basic assumption of both the medical approach and the cognitive behavioral approach to therapy is namely that a person's difficulties can be externalized and objectified as concrete problem behaviors that can be dealt with as discrete phenomena and can be treated as instances of universal problems. The problem gets taken out of the unique personal context of a person's existential situation, lifted into a theoretical world of knowledge about that problem as a universal construct, and translated back into the work with a particular client where it is used to frame the client's particular problem in terms of what is already known. Hence, the CBT literature is filled with a plethora of explanatory theories of depression, assertiveness, human emotions, and so forth, which is often used to frame the client's problem from the get go. Hence, depression is due to the trifold of negative view of self, negative view of world, and negative view of future (Beck, Rush, Shaw, & Emery, 1979); human beings have four primary emotions—mad, glad, sad, and scared (Beck, Emery, & Greenberg, 1985); there are four ways to communicate—passive, aggressive, passive–aggressive, and assertive (Paterson, 2000); and so on. Oftentimes, these constructs are not touted as universally true but as useful heuristics that enhance a person's ability to deal with life's challenges in practical ways. Such practical or pragmatic truths are often inventions of the CBT therapist who has tested them on a group of people that "on average" reported improved functioning after using the ideas. This is often what is meant by the epithet "empirically supported treatment": A series of practices based on the therapist's

conceptualizations of the world were found to be useful for people with a particular diagnosis. Hence, in the series *Treatments That Work*, which presents cognitive–behavioral treatment programs for specific disorders, the client with attention-deficit hyperactivity disorder (ADHD) is shown how to use a calendar and a to-do-list, prioritize the importance of different tasks, break down tasks into manageable steps, develop a mail sorting and paper filing system, and use an alarm device as a reminder to get back on task (Safren, Perlman, Sprich, & Otto, 2005). When the client adopts these practices by molding her life to them, she will obtain the predictable results of an average person who was shown to improve her functioning after doing so. What works for "someone" or for an "average" person, as established by trials in another treatment setting, thus becomes the standard treatment and is no longer really up for debate. It bears to mention that what works for someone or "on average" is seldom the best solution for any particular individual but is also rarely the worst. More important, however, the knowledge or preestablished truths carried to the situation by the therapist silences the client's own discourse and leads to conformity to an averageness that becomes a universal standard.[3] One of the gravest threats to this kind of CBT is subsequently the client's own subjective desire to set the agenda and speak about other things than those that fit within the predefined treatment plan. Hence, as Safren et al. (2005) write at the beginning of their treatment protocol for ADHD, "One of the challenges in this treatment is to avoid getting distracted by discussions of other problems the client may be facing" (p. 12). Similarly, in Wright, Basco, and Thase's (2005) introduction to CBT, they warn against "potentially therapy-disrupting behaviors" that include "attempts [by the client] to overly control the pace or topics of conversation during the interview" (p. 50). Part of the CBT agenda is thus often to explicitly *educate* the client about the meaning of their distress.[4] As the cognitive therapist Gary Emery writes, "Inevitably, an anxious person has misconceptions about anxiety, and helping him to correct these is one of the first tasks of therapy" (Beck et al., 1985, p. 169). In Beck et al.'s book on a cognitive perspective on anxiety disorders, the therapist is thus often described as someone who knows the truth about the client's symptoms. In one case, for example, the therapist states to the client:

> Strong emotions like anxiety are not mysterious. They are simply signals from your brain that you need to correct the way you're viewing the world or responding to it. . . . What message is your anxiety trying to send you? There are two possibilities: you need to *act* differently, or you need to *think* differently. (p. 238)

The antidote to the psychoeducational and knowledge-based model is not simply a return to a client-centered or collaborative approach where the client is asked to define her own problems, which are then used to devise the client's own goals for therapy.

This is because the problem we as human being are faced with is often not consciously in view as a simple fact about our existence, but as we saw in the opening vignette, is often so intermingled with our subjective existence that we cannot even see it. Hence, therapy must often serve as a process of disentangling the real problem from the multiplicity of pseudodefinitions and readymade explanations that the client initially and consciously makes use of to explain his malaise.

The client may have an understanding of what is not going right in his life and may also have goals that he would like to achieve, but he often has little or no awareness of how his very conscious perceptions, subjective desires, and explicit demands themselves form part of the larger problem of his existence.

In another case I was supervising, there was something problematic about the client's readymade understandings of her distress. This client understood so much about the reasons for her motivations and understood it so quickly that it was hard for the therapist to interject a question. The client would complete the therapist's sentences before hearing him out and would speak readily about her concerns about relationships and whether or not to commit to one man or the other. Although her immediate concern indicated an interpersonal problem that could perhaps easily be solved by means of a guided exploration of pros and cons about commitment versus autonomy or one man versus another, such a jump to solving the problem would close both the therapist and the client off to the "mystery." The mystery, to which the client has no ready access and which the therapist knows only vaguely, is that this client is already distanced to herself and to her therapist, fearful of being exposed to the uncertainties of her own experience and fearful of not having an answer. The therapist's hunch that there is a distance in the therapeutic relationship is here not a new problem to be solved but a clue about the client's way of interacting in the world that demands further exploration. The therapist knows that the client was sexually assaulted in the past and thinks there may be a link between the client's fear of vulnerability with him and some traumatic wound to her ability to trust and let her guards down again. Her explanation of men as "players" is likely another way to introduce distance and safety into her relationships. If she sticks with her explanation that all men are "players," she does not have to take them seriously and does therefore not have to take herself or her relationships seriously. As the

therapy unfolds, the client will reveal additional cues to her therapist that will either overturn his current hypothesis or add nuances to it. The problem is in this way not consciously communicated or pointed out and made subject to a problem-solving strategy but is allowed to unfold gradually and to enlighten both therapist and client as both begin to become curious about what remains mysterious and not yet understood about it. The problem is, in other words, not established as a precondition of the therapy. On the contrary, its partial obscurity and its lack of solution is what sustain the therapy in the first place.

This is the same point that Donald Schön (1983) makes in his book *The Reflective Practitioner*, where he analyzes the particular kind of reasoning deployed by a number of professionals, including an architect and a psychoanalytic psychotherapist. In all the cases of reasoning in action that he provides, the common denominator is that the starting point of the practitioner is one of curiosity and unconfirmed hunches rather than certainty and categorical knowledge. "In neither example is the problem given . . ." he states, "The situation is complex and uncertain, and there is a problem in finding the problem" (p. 129). As the practitioner approaches this situation, he holds several hypotheses of general scenarios that could explain the phenomena he is engaged with, but rather than try to fit the situation into his theory, he looks for what is different or unique about this particular case and reasons why the case might not fit his theories. In this sense, he learns from his engagement with the situation, which provides him with continuous feedback he can use to revise or reframe his understanding. The goal is here not to finally grasp the client in some categorical way but to keep pursuing the questions that new material and new discoveries bring up.

In the case of the client who seemed to already understand everything about herself, we could perhaps easily use our current understanding of the problem to devise a treatment plan that would aim at particular ways of ameliorating the client's trust issues, improve her relationships with men, and help her confront past trauma, but such goals would settle on fixed understandings of who the person is and would short-circuit the process of testing out other possible understandings. The client would now become this particular individual with these specific problems, and this would effectively stop the client's journey inward. It is for this reason that Levenson (1988) can give the advice that "the real task in therapy is not so much making sense of the data as it is, but resisting the temptation to make sense of the data!" (p. 5).

Therapy according to a process-oriented approach is the willful suspension of an attempt to define the problem and thus to define the self up front. This effectively means that who the subject *will* be and what the problem *will* become are both subject to the therapeutic process. The process of solving the

problem is here no different from the progressive realization of what the problem really is, for as my understanding of my problem changes so does my understanding of myself, and as my understanding of myself changes, so do the solutions, strategies, and goals I wish to pursue. Understanding the problem and providing a solution to the problem are thus not two separate moments. In fact, good therapy often progresses as a series of changes or reconfigurations in one's understanding of the problem, so that who one is and the solutions one wishes to pursue change concomitantly. This view of change, which can be described as dialectical because it involves the progressive reintegration and reconfiguration of previous knowledge, seems more fitting as a description of therapeutic change than does the medical concept of recovery or symptom reduction, which implies a simple return to a previous unspoiled or healthy state that leaves the person unchanged and unscathed. It is perhaps for this reason that Bugenthal (1999) has referred to therapy as a kind of suicide, for the self is itself in question in the therapy, and not merely a passive bystander or unchanged ego. As one of my reviewers fittingly commented, "The fundamental existential challenge is to integrate antitheses. A worldview based on a principle of noncontradiction is not a living human reality."

Critique of Therapy as a Linear Process of Getting From Point A to B

The second problem I have with the rational/planning model of therapy is that it imposes a linear direction of time on the therapeutic process. This follows, of course, from the first assumption that the problem can be sized up and determined ahead of time and can therefore be used to envisage a plan for changes we need to make to solve that problem. Once the goal of therapy gets established, therapy can then be thought of as a step-by-step progression toward that goal.

The assumption is that human beings, like other things in the world, live toward a future that can be projected as a function of their past. The future is thought of as an end state of a series of actions or a "place" one is moving toward.

This spatialized view of time is quite different from an existential view of time in which who I am is not an identity that moves around *in* time but an identity that is structured through time. As an existing person, I insert myself into situations such as to make time exist. This is quite different from saying that I myself exist "in" time. In the former situation, it is I who brings the past and future to a situation in and through the way I interact and make sense of it. In the latter, I am just an inert object that exists in a chronological series of factual events that involve me as just another atom or entity.

Because existential time is the time of "humans" and unfolds through choices and discoveries of our potentials, it is a much more dynamic understanding of time than the chronological view of time. Existential time is not the linear progression from a past state of affairs to a future state of affairs but the continuing transformation of what is significant and relevant of the past from the point of view of the potentials through which I am living out my life. The future, which is alive and yet to be determined, is here actively and ongoingly shaping my conception of who I was. It is the future not as a projected actuality but as an uncertain potentiality from out of which I will learn something new and will receive my past self differently. It is the future of a genuine encounter or experience in which what *will be* cannot be predicted, much like I cannot predict exactly what will happen when I attend a party, when I throw myself into a love affair, or when I initiate a conversation. It is the future as a potential that must be discovered and unlocked and always has the power to reveal new desires in me, and new ways of being myself.

Therapy unleashes an unpredictable future. The person must be led to have an experience that cannot merely be integrated into a preexisting worldview and tamed accordingly but demands a change in the worldview itself, which is no longer adequate to the realization a person is having. Something must happen that is beyond the predictive purview of both therapist and client; something about which both therapist and client can only be in the dark and which they can therefore neither see as a possibility nor know in advance. This future can therefore never be envisaged as a goal ahead of time but must be cultivated through an attentiveness to the moment from which it must first arise and surprise us.

Both client and therapist were at times turned toward this moment in the clinical anecdote I started my article with. Here, both client and therapist remained slightly in the dark about the problem and therefore also without a clear-cut goal. And yet they remained attentive to something that was being cultivated as an experience between them. Neither therapist nor client was master of this experience and yet it contained a potential that had the power to transform their understanding of what was going on. A future that could not be predicted and envisioned in advance was growing from out of the encounter and could lead to an unexpected transformation of the past moments of the therapeutic interaction, thus reconfiguring and changing both the conscious understanding of the problem and the projected solution that would follow from it.

The therapist could not have brought a treatment manual with him into this session, for such rigid adherence to a plan and to a predefined outcome would block access to this other future. The client would then have been confined to

the linear trajectory of achieving a solution to a prematurely understood problem. Instead, by opening up a space where this other future could take shape, the client was able to have an encounter with something previously unimagined and unpredicted from out of which she could first receive her problem and begin to formulate a goal.

Therapy, according to this revised conception, would thus not be defined by a definite starting point and a projected end state but by attentiveness to the "middle"[5] (Deleuze & Parnet, 1987) or "transitional" space (Winnicott, 1953/2005) from out of which a new past and a new future must be allowed to grow. Therapy as process proceeds precisely as a series of such transformations from the middle through which the client achieves a new understanding of the problem and a new future to live toward. Clients will have to rediscover who they are and what they want multiple times before they can be said to have achieved the full potential of therapeutic change. The idea that one can simply define and project a definite goal for therapy in advance thus runs counter to the time of the therapeutic process. It serves to keep the process in control like an animal in a cage and keeps the client captive to a mechanistic view of time as a mere linear progression from one objective state to another.

As therapists, instead of projecting goals from some known actuality, we should thus instead direct ourselves toward the potentiality of the uncertain outcome and the unpredictability of the encounter. We should, to use the language of Gilles Deleuze (1969/1990), learn to become "worthy of the event," which means to become able to receive something new from out of what emerges in the moment. This, according to Deleuze, always means to direct oneself toward something that has not yet been revealed or has not yet become present, or to quote Maurice Blanchot, to release "the part of the event which its accomplishment cannot realize" (Blanchot quoted in Deleuze & Parnet, 1987, p. 73). As therapists this would mean having the flexibility to let go of a plan and to allow one's understanding of problems and goals to be redefined and revised in an ongoing way.

To let go of a plan sometimes produces anxiety in both client and therapist. For the therapist, it leads to a discrepancy between what he is actually doing and what he thinks he is expected to be doing according to the ideals of rational planning, which may have been imposed on him from without. For the client, it leads to the anxiety of letting go of quick definitions of her problem and the promise of a quick and clean solution that can circumvent the more arduous task of self-discovery and does not have to implicate her entire sense of self. As we saw in the clinical anecdote, clients sometimes *want* to become "objects" in the comforting belief that they can then undergo the therapeutic

experience through a form of anesthesia and have the therapist pluck their symptoms from them without any need for painful self-examination and personal responsibility.

Without definite goals and a clear-cut starting point, both therapist and client can only turn themselves toward the emergent experience of the encounter between them where something is always unfolding and meaning is always being generated. One can only remain open to this process if one directs oneself toward it through a certain "faith" and without any expectation of where it might lead.

It follows that to do therapy from the middle, rather than from a ready definition of the problem or definite idea of the solution, can be both intimidating and emancipating. It leads to a therapy without "guarantees" and therefore also possibly to therapeutic failure. In this way, therapy reveals something that we all know about life: that the moments that really matter are always both the most dangerous and the most rewarding. Take falling in love as a case in point.

This is quite different from the rational/planning model in which outcomes are relatively certain and fixed. According to this model, therapeutic failure is a result of not adhering to the manual or not implementing the right interventions and is to be prevented by becoming more rational and constructing a better treatment plan.

In view of the perils and benefits of unleashing the true potential of "the middle" in the therapeutic encounter, I thus suggest that the proper goal of therapy should be to cultivate the right amount of intensity of the therapeutic moment. The goal of the therapist should be to allow for just enough structure for the potentials of the encounter to not overwhelm or scare away the client and to allow for just enough potentiality for the therapy not to become stale and unproductive. Hence, in actual clinical practice, therapy must often unfold in a dialectic between process and structure: too much process and clients may terminate due to frustration or fear, and too much structure and nothing therapeutic will unfold. Too much or too little process will kill the therapy, making it either stale (too much structure) or too chaotic and unwieldy to be endured (too much process).

Critique of Therapist as Master of the Therapeutic Process

My third criticism of the rational/planning approach to therapy is its presupposition of the therapist as a master of the therapeutic process and as someone who rationally plans and conducts treatment as if he could simply

produce an outcome by selecting the right means. This is of course an appealing fantasy and quite the antidote to the feeling most therapists have that therapy proceeds in a slow unexpected fashion and often makes the therapist feel quite impotent at times.

When we let go of the need to control and direct the therapy and become free to simply attend to the process rather than certain goals, what we discover is that the nature of clinical decision making changes considerably. The therapist's knowledge now no longer resides in books about how to treat x, y, z disorder, and the reasons for his actions are no longer in his possession prior to the actual therapeutic encounter. Instead, clinical reasoning emerges from out of the moment and out of the context of the interaction. It exists first as a hunch or a vaguely formed intuition and requires of the therapist that he stretch beyond what he already knows. When the therapist finally arrives at his idea or his intervention, it appears as if it arrived at him from without and was granted to him by the grace of the situation.

Eugene Gendlin has talked about this otherness as the *implicit* or *felt* sense, which often exists at the limit of our conscious understanding as the "body" of the situation that affects us and colors our expectations even before we have explicit awareness of it. As he has consequently stated,

> Therapy does not consist mainly of familiar, already defined kinds of experience, whether dreams or emotion, actions or images. Therapy is rather a process that centrally involves experience before it becomes one of these defined "packages" and again afterward when it dips back into the zone at the edge of consciousness. (Gendlin, as quoted in Hendricks, 2001).

The essence of the felt sense, as with the kind intuitive thought process expressed above, is that it is something that arrives at us from outside of our conscious rational deliberations. It is not something that is already in our possession and which we control but something to which we ourselves are beholden and can only be responsive. This point is accentuated even further, when we realize that the felt sense of the therapeutic encounter is not merely the felt sense of two individuals but the felt sense of an interaction or a situation. If there is a "middle" in terms of the temporal nature of therapy, we can thus similarly speak about a "between" or a "thirdness" in the spatial dimension of the therapy. I attribute this insight to Heidegger, who in his major work, *The Origins of the Work of Art* (1936/1993b), writes in a way that is analogous to the situation between therapist and client:

> The artist is the origin of the work and the work is the origin of the artist. Nevertheless, neither is the sole support of the other. In themselves and in their interrelations artist and work *are* each of them by virtue of a third thing which is prior to both. (p. 143)

The philosopher of "the middle," Gilles Deleuze, would agree with this statement, for as he writes in his book with Claire Parnet, "Something happens between people which is not in one or the other. We do not work together, we work between the two" (Deleuze & Parnet, 1987, p. 17).

Subsequently, the good therapeutic intervention is not something that is "done" to the client from some place of universal knowledge or by the therapist as one individual to the client as another. In the therapeutic moment, the therapist does not deploy a technique, does not *cause.* Instead, the therapist reacts or responds. If the response is "right" it is right due to "good fit," not due to achieving a predictable and precalculated effect.

A good intervention according to this model of therapy is dependent on timing and context. In this way it deviates from an approach that would have the therapist choose his interventions on the basis of a universal manual. A right intervention is not universally right but "fits" the context of the situation, such that the result is one of increased harmony, attunement, or intensity. The right intervention is *aesthetic.* It beautifies the interaction or enhances the moment. It adds a stroke or an accent. It makes a connection. It brings elements together so that something can be "seen" or "experienced" that was previously hidden from view. It reveals the truth, not as an accurate representation of a state of affairs but in the sense captured by the poet John Keats (1820/1919) when in one of his famous odes he says that "Beauty is truth and truth beauty" (*Ode on a Grecian Urn*). In the *Origin of the Work of Art*, Heidegger (1936/1993b) refers to this kind of truth as *aletheia*, which is a showing forth of something that was already there but has become lost or hidden. Aletheia is a way of seeing or catching a glimpse of something real or decidedly true about life or about oneself, and it is more often a feeling or an experience than an interpretation or an explanation. In being a revelation of what is, it needs nothing further. It has no need to be justified in terms of how it can be used or how it can be helpful. It is not insight as a means toward some other end but pure revelation, just as when one learns something about what it means to be human in and through the experience of falling in love, or when one comes to fully appreciate what one's experience of being abused has taught one about the reality of pain, betrayal, and loss that forms part of the human experience.

In my work with a sexual abuse victim such a moment of truth arrived from out of a context of the client speaking of his general shyness and social anxiety. “I don’t speak much,” he proclaimed. Given my intuition that abuse victims sometimes feel they have to keep secrets out of shame or fear, the fitting intervention here was for me to ask, “You don’t speak much? or you keep quiet?” thus linking two separate discourses with a simple well-timed reversal of meaning. At this point, to my surprise, my client started coughing and almost gasping for air. Uncertain about what was going on, I offered to fetch him water, but I soon realized that his visceral bodily reaction was a response to my intervention. Only because my intervention did not happen in a vacuum, but was inserted into a relational space that had been built up and allowed to unfold over several sessions, could the words I spoke attain their magical power. Had I been too early or too late, the response might have been entirely different: the right interpretation at the wrong time is the wrong interpretation, as one of my colleagues would rightly have said.

Another example of a contextual intervention that could not have been planned out in advance took place in my work with a 14-year-old female whom I met at a residential treatment program for behaviorally challenged adolescents. When I was first assigned this client I was struck by the very violent portrayal of the client in her chart. The portrayal of the client’s life resembled that of a child version of Bonnie and Clyde. The client had run away from home, had been co-opted into a prostitution ring, and had been charged with extorting money from a customer. She and her pimp had driven the customer to an ATM machine and had asked him to withdraw his money at gun point.

When I first saw this client, her outward presentation was quite different, however. She smiled and spoke in an almost timid voice. She wanted to dress up like a baby for Halloween, the “scariest” of holidays, and liked to make drawings of peace signs, butterflies, and hearts.

At other times, however, I would catch glimpses of subdued aggression. I noticed that she took pleasure in squashing bugs at the bench where we used to meet for weekly psychotherapy, and she told me of dreams she was having of a violent hurricane striking the treatment center and all the other clients dying due to their inability to escape the calamity. In group therapy sessions, she was the first to join in when someone was being criticized, and I remember thinking on several occasions that she did not seem to display the kind of empathic understanding that would cause others to pause, limit their criticism, or curtail themselves out of consideration for the other’s welfare.

This dynamic of warding off aggression by clinging to an image of herself quite opposite came to perfect expression one day when the client brought me

another one of her drawings. At first the drawing looked innocuous. It had butterflies, hearts, peace signs, fluffy clouds, and every such image that I had come to expect from her. In the middle of the drawing, however, in big block letters, she had written the word "HARMONY." As we were speaking, the client appeared particularly attentive to this word and took great care to color in its letters. At this moment it struck me that the word harmony contained everything that had been going through my mind regarding this client's contradictory presentation. It contained the word "harm" and this word was concealed underneath its opposite, the word "harmony." The client, in other words, was covering up aggression with peacefulness and sweetness and everything that had been played out in therapy was now being perfectly expressed in the moment. This was the right time for me to intervene. By being receptive to what was handed to me in the moment, I was able to make an observation that seemed "right" in the context of what was going on. I uttered the phrase "harmony," but with a pause following the word "harm" so the client could hear it. In this case, the client looked perplexed, smiled uncomfortably, then warded it off as insignificant, but I insisted on drawing her back to the paradox contained in the phrase and made my observation, this time, in the form of an interpretation.

The intervention deployed in this situation was not correlated with a specific outcome, which it was intended to achieve. It was not right because it had been empirically proven to bring about a predictable effect that had been deemed desirable ahead of the actual therapy; it was right because it enhanced the moment; because it fit; because like a missing piece of a puzzle, it turned something discrepant into something that made sense and brought "harmony" to something previously unharmonious. It was fitting because it beautified the interaction just like adding a guitar string makes a piece of music work that previously seemed flat and uninspiring.

I like to think of the intervention as producing *resonance*. It drew together discrete and seemingly unrelated moments into a higher order of meaning that allowed something that was previously concealed and out of view to become a further catalyst of new thoughts and new subjective reactions. Deleuze has a good description of what resonance entails: "You should not try," he says, "to find whether an idea is just or correct. You should look for a completely different idea, elsewhere, in another area, so that something passes between the two which is neither in one nor the other" (Deleuze & Parnet, 1987, p. 10). In the example above, "harmony" became this idea. It allowed something to resonate between the peaceful and aggressive aspects of the client's demeanor. These two aspects now became related in and through a "third" term.

The intervention described could not have been preplanned, for it took its cue from something that transpired outside of what could have been anticipated in advance. Also, it could not be transplanted from one client to the next and marketed as a standardized intervention, since it was fitting only in this particular situation, with this particular client, at this particular time. Finally, the justification for the intervention was not tied to the planned intention to produce a particular result. It was interjected into the process without any possibility of knowing where it might lead the therapy and how the client might respond.

So how do we evaluate the effectiveness of the intervention? In a rational/planning model of therapy, the justification for an intervention is that it helps the client reach a predefined goal. An intervention is rational only if it helps decrease depression in a depressed person, increase social interaction in a socially phobic person, and so forth. And yet when both the premise of a predefined problem and a predefined goal is suspended, we can no longer judge the merit of an intervention according to prespecified criteria tied to the problem and the goal. Instead, we must judge it on the basis of what it does to the "middle" of the therapy from which new insights always grow. *Does it allow a new future to emerge? Does it lead to a changed sense of past? Does it lead to the revelation of new details and further the approach to the mystery from out of which the client must receive herself?*

A therapeutic moment has quality and intensity when the client cannot ignore what has been stated and cannot ignore what has been felt. In other words, an intervention directed at the therapeutic moment is effective when it gives clients an encounter with themselves through the self-evidence and irrefutability of an experience. In such a moment the client receives herself. Something she said, something she felt, a reaction she had, is now an irrefutable fact about her existence, something that calls for or compels a response by the client with her entire being, or in such a way that something about the client's entire existence is understood in a new way.

The result of therapy is not a mechanical effect to be measured as a change in behavior but an immediate impact on the quality of an encounter as determined by its experiential value and significance.

Therapists know intuitively when they have had a good session with a client. A really good therapeutic moment is almost transcendent. The client says something, the clinician realizes something, a comment or observation rolls off the clinician's tongue without any need for deliberation, the feeling is right, the timing is right, something makes sense, the client has a clear reaction, a silence and intensity pervades the room. Both therapist and client receive something from this moment and are in awe of what has just transpired. Like

a good movie that leaves one shaken or astounded as one leaves the theatre, there is no need for words: talking about it too soon would cheapen it and trivialize it. The moment speaks for itself. Silence, laughter, or tears might be the only rational response since one is moved beyond the structures and categories of what one already knows or understands. As one leaves the therapy room, an effect or a mood lingers, excites and perplexes, or perhaps even fills one with anxiety of the unknown. One thing is for sure, life can never be exactly the same; something about the past is different now, and one's future possibilities have therefore changed.

There is no telling what will come out of such a therapeutic experience. It is not correlated with a numerical change on specific behavior variables; in fact, it may increase anxiety rather than decrease it and may unsettle or shake a person rather than shore a person up. And yet it needs no extrinsic justification, for just like a good movie, a painting, a delightful evening on the town, a good song on the radio, or a fulfilling personal encounter, such a therapeutic moment is complete in itself.

It is by means of a series of such intrinsically meaningful experiences and transformations of the past from the unanticipated future that clients come to rediscover both who they are and what they want. Hence, good therapy should not seek to control or direct behaviors by attempting to steer the client toward prespecified outcomes but should seek to facilitate a qualitative shift in the client's experience of self by unleashing the unrealized potentials or truth effects of the moment.

Conclusion: An Ethical Choice

We are now at the final stage of our journey where we can summarize the rational/planning approach to therapy and the process-oriented approach that has been offered as its alternative.

In the first approach, the therapist directs himself at a predetermined goal and treats the client as an object to be intervened on so as to achieve the predetermined goal. In the second approach, the goal is subordinated to the process, and it is assumed that attentiveness to the process will lead to a new understanding of both the problem and the goal.

The first model is rational and linear, with the therapist having been endowed with the power of foresight and having been cast in the image of the managerial mastermind or the scientific engineer. The second model takes these powers away and replaces them with a power inherent to the interpersonal process itself from which both client and therapist must continue to retrieve themselves and discover their potentials. In this latter model, therapy

cannot be "planned" but must be cultivated through an attitude of curiosity and a receptivity to the unfolding moment from where understandings must first be wrested. Although the former model sounds appealing to the mind, it is the latter that rings true to more seasoned practitioners trained in a process-oriented approach to therapy.

Louis S. Berger (1991) beautifully summarizes many key tenets of this "other" kind of therapy in his rendition of the nature of the psychoanalytic process. What he describes in the following perfectly fits with what I have thus far been referring to as a process-oriented approach to therapy:

> Let me review the kinds of clinical phenomena valued and seen in therapy by the analytically oriented clinician. When such therapy works well, then over time, little by little, though sometimes in quantum leaps, one sees regularities, thematic unfoldings, the coming into focus of meanings. In these therapies, there is an alive waxing and waning of symptoms, flight, and courage; central themes, previously hidden, unfold in their idiosyncratic ways. . . . Therapist and patient are led by the emerging material, which brings its own surprises and emotions; each therapy dictates its own form, sequence, needed process; the patient opens commerce with his or her own depths; alienation and dissociation are replaced, little by little, by aliveness, pain, pleasure. . . . After an initial period of settling in, both participants begin to sense continual subterranean shifts and movement that irradiate and ameliorate old problem areas but also unexpectedly have a beneficial impact on the patient in areas that previously seemed remote from or irrelevant to the initially identified therapeutic issues; new and unexpected goals and ambitions unfold, as do new, unanticipated difficulties; and little by little, the patient's environment (work, relationships, play) which originally had primarily been a problem-laden externalization of unconscious needs, changes and improves quietly but drastically. That description, I suggest, is a rough sketch of what happens to a good-enough patient in a good enough therapy with a good enough therapist. (p. 145)

In this description, Berger points out that therapy often unfolds in surprising ways with problems frequently being overturned and new goals frequently emerging to take their place. His description is peppered with terms such as *surprise, the unexpected, the unanticipated, the emergent*, and *the new*. Things that previously seemed significant fall into oblivion and things that previously seemed irrelevant take on importance. This is therapy as I know it and as I would want it to be.

And yet the choice between a rational/planning approach to therapy and a process-oriented approach is not merely aesthetic, nor can it be settled by a simple demand for a factual comparison of their effectiveness. Instead, as I alluded to in the beginning of this essay, the choice is an ethical one.

In the first approach, the therapist often becomes a moralist who makes judgments about what is good and bad, whereas in the second approach, judgment is suspended and the attribution of good and bad itself turned into a question to be decided through the therapy.

In the first approach, we are producing predefined outcomes in accordance with one or the other set of values; in the second approach, we allow values to be discovered out of an initial indeterminacy. In this latter approach, we are not trying to fit the client into a model of the good life, as defined by culture, theory, science, or public opinion, but to help the client discover who they are and what they want outside of and sometimes in contradistinction to such standards.

Hence, good process-oriented therapy is a threat to the rational/planning approach to therapy because it undermines the very pillars of such an approach: We no longer define the problem from some authoritative stance, we no longer know in advance where therapy is headed, and we no longer control how to get from one point to another. Hence, process-oriented therapy has a revolutionary potential that does not fit with a managerial society that is more interested in making people conform to social norms than in helping them discover the nature of their underlying desires. A process-oriented approach allows us to confront our values at the level of what Friedrich Nietzsche (1887/1967) and Max Scheler (1915/1961) have both referred to as the *revaluation* or *transvaluation of values*. A rational/planning approach leaves the question of value up to either the naïve opinion of the consumer who is assumed to know what she wants, or to collective values of a psychological or medical profession that imposes definitions onto the client from a supposed place of higher knowledge.

The problem with deferring the definition of the problem to the client is that we cannot assume that the client really knows what she wants. The idea that the person can simply reach inward to achieve accurate knowledge of their own desires, ignores the possibility that the client's sense of self could itself be an internalization of cultural ideals and definitions. Hence, research shows that Black children often internalize poor self-esteem due to experiencing themselves through the values of a White majority, and history is rife with other examples of people choosing their own oppression due to an internalization of alienated desires. Even if we do not choose to view ourselves through negative stereotypes, we might still find ourselves pursuing goals

that are not truly our own. Many of us, for example, keep living lives to achieve affection from our parents or admiration from others. Karen Horney (1945/1992), for example, has described how our culture is rife with people who seek to make up for empathic breaches in their childhood by a compulsive pursuit of perfection intended to make up for them. We can add many other esteemed authors to the list of people criticizing the belief in transparent self-awareness, including Friedrich Hegel, Karl Marx, Sigmund Freud, the Frankfurt School, Martin Heidegger, and Jacques Lacan. The collaborative stance of the cognitive behavior therapist, based as it is on a belief of language as a transparent medium of communication and subjective expression, thus often unwittingly leads to an uncritical reification of what passes for rationality within the prevalent cultural common sense.

If we leave decision making about a client's problem to the therapist, on the other hand, we run the risk of a different kind of alienation. Hence, there is very little evidence that what we have reified into "mental disorders" are really comparable to physiological diseases, and yet this assumption is often taken for granted in a medical approach to therapy. Oftentimes each such definition of a client's problem ends up foreclosing certain possibilities of discovery because the supposed knowledge from which therapy begins can never itself be overturned and questioned. A case in point was physician Samuel A. Cartwright's identification in 1851 of *Drapetomania*: A behavior disorder in African American slaves with an incorrigible desire to run away from their owners. A more recent example of the blurring of science and social norms was evident in the removal of homosexuality, and later ego-dystonic homosexuality, from the *Diagnostic and Statistical Manual* in 1974 and 1986, respectively. These examples are of course of the more dramatic kind, but other more subtle ones can easily be invoked. Karl Jaspers (1913/1997) refuted the illness model of psychological distress in his *General Psychopathology* book published in 1913. Since then the Kraepelian diagnostic system of the *DSM* has been criticized as making all or nothing classifications instead of viewing distress as a continuum. In Bentall's (2004) book *Madness Explained*, for example, he makes the argument that the differentiation between schizophrenia and bipolar disorder is arbitrary and tenuous since the boundaries between the two tend to blur. Currently several divisions of the American Psychological Association have criticized proposed revisions to the *DSM IV* for lowering thresholds for diagnosis of several "disorders" and continuing its quest to pathologize normal deviations within the human spectrum of experiences.

From a process-oriented perspective both these pitfalls are avoided because the starting point is not some predefined knowledge but an attentiveness to what is precisely *not known*. What will be true and what will be desirable is

here itself at stake in the therapy. It will emerge from the "middle" rather than from a starting point in the therapist's or the client's opinions. Both therapist and client will here be taught a lesson by the unfolding process that bursts the confines of any treatment plan.

As Berger (1991) writes,

> The process tends to be unpredictable except in terms of broad generalities and seems to almost have a will and direction of its own. The therapist and patient are almost like witnesses or bystanders. There is a compelling succession of themes, issues, and phases that, if properly facilitated, have an almost tangible thrust of their own. The unfolding is full of surprises, and in its particulars varies enormously from patient to patient. (p. 174)

It can of course not be assumed that a commitment to the ideal of being taught by the process will itself serve as a guarantee that the therapist will not bring her own agenda or collude with the client to accept as truth what asserts itself as common sense. More likely than not, therapy according to a process-oriented model will proceed through a series of repeated betrayals of the process. Hence, as we saw in the opening vignette, it is easy to be led astray despite initial good intentions, and there is always a need to bring oneself back to a receptivity and attunement to the moment. And yet, when all is said and done, there is an allowance in process-oriented therapy for an agency that transcends that of both therapist and client, which makes its own demand to be heard, and which if heeded guides both therapist and client toward a truth of its own. This fact is what prevents both therapist and client from imposing their own views on reality, for to use a phrase of Donald Schön (1983), "The situation talks back" (p. 135). To remain open and receptive to the process is thus to remain open to having one's views changed. The truth that here emerges is not that of an accurate representation of the facts but that of truth as revelation or truth as beauty. Both therapist and client are beholden to this truth. They do not engineer it, but must cultivate it and be able to recognize it in order to receive it. You cannot plan your way to it and it cannot be wrested from the situation before the moment is rife. This is therapy on therapy's terms and it happens always outside or in spite of the confines of rational planning. Such at least has been the thesis of this article.

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Notes

1. In Martin Heidegger's essay *Vom Wesen der Wahrheit* (1930), which has been translated into English as *On the Essence of Truth* (1993a), he describes a tendency for human beings to move toward a comprehension of themselves as "things." This movement away from the nature of oneself, toward the world of things, involves a turning away from an understanding of our true existential nature, which remains a "mystery" to us. Using Freudian terminology, we could view this comfort in our self-identification with objects (such as specific personal qualities, tastes, styles, and flaws) as a primary defense mechanism intended for us to avoid a confrontation with our underlying uncertainty about who we are, what we are, and why we are. "Man's flight from the mystery toward what is readily available, onward from one current thing to the next, passing the mystery by—this is *erring*" (p. 133). The translator makes a note that erring is derived from the Latin *errare*, which means "to wander from the right way" (p. 133).
2. It should be stated that CBT is not always used in as rote of a manner as I have described it here. There have been many recent adaptations of CBT, such as Dialectical Behavior Therapy and Mindfulness-Based CBT, which emphasize receptivity and the need for balancing problem solving with validation of the client's subjective experience. The need for rational planning and specific results, however, often leads to an application of these theories in practice that is consistent with the principles portrayed in this essay. Mindfulness, for example, becomes another technique to add to the treatment plan, and validation of the client's subjective experience becomes an initial intervention designed to facilitate an outcome that the therapist has already determined in advance. In each case, the client's subjective input and experience is restricted by a prior therapeutic agenda and can only be validated insofar as it does not challenge the knowledge-based assumptions of this agenda. Hence, there is no real dialectic of change that proceeds from the client as a subjective being, only change within the parameters

of a preexisting agenda that prejudges the client's subjective experience. Socratic questioning is a case in point: Here the therapist is seemingly interested in eliciting a subjective opinion or perception by the client but only to prove a point that the therapist has already arrived at.

3. Heidegger has criticized this tendency toward averageness as a form of alienation. In *Being and Time* (1927/1996), he describes the human tendency to live life like "everyone" and "no one" (Das Man) instead of as my unique self. In this mode of living,

   We enjoy ourselves and have fun the way *they* enjoy themselves. We read, see, and judge literature and art the way *they* see and judge. But we also withdraw from the "great mass" the way *they* withdraw, find "shocking" what *they* find shocking. The they, which is nothing definite and which all are, though not as a sum, prescribes the kind of being of [average] everydayness. (p. 119)

4. "One of the therapist's functions is to educate" (Beck et al., 1985, p. 186).
5. French philosopher Gilles Deleuze can be said to have developed a philosophy and worldview that privileges "the middle." Deleuze's starting point is always that of change instead of stasis. As a result he can make the statement, as he does in his coauthored book with Claire Parnet, that "there are only intermezzos, intermezzi, as sources of creation . . . we are always in the middle of a path, in the middle of something" (Deleuze & Parnet, 1987, p. 28).

References

Beck, A. T., Emery, G., & Greenberg, R. (1985). *Anxiety disorders and phobias. A cognitive perspective*. Cambridge, MA: Basic Books.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford Press.

Bentall, R. P. (2004). *Madness explained. Psychosis and human nature*. New York, NY: Penguin.

Berger, L. S. (1991). *Substance abuse as symptom*. Hillsdale, NJ: Analytic Press.

Bugenthal, J. E. T. (1999). *Psychotherapy isn't what you think*. Phoenix, AZ: Zeig, Tucker, & Theisen.

Cartwright, S. A. (1851). Report on the diseases and peculiarities of the negro race. *DeBow's Review*, *Vol.XI*.

Deleuze, G. (1990). *The logic of sense* (C. V. Boundas,Trans.). London, England: Athlone. (Original work published 1969)

Deleuze, G., & Parnet, C. (1987). *Dialogues*. New York, NY: Athlone Press.

Heidegger, M. (1993a). On the essence of truth. In D. F. Krell (Ed.), *Martin Heidegger. Basic writings* (pp. 115-138). San Francisco, CA: HarperCollins. (Original work published 1930)

Heidegger, M. (1993b). The origins of the work of art. In D. F. Krell (Ed.), *Martin Heidegger. Basic writings* (pp. 143-212). San Francisco, CA: HarperCollins. (Original work written 1936, published 1956)

Hendricks, M. N. (2001). *Focusing-oriented/experiential psychotherapy*. Retrieved from http://www.focusing.org/research_basis.html

Horney, K. (1992). *Our inner conflicts. A constructive theory of neurosis*. New York, NY: W. W. Norton. (Original work published 1945)

Jaspers, K. (1997). *General psychopathology* (J. Hoening & M. W. Hamilton, Trans.). Baltimore, MD: John Hopkins. (Original work published 1913)

Keats, J. (1919). Ode on a Grecian urn (A. Quiller-Couch, Ed.). *The Oxford book of English verse*. 1250-1900. (Original work published 1820). Retrieved from http://www.bartleby.com/101/625.html

Levenson, E. A. (1988). The pursuit of the particular. *Contemporary Psychoanalysis*, *24*, 1-16.

Nietszche, F. (1967). *On the genealogy of morals* (W. Kaufmann & R. J. Hollingdale, Trans.). New York, NY: Random House. (Original work published 1887)

Paterson, R. J. (2000). *The assertiveness workbook*. Oakland, CA: New Harbinger.

Safren, S. A., Perlman, C. A., Sprich, S., & Otto, M. W. (2005). *Mastering your adult ADHD. A cognitive-behavioral treatment program (Therapist guide)*. New York, NY: Oxford University Press.

Scheler, M. (1961). *Ressentiment* (W. W. Holdhein, Trans.). Glencoe, IL: Free Press. (Original work published 1915)

Schön, D. (1983). *The reflective practitioner. How professionals think in action*. New York, NY: Basic Books.

Wachtel, P. L. (2010). Beyond "ESTs." Problematic assumptions in the pursuit of evidence-based practice. *Psychoanalytic Psychology*, *27*, 251-272.

Winnicott, D. W. (2005). Transitional objects and transitional phenomena. In D. W. Winnicott (Ed.), *Playing and reality* (pp. 1-24). London, England: Routledge. (Original work published 1953)

Wright, J. H., Basco, M. R., & Thase, M. E. (2005). *Learning cognitive-behavior therapy. An illustrated guide*. Washington, DC: American Psychiatric Publishing.

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