Psychotherapy Guidebook

Phenomeno-Structural Psychotherapy

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Table of Contents

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DEFINITION

Phenomeno-Structural Psychotherapy is based on phenomenology and on structural psychology. It is a method used to treat neuroses and psychosomatic diseases. It is a face-to-face and a uniquely verbal psychotherapy. During the sessions (one or two per week, each lasting one or one and one-half hours), the patient expresses as spontaneously as possible and as authentically as possible his personal way of experiencing various life situations — what he feels, and how he reacts to them. He is free to choose his starting point, his way of expression, and direction. Verbal interventions of the therapist are comprehensive and nondirective. From the patient's speech and from his nonverbal observed attitudes or behavior, the therapist — without suggestion or interpretation, explication, advice giving or investigating causes, or making any diagnosis, but persevering in the intention to clarify themes — interprets the constants of the imminent organization of the patient's unique universe and of its structures of meaning.

The method is phenomenological because it is centered on the life of the patient. It excludes intellectual constructs and all etiological research — thus,

there is no reference to nosology (disease classification), to clinical a priori tables, or to any explicative metapsychology such as psychoanalysis.

The method is based on structural psychology in the sense that it supposes coherent organization between the meaningful structures that are nonconscious for the patient but which are working on his perceptions.

The coming back to health is conceived — in the Phenomeno-Structural Psychotherapy — as liberation of the Ego (or Ipse) with respect to pathological thematization, which inhibits or restricts the Ego's dynamism and potentialities.

Opposed to the Freudian classical psychoanalytic theory of the Ego, the phenomenological anthropology (Anschauung) considers the Ego and the personal consciousness as dotted with its own creative energy, capable of love and project, ontologically included into interhuman relationships and temporality.

HISTORY

Phenomeno-Structural Psychotherapy is linked with the ideas of Eugene Minkowski (inspired by Bergson's anti-intellectualism) on one side and with Ludwig Binswanger on the other side (inspired by the phenomenology of Hiedegger), creator of Daseins-Analyse. The Phenomeno-Structural

Psychotherapy is, because of this, a variation of existential analysis.

The name “phenomeno-structural” was proposed by Minkowski and the method is part of existential analysis practice of Binswanger (Switzerland), Roland Kuhn (Switzerland), Medard Boss (Switzerland), Rollo May (U.S.A.), Henri Ellensberger (Canada), Cargnello (Italy), and others.

Let’s talk of the historical influence from the nondirective psychotherapy of Carl Rogers, of which the principle is also the comprehension of the patient’s lived universe without reference either to nosology, or anamnesis (a remembering), or to any explicative a priori concepts. However, Dr. Rogers mistakes the conception of the pathological universe as meaningful-for-the-subject, a universe dotted with internal logic, with structural imminent organization.

Historically, structuralism comes from 1) linguistic conceptions (de Saussure), which considered the language as system, and 2) anthropological conceptions (Levi-Strauss), which considers all social organization as unconscious structure giving a meaning to observable expressions at the level of social behavior and values. Structuralism is applicable to psychopathology in so far as the entire mental illness universe may be considered a system.

The unconscious, in this method, is not at all the Freudian set of dynamic impulses pressing on an Ego, reduced to an awakeness oriented

toward the external reality. For us, the unconscious is always present in the subject's life, and it is the whole of the structures giving their meaning to perception-objects and to behavior. It is a set of patterns (Gestalten) without its own contents but structuring all informational or reactional content, in the way of an unvarying assimilator.

TECHNIQUE

The first preparatory session is concerned with the organization of the psychotherapy and informing the patient about the method. The rules of the patient's behavior are then clearly formulated: he must tell his feelings and discuss his life in everyday situations as well as in the therapeutic situation itself. Generally speaking, he must make the therapist understand what he feels; direct acting is prohibited (the patient must verbalize his impulses without acting out). He begins with what he wishes and goes on to spontaneous expression; if uneasy, he has the right to stop, but he must describe the uneasiness. The interventions of the therapist are also an object of information during the preparatory sitting: the therapist says that he will not be the first to break the silence, that he endeavors to try to understand what will be said, and says that he will be available even between sessions in case the patient feels anxiety or confusion. The therapist answers all the patient's questions (during the preparatory sitting) without forgetting to formulate the attitude implicated in the question itself in a climate of security

and confidence.

Security and confidence are two fundamental values to be protected throughout the therapy. Confidentiality is affirmed. Reminding the patient of those agreements will be useful later if the patient forgets them.

The sittings are face-to-face in a simple and friendly room, not too large or too small. The therapist's and patient's armchairs are identical and at a distance of one or one and one-half meters, set in a way so that they form an angle broad enough to permit the avoidance of direct face-to-face contact in order to reduce the possible uneasiness of unavoidable staring.

The initiative is always with the patient. The therapist's interventions are mostly like Rogerian reformulations, but as soon as the therapist (owing to content-analysis of the client's speech and observation of meaningful attitudes and postures) has enough existential context, he tries to single out themes, constants, and meaning-giving substructures. These later become more and more linked between themselves, toward the nonconscious fundamental structures.

The language of the patient is very important. The point is to understand his words with their personal connotations. The "semantical interrogation" (e.g., What do you mean
by...?, What does that mean for you...?, What do you want to say . . .?) are used

even for apparently simple words. It is necessary in the reformulations to use again the subject's words with their explicit meaning.

As in Rogerian psychotherapy, the patient's agreement is required for any reformulation, because that is the guarantee that the therapist has remained "inside the universe of meanings" of the patient and has avoided "interpretation." The patient feels strong emotional states, similar to abreactions (reliving a past event), when central structures are discovered and formulated (conceptualized).

As with semantic psychotherapy, the insight of a previously nonconscious subjective meaning's structure is the cause of what I call "new DEFINITION of concept" (redefinition du concept) by the reflexive consciousness and the auto-critic Ego. That phenomenon is very much like the "reality confrontation" used by all psychotherapy. Feelings called "transferential" are analyzed as soon as they appear and cannot be used as a principal medium for the therapy. In other words, the experience of a true and satisfactory interhuman relationship (the interpersonal relation born from the dialogue of the conscious thoughts) becomes paradigmatic, and interferes powerfully in the process of Ego's liberation.

APPLICATIONS

The typical indications are neuroses, psychoneuroses, and

psychosomatic diseases. This psychotherapy is not applicable to psychoses without help of neuroleptic drugs capable of reestablishing communication. Phenomeno-Structural Psychotherapy is not indicated for diseases associated with mental debility or loss of mental capacity (mental deterioration, cerebral damage or dysfunction, aging). It is not applicable in cases where the patient has constructed a life pattern satisfactory for him, even though pathological. These clients do not feel the need for help — for example, homosexuality, which is well organized and accepted, or the structured sociopathies of recidivist criminals. It is applicable to adolescents and children more than ten years old.