How is distress understood in existential philosophies and can phenomenological therapeutic practices be “evidence-based”?

Simon Wharne
The Open University; Middlesex University

Abstract
The “evidence-based practice” movement frames counselling and psychotherapy as causal processes, something the therapist does to the client. The value of what it is that is done is measured by interpreting mental and emotional distress as an abnormal behaviour, by giving this “symptom” a numerical score, before and after interventions in a quantitative research approach. In existential therapies emotions are viewed instead as healthy responses to our being in the world; as transient communications in relational contexts, altered only through the client’s autonomous choice. Human distress will be encountered and explored by all practitioners regardless of their modality. This article is an attempt to reclaim that exploration, as a phenomenological enquiry founded in the radically different epistemological framework of existential theory. Less value might then be placed on systemized measurement and control, and more placed on human responses to emotionality. Those who are distressed might feel understood and validated.

Keywords
distress, evidence-based, existential counselling, paranoia, phenomenology

It is claimed that if governments invest in mental health services, improving access to psychological therapies, more people will be able to sustain themselves in paid employment (Layard, 2005). Psychotherapy and counselling practice are evaluated in relation to this ambition in the established theoretical framework of “evidence-based practice” (Dalal, 2018). The methodologies of quantitative research are applied, and the effectiveness of different interventions is evaluated and compared, so that clear guidance and...
recommendations can be established (Kisch & Kroll, 1980). However, there is a range of existential therapies that embody a phenomenological epistemology. This is a different theoretical framework, which does not fit well with dominant understandings of what “evidence-based” means; or what it is that successful interventions bring about (Staines, 2008). This article explores the possibility that psychological therapies can be valued in an alternative epistemology, a reflexive process that attends more to the nature of human existence.

Existential therapies are aligned with phenomenological research approaches, which are thought of as qualitative, rather than quantitative. Phenomenological research asks: what is it like, as a human, to be in the world and to have experiences? Perhaps, if those people who hold authority in our societies only want to drive people back into paid employment, they do not need to concern themselves with how people experience that interpersonal pressure. However, if they are concerned about the nature and quality of human existence, they might wonder what it is like to be subject to the processes of evidence-based practice? They might ask what kind of impact does this framework have, as an ideology, on our culture and shared experiences? This article offers a critique of evidence-based practice, but also argues for an alternative epistemological framework within which to value the work of psychotherapists and counsellors.

The practices of psychotherapy and counselling have evolved in a rich encounter with human existence. In that encounter, a hope is commonly embraced that personal meaning can be found in facing challenging life difficulties, that this will open the possibility of change, leading to healthy adaptation and resilience (van Deurzen, 2012). However, in some healthcare policies it is assumed that personal meaning-making can be set aside; it is only improved functioning that matters (Collins, 2019; Marzillier & Hall, 2009; Staines, 2008; Watts, 2016). In this kind of practice, counselling and psychotherapy would not attend to the social or practical contexts in which people struggle. It is “symptom reduction” that is targeted. As an outcome, for example, symptom reduction is central to the current design of UK mental health primary care services (Dalal, 2018). Unfortunately, while practitioners try to deliver that outcome, the task of helping each client adjust and respond to their specific life difficulties might be set aside (Collins, 2019; Staines, 2008).

In UK primary care mental health services, clients complete self-monitoring outcome scales at each session. The numerical score that they give is believed to represent the degree to which they suffered from a symptom of mental illness over the previous week. Practitioners record these scores in an electronic monitoring system. Service providers are then evaluated and recommissioned based on their success in reducing the severity of symptoms and making people capable and employable (The British Psychological Society & The Royal College of Psychiatrists, 2011). Where mental healthcare policies are designed to reduce symptoms, they are consistent with the established theoretical frameworks of clinical psychology and psychiatric practice. Mental distress is understood as something that is only experienced by a limited number of people. It is believed to be expressed through identifiable symptoms, which will indicate that a specific diagnosis should be given. Within this reasoning, distress can only be addressed by experts who administer the appropriate evidence-based treatments; treatments that are found to
be effective in helping people with a given diagnosis. These treatments are designed to “fix” or “cure” the individual, so that they can take up a more functional role in society (Kisch & Kroll, 1980; Pilgrim & Treacher, 1992).

This article is an attempt to set out the philosophical framework of existential therapies as an alternative means of understanding and valuing psychotherapy and counseling. This attempt is made to provide a perspective from which the evidence-based practice movement can be viewed as just one possible way of doing things. The way that “it does those things” can then be seen more clearly. We can consider the move that is made, for example, when mental and emotional distress are interpreted as symptoms or abnormal behaviours; when a neutral, objective, and apolitical position is taken by the therapist. This is a move in which social contexts and interpersonal connections are set aside. The problem to be addressed is not then that clients experience inequality, discrimination, and abuse, or that they are distressed by this. Any mental or emotional distress that the client expresses is instead understood to be caused by a mental illness. It is the mental illness that is the problem (Dalal, 2018).

While they claim neutrality, practitioners might believe that they do not need to respond directly to the distress that their clients express. They might prefer to interpret that distress, to explain it away in a reassuring form of “psychoeducation.” In this neutrality, they would not need to consider their own social position, or their own limited perspective. They could perhaps feel confident that their knowledge constructions are always applied without bias, because they are evidence based. In contrast, practitioners who employ phenomenological approaches to knowledge construction tend to accept that they start off from a situated and given position. They will find that, if they can notice and attend to their own inherent bias, they might get nearer to understanding what is happening for their client, through an incremental process of challenging and unpicking their own assumptions (Gadamer, 1975).

When practitioners entertain the idea that someone suffers from a given psychiatric diagnosis, they are in a sense adopting a hypothesis. If they then seek evidence to support their hypothesis, they are borrowing from the methodologies of empirical science (Dalal, 2018). When practitioners are employing phenomenological approaches, they try to hold established understandings in question, working to engage with distress as it is experienced. For example, some practitioners in the UK choose not to use preformed diagnostic categories. Rather than asking, “What is wrong with you,” they suggest that practitioners ask, “What happened to you?” (Johnstone & Boyle, 2018). This is a step away from the use of pathologizing diagnostic systems, but unfortunately distress can still be approached as an unwanted symptom, but now a symptom of trauma. Ideas from empirical science can still be expressed in an understanding of cause and effect relationships, as if the person were a passive object within which past traumas cause current experiences of distress. Further steps are needed before an existential understanding can be established.

In an existential approach, practitioners explore each client’s response to their unique life-world (van Deurzen, 2012) and this does not fit easily in a setting where humans are understood as measurable things. In this alternative framework, it is not thought that people can be lined up and measured as if they were similar objects that can be changed or manipulated by the administration of treatments. It is observed in this article that when
practitioners are required to demonstrate improvements in functioning it can be difficult to attend to the client’s active meaning-making, or their self-motivation and autonomy (O’Loughlin, 2020; Staines, 2008). In one understanding, it is the practitioner who is in control, delivering standardized interventions that have been shown through research to make people more functional and employable. In another, it is the client who is supported in their explorations and in their attempts to make sense of experiences and associated distress. In a more collaborative phenomenological approach, the client would retain their control and find balance, meaning, purpose, and reasons to take up the unique opportunities that are open to them, through a sense of self-determination (van Deurzen, 2012).

Although clear distinctions can be made between approaches at a theoretical level, there will be a lot of overlap in the practice of those different therapeutic modalities (Kisch & Kroll, 1980). Practitioners adapt their approaches to the needs of their clients. The problem that this article observes is that helpful adaptations in personalized therapy are ignored or seen as inappropriate deviations from the prescribed treatment. What is happening is usually interpreted quite narrowly at the level of service organization and commissioning. At that level, it is the methodologies and constructs of empirical science that are most often applied, as promoted by the evidence-based practice movement. This article presents a critique or deconstruction of that current dominant world view. It is not, however, a critique of one therapeutic approach or another. What is examined is the reasoning and practice of service design and delivery, as it is transformed to fit within the frameworks imposed by evidence-based practice.

The critique that is set out in this article is of how things are understood in some therapeutic approaches; of how this is taken up in service design and commissioning. It is recognized that the current evidence-based movement in psychotherapy and counselling might force practitioners to work in oppressive conditions, providing poor quality of service (Cotton, 2020; Dalal, 2018). It is suggested that by promoting our understanding of what happens in phenomenological exploration, as framed within the philosophy of existential therapies, a more collaborative and effective service might be provided. This reframing might also be supportive for practitioners, relieving them from a pressure to deliver narrow outcomes, when they are set targets that seem to lack meaning.

In whatever approach they employ, before they can understand their clients’ experiences, practitioners need to engage in a relationship with them. This is revealed in the research finding that it is the nature of the practitioner, or the fit between the practitioner and the client—their relationship—that is the most effective factor in determining outcomes; more effective than the specific modality that the practitioner employs (Kisch & Kroll, 1980; Norcross & Lambert, 2019). It is unhelpful when the logic of some modalities transforms that mutually forged and collaborative encounter into a causal process. In that reasoning, it is the standardized therapeutic intervention that brings the desired therapeutic changes, not the two people who happen to be talking with each other in sessions.

The radically different philosophical groundings of existential therapies are ignored when different modalities are lined up in research studies and compared. This article is an attempt, instead, to recover our awareness of that different framework. In the following sections, several steps are set out in the development of existential theory and its application in mental health practice. The example of paranoia is considered, to draw
clear distinctions between different understandings, founded in different epistemological frameworks. A specific distinction is made between a form of phenomenological exploration that can be pulled back into an objective empirical science construction of the other, and a reflexive phenomenological exploration that attends more to relationship, context, and the exercise of power.

**Philosophical developments in existential therapies**

If we are to arrive at a phenomenological understanding of human distress, it is necessary to take several steps. As observed above, in evidence-based practice, it is often assumed that mental and emotional distress are symptoms of mental illness. If we examine this assumption, we are likely to notice related ideas; the idea, for example, that distress is located within the person; that if it is caused by mental illness it is unreasonable, that it might have no real meaning or relevance to anything, and that the person is therefore unable to experience a normal way of being (Dalal, 2018). When we adopt a phenomenological approach, we need to hold these assumptions in question. The kind of experience we might notice using a phenomenological approach includes the detail that distress is something communicated from one human to another. Attending to that communication, we can take the step of understanding emotionality as something that has meaning primarily in the way that it is experienced by humans in relationships with each other (Cohn, 1997; Spinelli, 2015; van Deurzen, 2012).

The project of clinical psychology and psychiatry is criticized for taking an expert, remote, and objective view on the suffering of others (Pilgrim & Treacher, 1992). Instead, existential therapies are built on a more direct attempt to understand what it is like to be the other. Simone de Beauvoir, for example, engaged in a phenomenological exploration of what it is like to have lived a day-by-day experience of gendered and situated existence (de Beauvoir, 1949/2009). This form of exploration does not assume that social categories such as gender exist prior to our experience and understanding of them. Subsequently, critical psychology understandings have developed in which intersectionality between gender, ethnicity, sexuality, and other differences is approached in its complexity, in its social and political dynamics (Hepburn, 2003; McCall, 2005). Civil rights movements have applied pressure, requiring that governments and authorities address these complexities. Similarly, some mental health policies and practices have been influenced by an emancipating tradition of phenomenological exploration, traced back to de Beauvoir and other pioneering writers.

Phenomenological approaches can be emancipating in the way that they break down our positioning of people as “other.” Mainstream psychology and psychiatry continue to propose that those who are emotionally or psychologically distressed are other, in the sense that they suffer from a mental health problem, and we do not. The distinction between “normal psychology” and “abnormal psychology” is maintained. At one point, however, when the practice of phenomenological exploration was more influential, theorists thought that this distinction might be dismantled (Spiegelberg, 1972). Researchers continue in their attempts to remove this distinction. For example, symptoms of psychosis can be understood as healthy responses when they are explored in relation to the person’s life context (Kamens, 2019).
In a reflexive phenomenology, the researcher (or therapist) would examine their own motivations and their role in the construction of someone as other, as abnormal. In existential therapies, practitioners do not usually interpret or diagnose, but instead adopt an accepting and enquiring position, enabling each client to refine their self-understanding (Churchill, 2016; Spinelli, 2015; van Deurzen, 2012). The following section introduces the work of several existential theorists, charting the development of phenomenological exploration in psychotherapy and counselling. A clear account is available of the developing practice of existential psychotherapeutic approaches in continental Europe (Cohn, 1997). This article attends more to evolving practice in English-speaking nations. New formulations of mental and emotional distress were generated (Laing & Esterson, 1964/2017; May, 1977/2015; Stolorow, 2007; Yalom, 1980). R. D. Laing was perhaps the most influential figure in these developments, inspiring social movements that challenged the use of power and authority within families and institutional systems (Laing, 1971).

R. D. Laing, Rollo May, Irvin D. Yalom, and Robert Stolorow

It is argued here that if practitioners are engaging with their clients, in whatever modality they use, they will be working phenomenologically to some degree. This phenomenological work was established in the last century when R. D. Laing led a revolutionary movement in mental healthcare. In collaboration with Aaron Esterson, he used a phenomenological approach to describe experiences of distress as expressed within family relationships (Laing & Esterson, 1964/2017). These accounts of complex intersubjective processes revealed a lack of essence in our being, which Martin Heidegger and Jean-Paul Sartre had pointed to; an ontological insecurity (Cohn, 1997). The idea spread that mental and emotional distress are not only symptoms of mental illness. They came to be viewed as a shared and understandable experience, when approached as something that happens within families, within institutions and within society, rather than just within individual people (Laing, 1971).

In the relationship network of an institution, it is observed that there are significant inequalities in who can exercise power and control and that in response to this, people will experience distress (Laing, 1971; Szasz, 1971). Oppressive ideologies and feelings of paranoia are found to float about in these cultural contexts, like an “emotional atmosphere” (Merleau-Ponty, 1962). In many countries, influenced in part by phenomenological understandings, mental healthcare policies required the dismantling of large psychiatric hospitals. Subsequently, in policies that are increasingly organized around consumerism, access to healthcare services is now influenced by notions of individual choice and freedom, while unfortunately the exercise of power remains a problem (Speed, 2007). In tandem with these developments, many psychotherapists and counsellors adopted a more “person-centered” approach. Principles from humanistic counselling rose to dominance for a while, although the roots of this approach in existential philosophies were perhaps lost, with the emphasis placed on practice rather than on theory (Spiegelberg, 1972).
R. D. Laing challenged the claim that mental and emotional distress are caused only by biological illness or psychological dysfunction. He helped us to understand distress in the context of social inequality, abuse, and interpersonal conflict (Laing, 1971). Laing and Esterson (1964/2017) introduced phenomenological research methodologies into the English-speaking world, although misunderstandings remain. It is often assumed that phenomenological exploration provides a subjective account that might complement scientific objectivity. It is then assumed that diagnostic categories exist prior to our construction of them, that other people already have these conditions, and that their experiences will be different from ours (Dalal, 2018). However, as Edmund Husserl explained, the “noetic correlate” as the intentional act of the observer, is inextricably linked to the “noematic correlate,” that which is observed (Husserl, 1911/2006). The observer and the observed are both brought about by that which presupposes them in an originating existence, pinned to a specific cultural understanding, in the life-world of that time and place (Molbak, 2011). The nature or value of both the client and the therapist are negotiated and constructed by whatever happens in the therapeutic encounter.

Rollo May tried to bridge the gap between subjective and objective perspectives, while maintaining the distinction between “normal” and “abnormal.” He introduced the use of the German terms _Ungst_ or _Angst der Kreatur_ to describe “normal anxiety,” which he thought of as being different from “neurotic anxiety.” He observed how we all experience normal anxiety and that “anxiety will dog the steps of the individual (if he does not engage in complete neurotic repression) until it is resolved” (May, 1977/2015, p. 45). May was promoting the idea that we adapt and mature through our experience of anxiety, while also retaining the otherness of the psychiatric patient, when their anxiety and repression seem to limit their potential for autonomy, adaption, and growth.

Rollo May combines theory from existential and psychodynamic traditions and Irvin D. Yalom then picked up these understandings and observed his own denials, which he worked to overcome in his psychotherapeutic practice. By observing and challenging his own assumptions and denials, Yalom explained how he overcame his experience of his client as “other,” bringing that client’s experience into shared awareness. In that shared awareness, it could be acknowledged that whatever it was that the client experienced could also be experienced by the practitioner. Yalom argued that we all try to deny certain given aspects of existence. These are the uncomfortable truths that we will die, that we are alone in facing our unique individual life choices, that life can lack meaning, and that we are always in relationship with others (Yalom, 1980). He traced all our distress back to those commonplace denials and avoidances, breaking down that distinction between “normal” and “abnormal.” He promoted a more inclusive, reflexive phenomenological understanding of distress, as something we share, by observing the existential dilemmas we all face.

As with R. D. Laing and Simone de Beauvoir before him, Irvin Yalom engaged in phenomenological enquiry, but often with a more informal and self-reflexive style (Yalom, 1989). Yalom’s reflections on his own limited and human responses, as the therapist, reveal the way that he was in the life-world, in the interaction, struggling with his own emotions and experiencing what it was that was opened up for him in his encounters with the person he was trying to help. Each example of therapeutic work that he described
is unique; an unfolding that could only happen between him and the specific person that he was working with. When we recognize the unique and contingent, clients are not squeezed into diagnostic categories. Treatments are not only targeted at reducing the symptoms associated with those categories, as if those who are administering and receiving treatments are peripheral to the process.

**The therapeutic use of phenomenology**

As explained above, the view taken in this article is that most psychotherapists and counsellors will be employing phenomenological approaches, even if they are unaware of the philosophy and research tradition behind these interventions. An account of existential theory is set out above, as applied by influential theorists, and a brief account of a phenomenological approach is provided in this section. In a phenomenological research approach, the researcher might mirror the participant’s movements, as that participant reexperiences their bodily memory of what they did in a past situation. For example, the researcher might hold their own hand to their chest, just as they have observed their participant to hold themselves, asking “What was happening there?” The memory of what the participant was doing at that point in their recalled experience is thereby brought more accurately into awareness (Bitbol & Petitmengin, 2017; Petitmengin, 2019). What the researcher does when using this methodology overlaps to a large degree with a phenomenological therapeutic approach in which personal awareness is recovered (Churchill, 2016; van Deurzen, 2012).

Phenomenological exploration asks us to turn our attention back to our being in a context, to explore what it is like to have a feeling, an experience; what it is like to encounter others. This asking can pull us out of our unthinking way of living within a supposed objective rationality, in which we assume an ability to see the world without bias in an unmediated manner, when it appears to be simply there. Through reflexivity, we become aware that we are constantly setting our personal experience aside to see the world as anyone else from our social context might (Stolorow, 2007). Phenomenological approaches are built on the discipline of constantly working to recover our actual and immediate experience.

Employing a phenomenological approach enables a complex interplay between the practitioner and their client. It is then quite difficult to sustain the claim that the practitioner is a neutral conduit, delivering an evidence-based intervention in a manual approach. The interaction is revealed to be more like a dance, in which each partner’s movement is a rhythmic play of active stepping forward and passive moving back in a synchronized pattern (Churchill, 2016; Langdridge, 2005). Through this constant active then passive movement around what is shared and what is separate, patterns emerge in the blended horizon of joint consciousness.

In our intended and shared consciousness, it seems that we are selective in choosing those things of which we will allow ourselves to be aware. Robert Stolorow describes how we leave home every morning saying something like “see you later,” to someone we care about; we do not maintain an awareness of the possibility, which applies to us all, that we might never see that person again (Stolorow, 2007). The phenomenological explorations, which can occur in counselling and psychotherapy, open the practitioner’s
awareness of these uncomfortable realities. The practitioner is not then denying the limiting qualities of loss and trauma, nor are they denying the remaining possibilities for self-determination and growth.

Robert Stolorow, like Irvin Yalom, adapts psychodynamic concepts such as denial and repression to an existential and intersubjective understanding. He observes that in our common denials and avoidances we choose to see through the eyes of people like us, rather than noticing our own actual experiences. He views traumatic experiences as problematic, most often because they force us to see the world in ways that others do not want to view it. Stolorow (2007) describes how, while he was at a conference, he picked up a newly printed book he co-authored and looked around for his wife, so that he could show it to her; he then suddenly recalled that she had been dead for 18 months. He had lapsed into a kind of disassociation which enabled him to be like all the other delegates at that conference, denying his own being as a bereaved husband.

A practitioner’s own traumatic experience, as understood in existential therapies, is an aspect of their personal journey towards a more honest and authentic way of being in the world. It will enable their engagement with the distress of their client. Edith Eger (2017) described this:

In other words, I began to formulate a new relationship with my own trauma. It wasn’t something to silence, suppress, avoid, negate. It was a well I could draw on, a deep source of understanding and intuition about my patients, their pain, and the path to healing. (p. 239)

Robert Stolorow’s disassociation and sudden feeling of being separate from others and alone in his grief was, he argues, partly a consequence of the denial of others; the denial that a distressing bereavement might happen for them. It is important to be aware that it is not only the client in therapy who struggles to talk openly about loss and trauma; we all try to defend ourselves, repressing our awareness (Yalom, 1980).

Academic theory is usually written in a third-person voice, as if our existence might be seen from a neutral perspective, a view from nowhere, from outside of time (Gabriel, 2018). Existential theory asks instead that we wake up and see this rational abstraction as a gloss over the actual experience of being (Churchill, 2016). It can be helpful to write about an experience of mental and emotional distress in the third-person voice, describing it in general terms as a range of signs and symptoms, or saying something about how frequently it is reported in a certain cultural setting during one historical period. For example, it can reveal correlations between social inequality, trauma, and distress (Cromby et al., 2007). This does not reveal, however, what our distress means to us as embodied living beings, here and now, enmeshed in our relationships with others, or what we should do about it.

**An existential awareness**

In this section, I take up the practice of writing in the first person, to work with a more contingent and context-driven form of knowledge construction. The project of dehumanizing therapy in an extreme form of evidence-based practice will, I suggest, inevitably create a sense of alienation (O’Loughlin, 2020) and, potentially, “paranoia.” I have set
out a brief account of distress, as it is understood in existential therapies, and I have given an initial impression of the reflection and awareness that is required in a therapeutic use of phenomenological exploration. I will now discuss the experience of paranoia, to provide an example of how reflexivity is used in that phenomenological exploration.

Merleau-Ponty (1962) described the experience of someone who has lost their right arm, in their action of unthinkingly offering that missing limb to engage in a handshake. We might assume this is only a habit they have not learnt to let go of. However, we are all taken up in a complex social world in which a multitude of these habits form our way of being. These constitute the sedimented habit of being a person like us. The average nondisabled person is, within this reasoning, the default position we all adopt. Feminist writers have developed understandings from Merleau-Ponty in which it is observed that the default position in modern Western societies is White, middle-class, male, and heterosexual (Foultier, 2013). Behind this default position, there will be a complex intersectionality (McCall, 2005), and in whatever way we configure our groups of people like us, someone is always left out.

Many of us would like to remain comfortable in our assumed understandings, believing that the way the world appears to be, as seen by people like us, happens to be the one true version of how things really are. Unfortunately, in clinging to this false security we can act in a manner that oppresses others. From an objective scientific perspective, we can see that people from minority groups are more likely to suffer from mental health problems; we have the evidence for this (Gajwani et al., 2016). We might also assume that they are therefore more vulnerable. Then, we do not notice the discrimination they routinely experience in our societies; the everyday micro-aggressions in which their difference is neither positively recognized nor adequately accommodated. It is not revealed to us that it is through these intersubjective processes that isolating and stigmatizing forms of mental and emotional distress are brought about (Capodilupo, 2016).

People who are a member of a minority group in our society are not necessarily more vulnerable, or more at risk of suffering mental health problems. They will be more aware of a potential for aggression, discrimination, and exclusion that anyone else could be experiencing. Are we more resilient than they are, when through our denial we avoid thinking about the possibility that we might also experience rejection and abuse? It is difficult to endure the discomfort of being different, so we might ignore, or unthinkingly disguise, our own gender, disability, sexuality, or ethnicity in order to fit in. We are then all alienated from our own being, discriminating against ourselves and others. However, those who are furthest from the “normal and ordinary” will struggle more to deny their own experiences. They are the ones we pick out in our societies requiring that they experience the distress of our collective alienation, and, in making that point, I will turn to the phenomena of paranoia.

A phenomenological exploration can feed into an objective construction of a person as “other.” We can construct the psychology of paranoia, for example, in someone who has not adjusted following their transition from childhood into adult independence. Their parents, who they experienced as ever-present and judgmental, have been replaced by powerful figures or agencies in society, who they now experience as following them around and watching their every move.
Wharn 283

In this construction, the paranoid person is struggling to come to terms with their adult freedom, a freedom that is experienced as overwhelming. They choose instead, at a preconscious level, to be held within limits, blaming the controlling actions of authority figures. Their life is not experienced as a meaningless series of random events, within which they are free to choose how to be. They see connections and meaning in every coincidental event and their world shrinks down to form containing limits. Someone who suffers from paranoia is denying their freedom in the hope of experiencing ontological security.

How then, do mental health services treat a paranoid person, or “make them better”? How can an evidence-based intervention, which is framed as a causal process, “do something to the client” that makes them experience their freedom? The prospect of making choices can make us anxious; our world will be changed, we will be changed, and we cannot go back to the way things were. The paranoid person, in this construction, does not commit themselves or take up possibilities in their unfolding world; they do not recognize or express their own agency and they avoid the choices that they could be making.

The phenomenological construction of the “paranoid other” that I set out above, lacks a reflexive awareness. It supports the objective medical view that other people suffer from paranoid delusions, while most of us do not. However, in our experience of the other as paranoid, we dismiss whatever it is that concerns them; we deny that there is any truth in their view of the world. We thereby pick them out, diminish, and isolate them, reducing their ability to influence others. We are not only objectively observing them; we are doing something to them. We invalidate them and their truth when we say “They are so deluded, poor things.” Meanwhile, in taking on the role of a therapeutic practitioner perhaps we deny our own freedom, constructing a containing parental figure in our regulating professional body. Experiencing ourselves as held within a professional system, we then feel paranoid when we glimpse the possibility that we might not be following therapeutic procedures exactly as they are prescribed. What if someone notices? What if we were picked out?

Primary mental health services in the UK are, it seems, set up to drive each person into being “a good citizen” by curing their illness (Dalal, 2018). Paradoxically, it is proposed that if that person could stop believing that there is an abusive exercise of power in our society, they could then take up unrewarding and underpaid work, in an undervalued social role. Do practitioners then represent the “powers that be,” paid by the state to pacify and control someone who resists social pressures? Perhaps the client should feel paranoid because the practitioner is trying to control and change them. Perhaps the practitioner should also feel paranoid because their ways of being are defined and controlled by their employers. Alternatively, through the understandings of existential philosophy we might respond to what is there for us in life, our facticity, recognizing that we always have choices (Frankl, 1946/2004).

Is it possible then, to help someone find meaning in their life, by exploring their paranoid concerns? A colleague described how she engaged with a client who was initially distressed by the thought that the counselling room might be bugged. Her approach was not to take the position of someone in authority, someone who might deny or confirm the presence of surveillance equipment, but to help the client to look for the bugs. In this
being alongside the client, she could engage in shared experience. This colleague committed herself to the world through her choice to join her client, becoming more open to the possibility of experiencing that with which her client was struggling. She thereby became more real and human to her client.

The way that this practitioner got up and joined her client in searching around the room for recording devices could raise concerns; is that not colluding with the delusional belief? Well, as a scientific practitioner, perhaps we should take an agnostic approach, not knowing if the room is bugged or not, not knowing if the client is unjustly paranoid or not until evidence is found for these things. However, mental health services are often highly hierarchical in their structure and practitioners will feel under pressure to behave in ways that are acceptable within fixed systems of meaning. If we are “being alongside a client,” that can feel perhaps as if we are working undercover, pretending to only be a professional worker, while secretly being an actual person. The honesty and awareness that is revealed when we commit ourselves to being present in this way is more often encouraged and accepted in existential therapies (van Deurzen, 2012).

Employing a phenomenological approach in counselling could trigger all these different aspects of paranoia. It can be alarmingly freeing in the sense that we do not know what will be revealed or what to do with that material. I am aware that practitioners need to feel supported when they are courageously using immediacy and working spontaneously, particularly in highly regulated and monitored employment settings. Perhaps it is safer to seek anonymity by placing ourselves above the map or in front of the picture that we are drawing in our theoretical constructions, when we pretend that we can cut ourselves out of the equation by being the objective observer (Hawes, 1998). When I do this, I sometimes notice a paradox. My client, who is experiencing paranoia, complains that people are: monitoring them, recording what they say and do, while, in the psychiatric services in which I work, we dismiss their concerns. We say “They are so deluded, poor things,” while monitoring them, recording what they say and do. This kind of paradox reveals the seams in the panorama we construct in our scientific observations (Latour, 2005).

Sometimes I might wonder if we are really encountering each other in our professional training and supervision or just policing each other; and this reveals my own paranoia. However, I am suggesting this paranoia does not exist outside of the moment when I feel that concern; it is an atmosphere that surrounds us, manifests in one person one moment and then another, moments later. If I were asked in some form of professional training to make an auditory recording of my session with a client so that a supervisor could check that I am following the correct procedures, perhaps the client and I would have good reason to feel paranoid. However, it is equally possible that we would feel supported in trusting relationships, free to open our experiences to an independent and impartial scrutiny.

Conclusion

This article set out a brief account of phenomenological exploration, as practised in existential therapies. In addition, it was observed that although practitioners might not be
explicitly aware that they are engaging in this phenomenological exploration, the reality that they are in human-to-human encounters means that it will be an aspect of their work. Reference was made to theoretical developments and therapeutic practices to illustrate the nature of phenomenological exploration. Different levels of exploration were considered. It was observed that these can construct an understanding of the other as abnormal, as paranoid, for example. Alternatively, phenomena such as paranoia can be experienced in the interaction, in the culture and setting of what is taking place; expressed by one person then another in a dynamic flow.

A phenomenological exploration reveals what has happened, where we are, what is there for us. It prompts the question “what now?” In our adoption of evidence-based practice, we require that therapists identify symptoms, that they diagnose and treat people in a robotic fashion, as if the practitioner were part of an assembly line. Is it still possible for them to understand and validate the distressing experiences of others? Is it necessary that they reify otherness, or can they stand with the other, seeing the world from their point of view? It seems likely that they are struggling to do this. It is found that primary mental health services in the UK do not provide a rewarding and sustainable job role for their employees (Westwood et al., 2017). Levels of burnout are worryingly high for some groups of employees in these services. The philosophical framework of evidence-based practice is starting to fold in on itself when practitioners understand themselves to be other; when they feel isolated, failing in their role because they are suffering from symptoms of burnout. A more empathetic response would be to ensure that they receive adequate supervision and support in maintaining a reflexive phenomenological approach (Wharne, 2019).

Evaluating the effectiveness of mental health interventions and services currently relies most often on the measurement of symptom reduction and improved functioning (Dalal, 2018; Kisch & Kroll, 1980). An evaluation that recognizes reflexive phenomenological practice would be quite different, attained most likely by using qualitative research approaches. I suggest that abuse and discrimination will not be addressed if we only ever count things. We also need to ask questions about whether a client in a therapeutic encounter feels understood, accepted, and validated. This questioning could attend to the degree to which the practitioner developed an understanding of them; an understanding that reveals where the client is in their life-world; enabling a sharing of human experience which helps the client to feel less alone.

An epistemological framework is adopted in existential therapies in which individual people are not the baseline unit of measurement; the potential for emotions and ideas to be expressed in human interactions rather than in individual dispositions is accommodated. Through a phenomenological exploration, we might notice that we are conscious of something: “where we are here and now with another,” first, and then we become aware of our separation as embodied individuals; this personal awareness arrives as a secondary and additional insight, overlying an innate, foundational, and shared cultural existence (Churchill, 2016; Felder & Robbins, 2011; Merleau-Ponty, 1962; Stein, 1921/1989).

In our assumed ability to see the world directly, we might construct some notion of “what is wrong” with the client, while maintaining a sense of our own validity through denial; viewing distress, paranoia, and anxiety all as aspects of this other person’s malaise.
Alternatively, we can commit ourselves to becoming a valued confidant or witness, open to the challenging experience of the other. It is only when our client experiences us as someone who struggles with similar dilemmas and emotions that they will feel understood by us. It is through the practitioner’s responses, disclosed knowingly or unknowingly, that they become committed to the world “as someone,” for that client.

When they are opening themselves to distressing possibilities, practitioners must maintain their own sense of balance and separation (van Deurzen, 2012). In this work, their use of a phenomenological exploration is not something they do to the client. It is an evidence-based intervention in the sense that it is based on the evidence of the client’s own experience. However, it is not something that can be captured or systematized outside of each context in which the emergence of phenomena is enabled. It always has the potential to surprise and unsettle us. While it involves a rigorous and methodical encounter with the world as it is experienced, it also involves an opening to unforeseen possibilities and troubling potential futures.

In this article, I have suggested that although existential philosophies have influenced contemporary mental health policies and ways of working, phenomenological exploration remains largely unacknowledged as a therapeutic intervention. However, the practitioner who avoids the use of a diagnostic model is perhaps using the epoché, as recommended by Husserl (1911/2006). They are bracketing or harnessing their assumptions, while attending to what happens.

Although in many countries the oppressive systems of psychiatric asylums have been dismantled, some of that controlling hierarchy is perhaps retained in the structure of our community services. Practitioners can challenge this institutional rationalism if they adopt a knowledge framework that is open to human experience. In this article I have worked to describe and summarize this kind of therapeutic work. The success of reflexive phenomenological interventions, as described here in human-to-human encounters, would be measured more appropriately in qualitative research. If, that is, we ask people what they experience, if we respond as a human, and then ask if they feel that they are understood.

**Funding**

The author received no financial support for the research, authorship, and/or publication of this article.

**ORCID iD**

Simon Wharne [https://orcid.org/0000-0001-7156-1831](https://orcid.org/0000-0001-7156-1831)

**References**

Bitbol, M., & Petitmengin, C. (2017). Neurophenomenology and the micro-phenomenological interview. In S. Schneider & M. Velmans (Eds.), The Blackwell companion to consciousness (2nd ed., pp. 726–739). Wiley & Sons.

Capodilupo, C. M. (2016). Microaggressions in counseling and psychotherapy. In D. W. Sue & D. Sue (Eds.), Counseling the culturally different: Theory and practice (pp. 197–212). John Wiley & Sons.
Churchill, S. D. (2016). Resonating with meaning in the lives of others: An invitation to empathic understanding. In C. T. Fischer, L. Laubscher, & R. Brooke (Eds.), *The qualitative vision for psychology: An invitation to a human science approach* (pp. 91–116). Duquesne University Press.

Cohn, H. W. (1997). *Existential thought and therapeutic practice: An introduction to existential psychotherapy*. SAGE.

Collins, B. (2019). *Outcomes for mental health services: What really matters?* Kings Fund.

Cotton, E. (2020, January). Working in the therapy factory. *Healthcare Counselling and Psychotherapy Journal*, 20(1), 16–18.

Cromby, J., Diamond, B., Kelly, P., Moloney, P., Priest, P., & Smail, D. (2007). Questioning the science and politics of happiness. *The Psychologist*, 20(7), 422–425. https://thepsychologist.bps.org.uk/volume-20/edition-7/questioning-science-and-politics-happiness

Dalal, F. (2018). *CBT: The cognitive behavioural tsunami*. Routledge.

de Beauvoir, S. (2009). *The second sex* (C. Borde & S. Malovany-Chevallier, Trans.). Random House. (Original work published 1949)

Eger, E. (2017). *The choice*. Rider.

Felder, A. J., & Robbins, B. D. (2011). A cultural-existential approach to therapy: Merleau-Ponty’s phenomenology of embodiment and its implications for practice. *Theory & Psychology, 21*(3), 355–372. https://doi.org/10.1177/0959354310397570

Foultier, A. P. (2013). Language and the gendered body: Butler’s early reading of Merleau-Ponty. *Hypatia, 28*(4), 767–782. https://doi.org/10.1111/hypa.12040

Frankl, V. E. (2004). *Man’s search for meaning*. Ebury. (Original work published 1946)

Gabriel, M. (2018). *Neo-existentialism*. Polity Press.

Gadamer, H. G. (1975). *Truth and method* (J. Weinsheimer & D. G. Marshall, Trans.). Continuum.

Gajwani, R., Parsons, H., Birchwood, M., & Singh, S. P. (2016). Ethnicity and detention: Are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007? *Social Psychiatry Psychiatric and Epidemiology, 51*, 703–711. https://doi.org/10.1007/s00127-016-1181-z

Hawes, S. E. (1998). Positioning a dialogic reflexivity in the practice of feminist supervision. In B. M. Bayer & J. Shotter (Eds.), *Reconstructing the psychological subject: Bodies, practices and technologies* (pp. 94–110). SAGE.

Hepburn, A. (2003). *An introduction to critical social psychology*. SAGE.

Husserl, E. (2006). *The basic problems of phenomenology: From the lectures, winter semester, 1910–1911* (I. Farin & J. G. Hart, Trans.). Springer. (Original work published 1911)

Johnstone, L., & Boyle, M. (2018). *The power threat meaning framework*. British Psychological Society.

Kamens, S. (2019). De-othering “schizophrenia”. *Theory & Psychology, 29*(2), 200–218. https://doi.org/10.1177/0959354319828531

Kisch, J., & Kroll, J. (1980). Meaningfulness versus effectiveness: Paradoxical implications in the evaluation of psychotherapy. *Psychotherapy: Theory, Research & Practice, 17*(4), 401–413. https://doi.org/10.1037/h0085939

Laing, R. D. (1971). *The politics of the family*. Tavistock.

Laing, R. D., & Esterson, A. (2017). *Sanity, madness and the family*. Routledge. (Original work published 1964)

Langdridge, D. (2005). “The child’s relations with others”: Merleau-Ponty, embodiment and psychotherapy. *Existential Analysis, 16*(1), 87–99.

Latour, B. (2005). *Reassembling the social: An introduction to actor-network-theory*. Oxford University Press.
Layard, R. (2005). *Happiness: Lessons from a new science*. Allen Lane.

Marzillier, J., & Hall, J. (2009). The challenge of the Layard initiative. *The Psychologist, 22*(6), 396–399.

May, R. (2015). *The meaning of anxiety*. W. W. Norton. (Original work published 1977)

McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society, 30*(3), 1771–1800. https://doi.org/10.1086/426800

Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). Routledge.

Molbak, R. L. (2011). Lived experience as a strife between earth and world: Towards a radical phenomenological understanding of the empirical. *Journal of Theoretical and Philosophical Psychology, 31*(4), 207–222. https://doi.org/10.1037/a0023192

Norcross, J. C., & Lambert, M. J. (2019). *Psychotherapy relationships that work*. Oxford University Press.

O’Loughlin, M. (2020). Ethical loneliness in the psychiatric clinic: The manufacture of non-belonging. *Ethics, Medicine and Public Health, 14*, Article 100518. https://doi.org/10.1016/j.jemp.2020.100518

Petitmengin, C. (2019, March 22). *Applying phenomenology in experiential research* [Paper presentation]. Applying Phenomenology in Experiential Research, British Psychological Society, London, UK.

Pilgrim, D., & Treacher, A. (1992). *Clinical psychology observed*. Routledge.

Speed, E. (2007). Discourses of consumption or consumed by discourse? A consideration of what “consumer” means to the service user. *Journal of Mental Health, 16*(3), 307–318. https://doi.org/10.1080/09638230701299210

Spiegelberg, H. (1972). *Phenomenology in psychology and psychiatry*. Northwestern University Press.

Spinelli, E. (2015). *Practicing existential therapy: The relational world* (2nd ed.). SAGE.

Staines, G. L. (2008). The relative efficacy of psychotherapy: Reassessing the methods-based paradigm. *Review of General Psychology, 12*(4), 330–343. https://doi.org/10.1037/1089-2680.12.4.330

Stein, E. (1989). *On the problem of empathy* (W. Stein, Trans.). ICS Publications. (Original work published 1921)

Stolorow, R. D. (2007). *Trauma and human existence: Autobiographical, psychoanalytic and philosophical reflections*. The Analytic Press.

Szasz, T. S. (1971). *The manufacture of madness: A comparative study of the inquisition and the mental health movement*. Routledge & Kegan Paul.

The British Psychological Society & The Royal College of Psychiatrists. (2011). *Common mental health disorders: The NICE guidelines on identification and pathways to care*. National Collaborating Centre for Mental Health.

van Deurzen, E. (2012). *Existential counselling and psychotherapy in practice*. SAGE.

Watts, J. (2016). IAPT and the ideal image. In J. Lees (Ed.), *The future of psychological therapy: From managed care to transformational practice* (pp. 84–101). Routledge.

Westwood, S., Morison, L., Allt, J., & Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout among improving access to psychological therapies (IAPT) practitioners. *Journal of Mental Health, 26*(2), 172–179. https://doi.org/10.1080/09638237.2016.1276540

Wharne, S. (2019). *How do mental health practitioners understand and experience resilience?* [Unpublished doctoral dissertation]. New School of Psychotherapy and Counselling, Middlesex University, London, UK.

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

Yalom, I. D. (1989). *Love’s executioner and other tales of psychotherapy*. Basic Books.
Author biography

Simon Wharne has worked in community mental health services for 30 years and managed teams for 20 years. He has specialized in extending services to people who have complex needs and he led in a national organization promoting good practice and innovation. He completed a PhD with The Open University, UK, exploring decision making in mental healthcare. He returned to counselling practice, gaining a DCPsych with the New School of Psychotherapy and Counselling, Middlesex University, UK. He is currently a counselling psychologist registered with the BPS, UK, working in an NHS community team, while also teaching and in private practice. His interests include the use of existential philosophy and critical social psychology in psychotherapy and counselling. Recent publications include “Trauma, Empathy and Resilience: A Phenomenological Analysis Informed by the Philosophy of Edith Stein,” in The Humanistic Psychologist (in press) and “‘On Being an Auditory Hallucination’: A Reflection on Theory, Practice, Existential Philosophy and Hearing Voices,” in The Humanistic Psychologist (2018).