FROM PSYCHOTHERAPY TO ANTHROPOTHERAPY

Unpublished manuscript by

A.K.T. Tsang

University of Hong Kong (1984-1989)

First Draft: December 1984
Revised: December, 1989

PLEASE DO NOT USE WITHOUT PERMISSION FROM THE AUTHOR

Current Contact:

Professor A. Ka Tat Tsang
Factor-Inwentash Faculty of Social Work
University of Toronto
246 Bloor Street West
Toronto, Ontario
Canada M5S 1A1

Email: k.tsang@utoronto.ca

INTRODUCTION

When I first began practising as a psychotherapist I came under the influence of a certain eclecticism which was actually a curious blending together of the various humanistic approaches. Techniques derived from Gestalt Therapy, Client-Centered Therapy, Transactional Analysis, etc. were used interchangeably without bothering much about their theoretical foundations and implications. As a novice I was preoccupied with effectiveness and the statement of "we use whatever method that works" was a frequent incantation. Being inexperienced and uncertain of one's competence, it came naturally that one should carefully monitor one's own conduct in the therapy process. I then developed the habit of tape-recording my own therapy sessions and reviewing them with my colleagues.

Gradually I grew out of the initial fascination with the more active and relatively short-term humanistic approaches and felt more and more attracted to the psychoanalytic tradition under which I had been brought up professionally. The continual critical reviews and questioning however led me into a rather different direction and at one point I came to realize that I was practising a yet unknown kind of therapy which was essentially different from the various psychotherapies that I knew of. An anxious and rigorous search for a theory to explain what was happening and to guide further work was then pursued and the present paper is intended to be a summary of such a search and the consequent reconceptualization of what therapy is.

THE TURN

In my own practice of therapy most of the time I have the common-sense awareness that I cannot possibly know my patients better than they themselves do. All the material that I can get

hold of concerning my patients are presented and produced by themselves. In applying my feeble psychological formulations to them I see what is conditioned by these theoretical structures which construct the "reality" for me. I do not feel comfortable to assume that this reality so constructed on the basis of my psychological theories do actually resemble the reality which is my patients' living in their own worlds. The meaning of each act, including verbalization, does have its private horizon. We are not able to know the patient unless s/he allows us to do so. Refraining from what appeared to me as an arrogant claim of superior knowledge, I came to believe that it was the patient who knew best about him/herself. Whatever understanding we may get out of him/her is always limited by what is allowed by the patient him/herself.

Moving towards such belief I began to doubt the value and necessity of the therapist's techniques and inputs. When I was progressively limiting active inputs which had been calculated to influence the patient in a "therapeutic" manner, I discovered that the patient was able to make progress, examine him/herself within the context of his/her situation without direction, emotional support, guidance, etc. and was able to make significant reconstructions in his/her thinking, emotions, behavior, and relationship with the world. It may appear incredible here but my experience is that the patient can actually change without getting anything from the therapist other than what s/he has given to the therapist in the first place.

Following my patients and watching them change helps me to loosen up my own restrictive notions of health and disease. It also teaches me that there is not only one ideal prototype of well-being, not only one concept of health or cure, nor is there only a few possible sets of insights, be them Psychoanalytic, Gestalt, Rogerian, or whatnot. I am open to lives which are full of colours

and richness. And more important, each person living his/her own life is unique and irreducible to any set of variables prescribed by the psychological theories.

Such discoveries in clinical practice naturally raises difficult theoretical problems for myself. How am I going to account for what were happening in those therapy sessions and whether what I am doing, which quite clearly violates the prescriptions of most established systems of psychotherapy, can still be called psychotherapy. There is also an ethical question of whether my practice is compatible with the socially sanctioned professional status and its associated role. In the attempt to make sense of what I am doing and to answer these questions, it has occurred to me that I really need to build a theoretical foundation for my work. Many options have been considered and many lessons have been learned from different sources ranging from the philosophical reflections of Phenomenological psychology and psychiatry (May, 1959, Boss, 1963, 1979, Straus, 1966, Binswanger, 1968, Giorgi, 1970, Berg, 1972, Koning and Jenner, 1982) to that of Zen Buddhism (Reps, 1957, Fromm, 1960). These not only radically changed my approach to therapy but also my conception of what is a human science.

PSYCHOTHERAPY CONSIDERED

The Grand Presupposition of Psychotherapy

Granted the different interpretations of what the "psyche" in psychology is, the various schools of psychotherapy presuppose that the psyche of the patient can be treated by the therapist (or the psyche of the therapist) through a process called psychotherapy wherein the therapist does something to the patient in order to cure his/her disease. This description is equally applicable to behavior therapy if the word psyche is consistently changed to that of behavior. In such a process of

psychotherapy, the therapist determines what is the disease or problem, what is cure (or the ideal state to be attained), and what is to be done to and by the patient in order to attain that cure or ideal state. It is also necessary to assume that the therapist knows best concerning what the patient's disease or problem is and that the therapist also knows the patient's situation and conditions better than the patient him/herself.

Furthermore, the therapist is believed to know and possess the essential ingredients necessary for therapeutic change (e.g. insight, warmth, empathy, methods of learning appropriate responses, unconditional positive regard, rules of rational thinking, etc.). In order to get well, the patient therefore has to get something from the therapist (e.g. interpretation, empathic understanding, guidance, knowledge, social skills, advice, assignments, etc.) The therapist is always seen as the one who possesses superior knowledge and knows exactly what is wrong while the patient has to acquire the therapist's knowledge, attitude, perspective, or behavior. The usual course of events is that the patient's psyche will come to resemble that of the therapist's.

Psychotherapy and the Ideal Person

In psychotherapy the therapist usually has some idea about what is the ideal state for a person to be in. This ideal is usually prescribed by the theory espoused by the therapist. Some are more conscious of their ideal and provide an explicit theoretical basis for them. Others may be less conscious and less explicit while some simply take the prevalent social or professional view for granted. Having had the experience of moving in and out of different systems and cherishing the respective ideals I realize that though the kind of ideal held by different therapy systems may vary, therapists of these respective systems are consistently insisting on the patient's attainment of such

ideal. Whether it is congruence, insight, rational thinking, adaptive responses, adequate social skill, or simply the absence of symptoms specified in diagnostic manuals, the ideal guides the therapist who in turn guides the patient into this blissful state. At the same time, disease, illness or problem is understood as falling short of such an ideal. Successful therapy shall produce ideal women and men who should be very similar to each other, at least psychologically.

Psychotherapy may therefore be seen as the application of a particular technology in changing the patient into a person prescribed by the therapist's ideal. To what extent is any particular ideal acceptable has of course been the subject of many discussions and the present one will question whether any form of an ideal conception of what the patient has to become should or ought to be presupposed by the therapist.

The Therapist as Technician and the Patient as Object

In pursuit of the ideal "for the benefit of the patient" (in accordance with the view of the therapist), the therapist has a method or a set of techniques to apply to the patient. The patient is expected to respond to such methods in a systematic, lawful, and predictable manner. Though occurrences that violate such expectations are not at all infrequent, they are usually explained as something wrong with the patient such as resistance or lack of motivation, or simply neglected as part of the efficacy statistics.

While each therapist has an armamentarium of techniques and applies them consistently, the rationale behind these techniques is always questionable. Rogers for example, when discussing the necessary and sufficient conditions for therapeutic personality change, criticized the more psychodynamically oriented techniques and proposed his own set of procedures (Rogers, 1957).

These were however considered to be unnecessary by Ellis (1962) who then concluded that perhaps no one single condition is absolutely necessary for therapeutic change (pp. 110-119). The necessary conditions proposed by the different psychotherapies, in other words, do not have a common factor. More recent psychotherapy researches also seem to suggest that different systems of therapy work just as well (e.g. Sloane, Staples, Cristol, Yorkston, and Whipple, 1975, Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, and Parloff, 1989).

In actual clinical practice, however, there is an obsession with techniques. The so-called eclectic practitioners who claim to use whatever method that works would not bother to explain the ground of their choice of particular techniques in particular situations. Neither are these practitioners having a clearly defined concept of "work" though many of them are actually referring to symptomatic improvement. Students of psychotherapy are showing more interest in techniques as practised than in their rationale. And there are psychotherapists who blatantly claim that they are atheoretical (e.g. Bandler and Grinder 1979) and are only interested in "how things work". As a technician it is only natural that one is only interested in how things work and not in how people live while one would not be too upset if the underlying process is not understood. Here the patient is to the therapist a thing to be done or a task to be accomplished. The process is not in any essential way different from that of a technician fixing some machinery. It is only that our machinery to be fixed is the human psyche which is also considered a part of the natural order to which a language of natural science and the technology derived from it can certainly apply.

FROM PSYCHOTHERAPY TO ANTHROPOTHERAPY

The Anthropos (Whole Person), Not the Psyche (Mind)

The practice of this new kind of therapy starts with the recognition of the patient as a human being, not as a sample case of any particular psychological theory. There is no assumption of treating the patient's mind or any other isolated part of him/her, be it behavior, cognition or emotion. The person whom the patient is experiences him/herself as a unified whole and within the context of a world. It is on this basis where therapy finds its starting point. When the patient comes into the consultation room s/he is experiencing a problem or a dis-ease which has some meaning to him/herself within the context of his/her world. And while the problem is experienced by the patient it is his/her problem no matter how the psychopathologist will attribute the etiology. The individual is *in dividuum* (cannot be divided). It is this individual person within his/her given world that forms the focus of therapy.

Therapy is not a set of technological procedures applied by a technician to an object. The patient is not understood as a conglomerate of systematic, lawful, predictable and controllable facts. His/Her complexity and uniqueness are recognized. The inadequacy of the present human or social science theories in providing a reliable framework for explanation and manipulation of facts comparable to the physical sciences is readily admitted. While some regularity and lawfulness, following the method of the physical sciences, have been observed (if we are willing to accept a certain level of statistical significance) when different parts of the total human phenomenon have been isolated, the total situation is far from being understood. While some important similarities among human beings have been demonstrated, more or less to the satisfaction of the scientists, the

uniqueness of the individual person still strikes us as an all the more obvious fact. Reducing a human person into items under the explanatory nosology of social science always leaves a residual which is nonetheless very significant, at least to the person him/herself. With such recognition, this new form of therapy intends to be a humble attempt to understand the person within the context of his/her world. The therapist always allows the patient to present his/herself within his/her world in his/her own way and in his/her own terms. The therapist is not preoccupied with seeking explanations, finding causes, classification and labelling, s/he listens and watches with the hope to understand. In this way, the therapist practices a science which starts by facing the facts. In order to mark the difference between this form of therapy from the psychotherapies, the term anthopotherapy is coined.

The Process of Anthropotherapy:

Presentation and Re-presentation

Believing that an individual must be understood in his/her own terms, anthropotherapy deals mainly with the patient's own presentation. Here presentation refers to the total phenomenon of the patient within the therapy situation, including how s/he conducts him/herself as well as his/her verbalisations. The patient's presentation usually includes a problem or problems experienced by the patient him/herself. The anthropotherapist does not seek to explain the patient's problem in terms of an objective and foreign theory. It is therefore not necessary for the anthropotherapist to match the patient against his/her own theoretical formulations and predictions. The anthropotherapist is therefore not guided by any principle to obtain certain kind of information

and there is no need for questioning the patient. The patient is allowed maximal freedom in presenting his/her own problem without being guided by the therapist.

When a patient experiencing dis-ease seeks help and presents a problem before a therapist, the problem is first and foremost experienced by the patient him/herself. The problem is made possible by certain structures and processes within the context of the patient's world. If a patient complains of an uncontrollable fear of objects which s/he thinks is irrational, the anthropotherapist will not find the label phobic reaction and the various explanatory theories very useful. What is more important is to look at the problem within its context. There are certain things within the patient's world which make this fear and its repeated occurrence possible. The feared object is experienced by the patient in a unique manner. Two patients having similar uncontrollable fear toward the same object experience it differently. In the therapy situation, they describe it differently, present it in different sequences with other events, and they assign different significance to it. Taking patients as standard and uniform and that they are experiencing similar events in a mechanically uniform manner is just an unfounded assumption. Patients always provide the background against which their problems are portrayed. The therapist's interruptive questioning and guidance only serves to transport the patient's problem into the therapist's world in which the patient's experience is distorted and reconstructed. Facing the problem as a fact means that we look at it as it is constituted within the patient's world. It is within this world that the event is experienced as a problem.

The anthropotherapist therefore watches attentively as the patient presents his/her case. What is described as problematic, what language is used to describe it, what contextual structures

are provided, what significance is assigned, etc. are to be learned from the patient. For example, a male patient may present his problem in the following sequence:

> *This is the first day of going back to work. I feel very uncomfortable. I have a headache, it's the response of my body. (Pause) Well, in relation to sex, my wife is not well and I do not have much interest. I have not tried it for a long time. It's two weeks. I always want to prove that I have no problem sexually. But one success doesn't guarantee the next. (Pause) Something is pressing. It's the first day of work and I want to type my resignation letter and quit.*

It appears that he is having trouble at work, feeling physically uncomfortable and there is also problem with sex. All these might be true. The first important thing for the anthropotherapist is not to decide for the patient which is the problem or what is more important. The anthropotherapist believes that all these are connected, not necessarily in some psychodynamic manner, but that all these are experienced by the patient himself. Instead of evaluating, analyzing and organizing the patient's presentation, the anthropotherapist simply lets the patient go on constructing his own presentation of his situation and tries to understand it through the patient and in his own terms.

Here, some questions may be raised. The first is how does the therapist do that. The second is how will the patient improve if the therapist just lets him/her keep on presenting his/her own situation. There can also be a third related question of what is actually done by the therapist during anthropotherapy and what are the reasons for doing that.

To answer these questions we move on to the description of the anthropotherapeutic process. Anthropotherapy is a process made possible by the coming together of at least two persons constituting a situation, one of them is the therapist and the other the patient. The patient

experiences a problem or dis-ease and wants some change. The therapist, through getting together with the patient, helps to constitute a situation wherein change is made possible. The patient brings his/her problem into the situation by means of *presentation*, usually through a primarily verbal means while the therapist will not bring anything specific into the situation but simply re-presents back to the patient what has happened in the process and this is called *re-presentation*. At first glance, re-presentation may remind some therapists of the notion of reflection while to some others it may be sheer parroting. A closer examination of the anthropotherapeutic process is needed to reveal its essential character.

Let us consider again the above example who is a middle age man who works as a teacher. He has difficulties in his work, his relationship with his wife, and in achieving and maintaining penile erection. During one of the sessions he said, "Last week it was my wife's birthday. I bought her an elegant pen together with a card with a very romantic message. I gave it to her and she didn't say anything." A therapist who is eager to reflect his feelings might say, "Then you must be very disappointed." The anthropotherapist will not assume that the patient must experience disappointment. It is of course quite probable that the patient did experience something which he might also call disappointment but that may not be the most significant dimension of his experience while it is equally likely that he was also experiencing other things. The anthropotherapist therefore would only re-present, "You said that it was your wife's birthday last week. You bought her an elegant pen together with a card with a very romantic message. You gave it to her and she didn't say anything." In this particular case, the patient continued by saying, "I felt very angry." Towards the end of the session, the patient was saying "It was actually very difficult for my wife. If she was passionate I would doubt whether she's genuine but if she was cold and detached, I felt angry."

Here we see that re-presentation is the bringing of material back to the present and let them be experienced by the patient again, allowing but not requiring him/her to examine his/her own presentation of his/her own problem within the contextual totality of the world s/he has constituted for him/herself. The therapist does not introduce a new language or a new vocabulary not used by the patient and does not have a particular point of view, emphasis, interpretation or desired direction. The therapist does not assume superior knowledge in how a patient should feel and respond or assume that a certain psychological process is more important than another (e.g. the "Don't tell me what you think, tell me how you feel" line). The way a patient experiences events in life is not necessarily divisible into feeling and thinking, or emotion and reason. The anthropotherapist recognizes this simple fact and re-presentation as a procedure will allow the patient maximal freedom in constructing the problem experienced within the therapeutic situation. The patient is free to make whatever change or reconstruction s/he wishes, if at all.

Here it should also be shown that re-presentation is not parroting or something that can be more effectively done by talking to a tape recorder and play back to oneself. Re-presentation does not mean that when the patient makes a presentation "A", the therapist re-presents by saying, "You said A." and then the patient says "B" and the therapist re-presents B, and then the patient says "C" and the therapist follows with re-presenting C. Let us consider a simple illustration from a session with a teenage girl:

Pt : I have nothing to tell you today.

Th : You said you have nothing to tell me today. (Long period of silence)

Pt : Why don't you ask me questions?

Th : When you first came in you said that you had nothing to tell me today. After a period of silence you asked why I didn't ask you questions.

Pt : Sometimes, it is difficult to talk about certain things.

Th : Sometimes it is difficult to talk about certain things.

(Pt. went on talking about her experience of incest with her father and uncle.)

In this very short excerpt we can see that re-presentation, apart from including the patient's presentation, also puts the patients' presentation in the context of the overall therapeutic situation which is constituted of the therapist and the patient. The therapist's previous representation, the silence jointly produced by both therapist and patient and the temporal sequence of events can all be part of a re-presentation. The patient can see for him/herself in this common world shared with the therapist how the experienced problem is presented and the contextual structures which make the constitution of his/her problem possible.

Anthropotherapy as Re-constitution of the Patient's World

The anthropotherapeutic interaction of presentation and re-presentation can be seen as a hermeneutical process through which the patient makes sense of events in his/her world. His presentations in the therapy session may be regarded as the text while his/her overall life-world will be the ultimate context. It should however be noted that the therapeutic situation itself also constitutes another context against which the text is to be read. The therapeutic situation is of course one of the domains of the patient's life-world and it is the one which is jointly constituted with the therapist. It can therefore be said that the patient is bringing his/her life-world into this particular artificially constituted common world called anthropotherapy.

The meaning or significance of any presentation is to be determined by the patient within the context of his/her life-world. The anthropotherapeutic interaction will allow the patient to see the context surrounding and making possible his/her problem. The re-presentation of the therapist allows the patient to focus on how s/he presents him/herself with a problem experienced in his/her life-world. Through examining the structures, processes and relationships that make his/her problem possible the patient is also open to possible alternatives. Change in an experienced problem is always related to changes in he structures, processes and relationships which made it possible in the first place. In anthropotherapy we do not only see the solution of a problem but a re-constitution of the patient's world within which the problem is created, modified or dissolved.

It should be made clear here that constitution and re-constitution as used here are not intended as purely cognitive terms. To constitute a world involves that whole person, perceiving, feeling, thinking and acting. Re-constitution therefore requires different ways of perceiving, feeling, thinking and acting. The anthropotherapist of course does not see these different human activities as exclusive categories, any one of them almost invariably involves the others, actually it involves the whole person. The person cannot be isolated from the behaviours of perceiving, feeling, etc. In anthropotherapy one therefore does not assume any of these processes to be of primary significance but as different acts of the person who constitutes the world. Change in anthropotherapy is not assessed in any unidimensional measure like behavioral assessment, spontaneity in emotional expression, or the attainment of insight, but in the overall change of the person's being-in-the-world.

Re-presentation and the Hermeneutical Process

Here comes the question how does the patient change if the therapist has not put anything into therapy. It should first be observed that the patient is actually always changing, at least in the sense that s/he is constantly being exposed to new experience and learning. Such changing and learning, however, are very often restricted by the existing structures of a person's life-world. Many human actions are so organized within the life-world in terms of unexamined structures which are simply taken for granted. To the extent that such structures are not experienced as problematic they are maintained in day to day living without much attention paid. While it is on the basis of such structures that a person's life, problems included, is constituted, when a problem is experienced it is usually its facticity and immanence instead of its constitutive structures that are attended to.

When one experiences a problem or dis-ease and feels unable to handle it on one's own, one is actually experiencing a certain rigidity of the structure of things. There seems to be little to be done to improve the situation. Going to a professional for help is an act of faith with the hope that by some yet unknown process the professional may lead oneself to a new possibility which may then solve the problem and brings well-being. When a patient presents his/her problem s/he is seeing it as something which is present and fixed. This problem is constituted within a fabric of structures with which the patient builds his/her life-world. These structures make the problem possible. These structures, not the problem, are the taken-for-granted notions concerning life, including how one perceives, thinks, feels, and acts in relation to the world. In anthropotherapy, the therapist's refusal to commit to any of these notions calls the take-for-grantedness of the patient's structures into question.

For instance, a patient says, "I hate my boss because I think that he's being unfair to me." This is taken as it is by the patient. Hating the boss is a fact, a feeling associated with certain ways

thinking and acting. The unfairness of the boss is similarly taken as a fact, perhaps related to memories of particular experiences. The causal relationship (unfairness causes hatred) is also taken for granted. In daily life experience we all do much of the same thing, we are actively constituting own worlds without examining thoroughly how the various parts are put together or how things might be experienced differently. In anthropotherapy, the re-presentation is actually a process through which the patient may examine his/her own structures used to constitute his/her life world within which dis-ease or problem is experienced. Following the above example, the therapist's re-presentation of "You said that you hate your boss because you thought that he was being unfair to you" will allow that patient to examine this particular structure. The therapist does not accept, deny, encourage, approve, pacify, extract either the emotional or cognitive component, but simply re-present it to the patient as one possible way of experiencing things. The patient is afforded the opportunity of examining what has been taken for granted.

The patient however is not required or pressed to do that, s/he can do it in his/her own time in his/her own way and according to his/her pace. The patient can choose when and how to consider alternatives. The patient can also choose where to start the re-construction. The anthropotherapeutic process (not the anthropotherapist) will help the patient to see his/her experience more clearly and make more sense of it.

This exercise can be compared to a hermeneutical process. The patient is presenting a text which s/he may have problem in understanding, or in making sense of. At the point a patient is presenting a certain text, s/he may not be aware of the contextual situation within which s/he is presenting. This context is of course also a product of his/her own construction. For example, a patient may have referred to a person several times during the therapeutic process and talked about

different aspects of that person, and now s/he is referring to that person again. The anthropotherapist's representation may then be a recounting of his/her previous references together with the present one. For example, "Now you said that you didn't want to look like your mother. In previous sessions you mentioned that your mother looked much older than her age and that she appeared to be very weak in character, as if she was very willing to be bullied. The first time you mentioned your mother was that she was very submissive to your father." Hence, the patient (a female) will make more sense out of her current presentation, considering it against the context she herself has previously provided. In the example quoted here, the patient went on to talk about her relationship with her father and how she had taken over the role of her mother ever since childhood.

Here we see that the patient may choose to respond to any particular structure s/he might identify out of the therapist's re-presentation of contextual material. S/He is not restricted or pressed to respond to all or any of them. Actually, if the patient so chooses, s/he can totally neglect (at least superficially) the therapist's re-presentation and move on to something else. The therapist of course may then re-present by saying that, "You just said that you didn't want to look like your mother and then I told you some of the things you had said about your mother in previous sessions. After that you said.........." At this point, the patient still has a wide range of choices as to what s/he would like to go on talking about, if at all. S/He may even respond by asking "Why are you telling me this?" or "Are you suggesting that there is some connection between this and that?" The therapist will, under this kind of situation, usually respond by saying "I told you .... and then you asked ...." There is no answer given, no relationship suggested, no position held, no assertion made, no point of view pushed, the patient is free to proceed.

What can usually be observed in anthropotherapy is that the patient may, in response to the therapist's re-presentation of what s/he have originally presented, actually change the way s/he organizes or structures experiences. New relationship may be seen, new meanings derived, new possibilities considered, and new responses may also be made.

To the anthropotherapist, the patient is actively making sense of his/her own experience through the process of therapy wherein s/he comes to experience his/her own way of constituting the world as one of the many possible ways. Once the patient stops to take his/her own way of world constitution for granted and consider it as an absolute given, s/he is open to infinite possible changes in many ways, on various levels, and to different extent. When the structures are changed the original constitution of the problem cannot be maintained. The whole situation is then experienced differently. When the whole process of constitution loosens up, the patient experiences more choices, among which are various possibilities of improved well-being. At the point where the patient is relatively satisfied with his/her being-in-the-world, therapy may then be terminated at his/her request.

Putting Things Together: Selection and Direction

Given what is stated above, it is quite clear that the anthropotherapist's re-presentation may include a wide range of materials presented by the patient and their relative locations within the overall movement of therapy. It may be of interest to know when and with what combination of content are re-presentations performed. It is quite obvious that after a very short while the therapist's re-presentations must be constituted of materials selected from previous happenings. What rules

then shall govern the therapist's re-presentation? And if there is selection of material will it then push the patient towards any particular direction?

With regard to when re-presentation is performed, it may be described as a natural meshing. Whenever the patient comes to a natural pause it can be the time for re-presentation. This, however, is not followed in a mechanistic manner. Sometimes it is not necessary for the therapist to re-present at all and the patient may just move on. It is nevertheless general practice for the anthropotherapist to concede right of way to the patient and to make a summary re-presentation at the end of a session.

What constitutes the content of a particular re-presentation does vary. The only fixed and fast rule is that it must be primarily material presented by the patient although, as mentioned above, it may include different combinations and sequences of presentation and those of previous therapist re-presentations. Given this, re-presentation may be organized in several possible ways. It can be organized around a person presented by the patient as in the example quoted above. The therapist may recount the patient's previous representations concerning that particular person, be that parent, spouse, sibling, friend, colleague or whatever. Another way to make a re-presentation is the putting together of experiences which are similarly constructed by the patient. For example a patient has just finished presenting an experience described as "one of the most humiliating experiences in my life", the therapist may then re-present by putting together other previously presented experiences also described by the patient as "humiliating experiences".

A third way of re-presentation is the re-presentation of the patient's presentation in relation to the therapist's re-presentation. For example: "You was talking about going to see your father last

week and then I told you that you had said in a previous session that you would never go to see your father again. Then after a short pause you said that you wanted to buy a new T.V. set."

Re-presentation can also be organized around references to particular situations like going to school, attending funerals, giving parties, etc. Actually there can also be other types of re-presentation but the general principle is that material is put together with either neutral structures such as person, time, space, relationship, etc. or structures provided by the patient such as the "one of the most humiliating experiences of my life" mentioned above. Sometimes when patients describe different experiences as "another personal defeat" or "a further proof of my wickedness", the therapist may then relate this with those experiences previously mentioned as "personal defeat" or "a proof of my wickedness". It is also permissible for the therapist to put different occasions of performance of the same act together, such as, "You just said that you had had lunch with your father last Wednesday, the last time you talked about having lunch with father was when you were talking about how your father used to pick on you and criticize you when having meals with you." The point is that material should not be organised for re-presentation according to any theoretical formulation held or specific relation perceived by the therapist that could not be seen as naturally related by the patient.

Granted the above precaution and considering the fact that the patient is always allowed the freedom to respond to re-presentations in whatever way s/he likes while all the therapist may do is keep on re-presenting, there is little possibility for the anthropotherapist to guide his/her patient into any particular direction. Furthermore, anthropotherapists are encouraged to maintain good discipline by regularly reviewing their treatment sessions with their colleagues to monitor any possible playing in of their own pre-occupations.

Anthropotherapy as Help

Here we can see that anthropotherapy is an attempt to widen the patient's range of possibilities. The changes achieved by the patient which leads to a reconstitution of his/her life-world is the result of a process of making sense of one's own experiences and employing new structures. There is no coercion towards conformity with any social, cultural, political, or "therapeutic" ideal. The patient with dis-ease or problem comes on his/her own accord and leaves when well-being is experienced. Structures used by the therapist are not superimposed onto the patient to make him/her an object of explanation or classification. What is more important is that the therapist does not give the patient things that s/he really does not need and let him/her believe that s/he has got well because of the therapist's inputs. The inherent capacity to examine one's own constitution of the life-world and to change is respected and enhanced. The therapist is not a cause of cure. It is only that the therapist together with the patient constitutes a therapeutic situation wherein cure is possible.

Research

To date, anthropotherapy has been developing out of a gradual revision of clinical practice. There has not been systematic research into its validity and effectiveness. Although the initial clinical experience is encouraging, it is necessary for it to be subject to rigorous scrutiny. However it should be noted that conventional research methods which objectify the patients and superimpose a Pythagorian structure onto their worlds are incompatible with the basic premises of anthropotherapy. There are increasing numbers within the human sciences who insist that research

should be humanly as well as scientifically acceptable (e.g. Reason and Rowan 1981). It is hoped that along similar lines future research will help to refine the theory and practice of anthropotherapy.

Acknowledgment

I wish to acknowledge the contribution of Dr. Elsie S. Y. Ho, who worked closely with me in the early 1980s. Anthropotherapy would not be possible without her input, both in terms of conceptualization and refinement of practice skills.

REFERENCES

Bandler, R. and Grinder, J. (1979). *Frogs into princes : Neuro Linguistic Programming*. Moab, Utah: Real People Press.

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

Binswanger, L. (1968). *Being-in-the-world: Selected papers of Ludwig Binswanger* (Transl. by J. Needleman). New York: Harper and Row.

Boss, M. (1963). *Psychoanalysis and daseinanalysis* (Transl. by L.B. Lefebre). New York: Basic Books.

Boss, M. (1979). *Existential foundations of medicine and psychology*. Transl. by S. Conway and A. Cleaves. New York: Jason Aronson.

Elkin, I., Shea, T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.D., Docherty, J.P., Fiester, S.J., and Parloff, M.B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program : General effectiveness of treatments. *Archives of General Psychiatry, 46*, 971-982.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. Secaucus, NJ: Citadel Press.

Fromm, E. (1960). *Psychoanalysis and Zen Buddhism*. London: Unwin.

Giorgi, A. (1970). *Psychology as a human science: A phenomenologically based approach*. New York: Harper and Row.

Koning, A.J.J. De, and Jenner, F.A. (1982). *Phenomenology and psychiatry*. London: Academic Press.

Reason, P. and Rowan, J. (eds.) (1981). *Human inquiry : A sourcebook of new paradigm research*. Chichester: John Wiley & Sons.

Reps, P. (1957). *Zen flesh, Zen bones*. Middlesex : Penguin.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 459-461.

Sloane, R.B., Staples, F.R., Cristol, A.H., Yorkston, N.J., and Whipple, K. (1975). *Psychotherapy versus behavior therapy*. Cambridge, MS: Havard University Press.

Straus, E.W.M. (1966). *Phenomenological psychology : The selected papers of Erwin W. Straus*. New York: Basic Books.