A PHENOMENOLOGICAL APPROACH TO PRACTICAL KNOWLEDGE IN PSYCHOTERAPY

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Many professions involving relational work as an essential component – such as nurses, social workers and psychotherapists – are currently challenged by a growing demand on so-called "evidence-based" methods. In the debate, professional practioners from these fields have repeatedly voiced the complaint that there are crucial aspects of knowledge involved in their professions that do not fit into this paradigm. Their professional abilities, they claim, include a kind of knowledge that might not be "scientific" or "evidence-based", but is still essential to what they do. This article will discuss how this "practical knowledge" can be approached using resourses from Heidegger's phenomenological appropriation of Aristotle.

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Introduction

Psychotherapy is a field where the challenge of evidence-based medicine is presented in its clearest form.. On the one hand, psychotherapists have been closely intertwined with psychiatric and medical institutions. On the other hand, this profession can be seen as focussing on exactly such relational aspects that demand professional abilities that arguably cannot be articulated properly within the paradigm of evidence-based medicine.

In what has been called a "technologization" of psychotherapy[1], the professional knowledge of the psychotherapist has been construed as instrumental problem-solving, supported by scientific theory and tested techniques. As we will see, this view has largely ignored the importance of the phronesis of the individual psychotherapist, as well as the relational and dynamic aspects of the process.

I will begin by giving a rough overview of the situation as it presents itself through the lens of psychotherapy-research. This is a highly contested field, with bitter and not seldom ideological conflicts between proponents of different psychotherapeutic schools. The results from different research-projects are often used polemically. In my view, the heated debate and the clash of incommensurable paradigms is also an indication that psychotherapy is often approached from perspectives that are at odds with the concrete practice.

After this first overview, I will offer some reflections on the relation between phenomenological philosophy and psychotherapy, and give a couple of examples of promising attempts at exploring the professional knowledge of the psychotherapist and investigating psychotherapeutic practice as a phenomenon in its own right.

[1] See Jørgensen (2000: 101), drawing on Frank; Frank (1991).

Psychotherapy-Research and the Paradigm of Evidence-Based Medicine

In 1952, Hans J. Eyseneck published an epoch-making article, claiming that there was no evidence that psychotherapy had a measurable effect at all, compared to spontaneuous healing. This led to what has been called the "first wave" of modern psychotherapy-research, during the late 1950s and in the 1960s, attempting to answer Eyseneck's challenge by focussing on *effect*. This question was considered settled by most of the scientific community some time in the late 1970s or early 1980s: psychotherapy, it was now evident, has a significant effect that exceeds spontaneuous healing[2].

Since then, what has been called a "therapy industry" has developed – that is, a large increase in the number of professional therapists as well as mass-media interest in psychotherapy. Sociologically, this might be described as a double expansion: an expansion of the segments of the population who see psychotherapy as an option; and an expansion of the aspects of life that are experienced as fraught with problems treatable by psychotherapy.

While the question of "generic" effect was thus for quite some time the dominant trend in psychotherapy-research, there has in later decades been a development towards the question just *which* psychotherapies have effects, and which ingredients or specific techniques are to be credited for this effect.

In the beginning of the 1990s, the concept of "evidence-based medicine" was introduced by a group of Canadian researchers. This trend has since rapidly spread in different branches of health care, to an extent that it can today be called "paradigmatic" (Stiwne & Abrandt Dahlgren 2004). Most importantly, there have been established special centres, libraries or databases designed to review and to systematically organize research findings from this perspective (most important is probably the Cochrane Library)[3].

As thousands and thousands of scientific articles on medicine are published worldwide each year, there is indeed a need for instruments that review this information systematically, especially if this information is to function as a base for decision making – for the individual clinician as well as for organizations and funding authorities. When applied to clinical practice, the explicit aim of evidence-based medicine is to make sure that new clinical research-findings are integrated into everyday practice. And many organizations and political institutions in the health-care sector has come to use these databases as a reference-point, to separate treatments with a validated effect from those for which there is weak or no evidence.

An example in point would be the situation for psychotherapists in Sweden during the last few years. In Sweden, health professionals (including psychotherapists) are granted a formal status by the National Board of Health and Welfare (Socialstyrelsen). When it comes to academic training of health professionals, the National Agency for Higher Education (Högskoleverket) review the quality in this field – using the idea of what is "evidence-based" as one of their criteria. In 2007 the Swedish National Agency for Higher Education evaluated 18 institutions which had programmes for the education of psychotherapists. The evaluation resulted in a radical critique that would strip 14 of these 18 institutions of their state legitimacy, in case they did not within the next semester sufficiently reform their educational program. A recurrent theme in the complaints was the failure of the institutions to

[2] The meta-study by Smith; Glass (1977), combining data from hundreds of studies (of different forms of psychotherapy) is often referred to as a turning-point. Later research has largely corroborated their findings, see Lambert (2001).

[3] Internationally, one of the most influential centers is the Cochrane Library (see <www.thecochranelibrary.com>). In the Swedish context, the example would be The Swedish Council for Technology Assessment in Health Care (Statens beredning för medicinsk utvärdering, see <www.sbu.se>).

meet the demands for evidence-based methods. In the winter of 2008–2009, the agency made a follow-up on these suggested reforms, and decided to finally strip 7 of the 18 of their legitimacy – notably both of the two Swedish institutes for the training of psychoanalysts. There is thus in Sweden today no psychoanalytic training that gives academic credits or the right to call the examined students "authorized psychotherapists"[4].

What then, is meant by "evidence" in this case? Although the proponents of evidence-based medicine recognise that scientific evidence may be of different kinds, these kinds are organized in a clear hierarchy of standards. Results from well-designed randomized controlled trials (so called RCTs) are at the top, while qualitative studies are ranked at the very bottom. It seems clear that this hierarchy, as well as many of the basic assumptions of psychotherapy-research has been taken from a paradigm foreign to its practice (Polkinghorne: 1999). Psychotherapy is treated as if it could be examined and assessed in the same way as a medical technology or a pharmaceutical drug[5].

Let us now examine some of the presuppositions for assessing a specific psychotherapeutic technique in a Randomized controlled trial (RCT). The motivating idea here is the *standardization* of treatment, as the proponents of Evidence Based Medicine like to phrase it: it is important to secure that the treatment offered is also the treatment given[6]. The idea is thus that the psychotherapeutic treatment should not be depending on the individual therapist's specific implementation of it.

That which is to be tested is a manualized variable that should be independent of other factors. These are factors relating to the individual therapist, but also factors relating to the clients problems: it is important to test the method's efficiacy in relation to a specific and well-delineated symptom, and to find patient "material" for the study that do not have other symptoms that might be related to the symptom studied.

Ideally for a well-designed RCT of a pharmaceutical substance, it should be a double-blind test in which neither the doctor nor the patient knows whether the active substance is provided or not. This, of course, is not really doable in the case of psychotherapy.

As we will see, the use of the model of evidence-based medicine for an assessment of psychotherapy, and its privileging of the RCT as the research-design as providing the highest form of evidence, has of course not been undisputed within the research-community. We will now turn to a brief overview of the internal debates within the field of psychotherapy-research. The point of this overview is to give a first indication of the possible interface between phenomenological philosophy and psychotherapeutic practice.

The Dodo-bird and the Common Factors-Approach

According to the medical model of psychotherapy, the best form of evidence is given by the RCT-design. This model assumes that the patient and therapist factors can be screened out, so that what is tested is a specific, manualised technique, as the specific ingredient in the therapy that does the job (much like the active substance in a pharmaceutical drug).

[4] These developments are analysed in more detail in a recent book by Jurgen Reeder (2010).

[5] In the US, the critieria for determining whether a treatment is to be classified as a legitimate one are patterned after the Food and Drug Administration's criteria for certifying drugs, and thus treat therapies as analogies of drug treatments. The fact that the Swedish agency that for example have assessed the evidence for different psychotherapeutic methods directed to depression is called "The Swedish Council for *Technology Assessment* in Health Care" (my emphasis), might be taken as an indication of the paradigm used.

[6] Interestingly, manuals were originally developed to control therapist variance in research on psychotherapy, but are now, by the EBM movement, recommended in clinical practice (Ekeland 1999; Parloff 1998).

Critical voices within the field of empirical psychotherapy-research have recently argued – based a meta-analysis of the results in different kinds of effect-oriented research on psychotherapy – that most of the benevolent effects of psychotherapy are due to factors that are unrelated to specific techniques. Indeed, the variation in effect between different individual psychotherapists are greater than the ones between different techniques. Thus it seems that so far, much psychotherapy-research has been looking in the wrong direction.

The proponents of what is called the "common factors"–approach often refer to a paper by Saul Rosenzweig published already 1936 as anticipating its core idea[7]. Rosenzweig in his article suggested that the effectiveness of different therapy approaches might have more to do with their common elements than with the theoretical tenants on which they were based:

> "given a therapist who has an effective personality and who consistently adheres in his treatment to a system of concepts which he has mastered an which is in one significant way or another adapted to the problems of the sick personality, then it is of comparatively little consequence what particular method the therapist uses" (Rosenzweig 1936: 414f).

Asking "Which treatment-technique won?", Rosenzweig found the answer of the Dodo-bird in Lewis Caroll's *Alice's Adventures in Wonderland* to be applicable: "Everybody has won, and all must have prizes!" In the same way, Rosenzweig argues, the effective traits in psychotherapy are not specific to any one tradition. The impact of specific techniques is marginal compared to the common factors. This Dodo bird-verdict has largely been corroborated by recent meta-analysis of the available research results (Lambert & Ogles 2004; Wampold 2001: 72–118)[8].

This insight has thus been an inspiration for what is currently called the *common factor*-approach. This approach has attempted to take leave of the bitter struggle between the individual schools of psychotherapy, and focus on the common factors of the actual practices. What then are these "common factors" that are responsible for most of the treatment-effect in psychotherapy? Wampold (2001: 206) provides a useful brief summary in four dimensions:

a) an emotionally charged confiding relationship with a helping person;
b) a healing setting that involves the client's expectations that the professional helper will assist him or her;
c) a rationale, conceptual scheme, or myth that provides a plausible, although not necessarily true, explanation of the client's symptoms and how the client can overcome his or her demoralization; and
d) a ritual or procedure that requires that active participation of both client and therapist and is based on the rationale underlying the therapy.

This account, while being quite inclusive, does not imply that anything goes. Nor does it imply that we can do without excellence in individual techniques: the individual technique is still important – but now mainly as a component of the healing context. The need for both therapist and client to have faith in the efficacy of the technique used shows that the option of "no technique" is non-existent. It is impossible to form a therapeutic relationship without having *some* "well-conceived" mode of therapeutic practice (Wampold 2001: 217).

The proponents of the common factors-approach basically use this list of four common factors as a starting point to suggest that research in psychotherapy to a greater extent

[7] The Dodo-bird verdict, while largely accepted, is not entirely undisputed, see for example the critical article by Hunsley; Di Giulio (2002).

[8] According to Assay; Lambert (1999) only 10–15% of the variation in treatment effect is related to the specific therapeutic technique. Factors related to the individual patient are said to contribute to 50–55% of the variation, while factors related to the individual therapist and to the relation between therapist and patient with approximately 40%. The exact numbers are of minor importance for the present argument.

should be directed towards exploring these factors, irrespective of specific techniques of treatment[9]. Sometimes this is also coupled with a call for more eclectic and integrative training programs for psychotherapists[10].

Wampold notes that "very little is know about the qualities and actions of therapists who are eminently successful" (2001: 211). Wampold thus argues for less research on clinical trials and on manuals, and more research on the *actual process* of psychotherapy, focusing on the common factors, on relation and on the practice of well-renowned psychotherapists.

In a recent anthology mapping the common factor-trend, Tallman and Bohart argue that the client factor is the most potent factor that explains the Dodo bird-verdict (Hubble *et al.* 1999). The variation in the client's own capacities to take what the different therapies have to offer and use them is more important than just which individual psychotherapeutic technique is applied. In Tallman and Bohart's view, effective therapy primarily provides a safe setting, an extended "workspace" for the client to work through problems and to experiment with potential solutions. A related avenue is to focus on the psychotherapist's ability to create an *alliance* with the client[11].

Wampold (2001) argues that the medical model (or "meta-theory") does not adequately explain the benefits of psychotherapy[12]. He proposes instead what he calls a "contextual model", the context being defined by the common factors listed above. The traits in this "contextual" model indeed seem compatible with the phenomenological perspective that I will be suggesting in this paper: the common-factor orientation in an important way stays close to the practice as such. In an important anthology from the common factor-camp, *The Heart and Soul of Change*, the editors writes that "knowledge of what makes therapy effective is already in the hands of mental health professionals" (1999: 10). This suggests that the practice should be examined in its own right.

A word of caution is however called for: while on the one hand, the common factor-approach is compatible with a non-medical view of the psychotherapeutic process as primarily providing a contextual framework, on the other hand, this approach is still oriented towards an analysis of the effective traits in the process, and thus, tends to fall back into a medical (or "technical") model.

In what follows, we will approach the question of what this rediscovering of one's own practice might mean, and in what way phenomenology can offer a helpful perspective in this respect.

Exploring the Psychotherapist's Professional Knowledge: Phenomenological Approaches

The challenge of evidence-based medicine has led to a crisis in the self-understanding of dynamic psychotherapy. A crisis is something

[9] One of the pioneers of the common factor-approach, Jerome Frank, used these factors to present a genealogy of psychotherapy, historically associating it with magical-religious healing rituals. See Frank; Frank *Persuasion and Healing*, published in three much revised editions, 1961, 1973, 1991.

[10] For an example in the Swedish context, see Larsson (2007). When reflecting on the importance of the common factors, it might be helpful to know something about what is referred to here as "specific techniques". In Hubble *et al.* (1999: 10), the following are given as examples: "the miracle-question in solution-based therapy; the use of the genogram in Bowen-oriented family therapy; hypnosis; systematic desensitization; biofeedback; transference interpretations".

[11] This factor has been shown to be more determining for the outcome than the choice of method, see Walmpold 2001; Roth and Fonagy 2005.

[12] Jorgensen (2000) polemically notes that 40 years of research on the effect of different psychotherapies with few exceptions still have not been able to single out models for psychotherapeutic treatment that are notably more effective than others. Given these meager results, the question should be asked why so much of the resources for research is used on listing which treatments are "evidence-based" – lists that typically focus exactly on the effectiveness of specific techniques.

shattering and painful, and for sure the consequences for many practitioners are cumbersome. Still, I would like to grasp the current situation also as a possibility to rediscover psychotherapeutic practice with an open mind and with some curiosity.

It seems that the medical model in the current guise of "evidence-based" medicine is no longer a viable paradigm for self-understanding. Instead of then looking for another already fixed model for what psychotherapy is, this to me presents itself as an opportunity to explore what is actually taking place in the encounter. And here is where phenomenology might enter.

But how should this be done? I would argue that is important to explore psychotherapeutic practice as close to experience as possible, and not start out from external theoretical models. It would be a mistake to assume that this task would be simple. Finding a way to explore practice in this sense is not an easy task at all – after all there are reasons why this kind of knowledge sometimes is referred to as "tacit".

I would like to offer two examples might give some indications of how the problem of exploring psychotherapeutic practice might be dealt with.

My first example is an international research-project – a collaboration between a number of European psychoanalytic organizations belonging to the IPA (Canestri *et al.* 2006; Tuckett *et al.* 2008). These organizations seemed to share many interests and to use the same conceptuality – but, they asked themselves, do they mean the same thing when using word like "unconscious", "interpretation" or "free association"? During the discussions, a psychoanalyst from one country stated that he often made 20 interpretations or more during a single session. A psychoanalyst from another country replied in astonishment that he perhaps made three or four interpretations in a whole year! This has somethimes been described as the "babelization" of psychoanalysis. The historical reasons for this babelization is of course that after Freud's death, different approaches have developed locally, often keeping Freud's conceptuality, but interpreting it in their own ways. Given this situation of "babelization", the psychoanalysts in the European Federation asked themselves: What do we actually know about the differences between what is called a psychoanalytical process in Paris, in London or in Stockholm?

During the research-project, for 6 years, experienced psychoanalysts from a number of countries met regularly in order to develop a method to describe and compare their own practices as close to experience as possible. The fact that different theoretical traditions used the words in different ways, made it important to find ways of making the presentation as concrete as possible. How does the psychoanalytic work proceed? What interventions are made by the analyst? Is it possible to find a way to get closer to the actual practice, and reconstruct the implicit theories of the analyst from this description, rather than starting off from the analyst's theoretical self-understanding?

Peter Fonagy (2006) has written an interesting article about this project, which has the telling title "The Failure of Practice to Inform Theory". In his own way, Fonagy in this article formulates a classical thesis in the study of practical knowledge: *practice is not applied theory.* In other word: the psychoanalytical clinical practice should be studied in itself, and not be treated as if it was some kind of direct logical consequence of psychoanalytical theory. According to Fonagy, psychoanalytical practice has changed relatively little compared to the quite comprehensive theoretical reformulations and conflicts between different approaches that have been seen during the entire 20th century. Fonagy further notes that different psychoanalysts sometimes refer to the same theoretical framework, but their practice differs widely. And sometimes he has found the opposite: that some psychoanalysts work within quite different theoretical frameworks, while the differences in their clinical work are negligible.

Irrespectively how we evaluate the different strands of Fonagy's argument, it seems clear

that psychoanalytic practice is worth exploring in its own right.

In this project a psychoanalyst would give a presentation of a session of ”normal” work to a small group of experienced analysts. This aim of the presentation was not to ask for supervision. A basic assumption for the whole project was indeed not to evaluate from some pre-conception of what psychoanalysis should be, but to use the following definition: What is psychoanalysis? Psychoanalysis is what experienced psychoanalysts in well established organisations do.

After these presentations the group of analysts would collaborate to categorize the different interventions performed by the analyst, and then reconstruct his implicit theories. This would be collective work for a whole day. Many of the analyst afterwards said that they were surprised when they realized what their own work looked like. One analyst thinking that he was a strict kleinian, for example, through the seminar came to understand that his practice was not at all as kleinian as he assumed. So he could, with the help of the reflecting group, discover his own practice with some sense of surprise. Not necessarily to reform it, to make it more kleinian, but to know something about it, and perhaps experience a new openness when approaching his own work.

A second example of how the problem of exploring psychotherapeutic practice might be dealt with, is closer to my own experience. I have for some time led seminars with psychoanalysts and psychotherapists in training. I have asked them to write about their professional knowledge using a kind of process-writing, asking them to start with describing as close as possible a difficult situation they have handled – or failed to handle – in their clinical work.

We then discuss these texts in small groups, and I encourage them to further reflect on the professional abilities needed in this situation. What kinds of knowledge are involved? What was lacking?

This kind of essayistic writing with a basis in personal clinical experiences has proved itself to be a productive way of gaining access to, articulating and reflecting upon the kind of professional knowledge that is at stake in the intimate clinical relation. This way of tarrying with one's own experience allows for taken-for-granted background knowledge to become more explicit.

Two Forms of Practical Knowledge: ***Technē*** and ***Phronesis***The exploration of the role of practical knowledge in the professions involving relational work as an essential component, is in one sense already an established avenue for research[13]. Philosophically, the most thoroughgoing work has focussed on the medical professions, often starting out from a reflection on Aristotle's notion of practical knowledge as respectively ***techne*** and ***phronesis***[14]. In the field of psychotherapy, I would like to suggest the following, tentative, interpretations:

1) *epistemē* – science, such as neuropsychology or affect-theory for example,
2) *technē* – the psychotherapist's personal vocabulary of specific psychotherapeutic forms of intervention,
3) *phronesis* – the psychotherapist's overall ability to grasp the individual situation in its critical potentiality.

In Aristotle's vocabulary, the two forms of practical knowledge, *technē* and *phronesis*, are linked to two aspects of human conduct, which

[13] For an overview, see Pellegrino; Thomasma (1993; 1997), Svenaeus (2001; 2003) and, more general, Dunne (1997).

[14] In his seminars during the 1920s, Heidegger approaches the question about the activity of philosophy through a reading of Aristotle's presentation of the five dianoetic virtues of the soul in the sixth book of the *Nicomachean Ethics*: techne, phronesis, episteme, sophia and nous. According to Heidegger, these should be understood as different modes through which Dasein discloses the world – but also discloses Dasein itself. Thus Aristotle's classic determination of phronesis as “deliberation on what is advantageous for the good life as a whole”, Heidegger interprets as describing Dasein's activity of self-disclosure. Through phronesis, Dasein discloses itself to itself as its own for-the-sake-of-which and as a being that can be otherwise. This phrase I think should be read with some emphasis on the word “can”, indicating the potentiality of Dasein.

he refers to as respectively *poiesis* ("productive" activity) and *praxis* ("ethical" activity). While poiesis has a clear aim that can be separated from the process as a final "product" or "result", praxis can be said to carry its *telos* within itself in a peculiar way. In lack of an external goal, the success of praxis can thus not be assessed in relation to a separate result, but only through the character of the carrying-through of the action itself. A well performed action (*eupraxia*) is a movement in itself, not something "finished". Poiesis on the other hand is "heterotelic", and its success can be assessed through the work (*ergon*) that has been produced.

According to Aristotle, *phronesis* is a kind of knowing in which we "see ourselves" without objectivating ourselves (1995: 1141b35). In his interpretation of this passage, Heidegger describes this as a kind of vision *in* the concrete situation of existence, a vision in which one's own being is in question[15]. As Heidegger insists, in the realm disclosed by *phronesis*, we cannot experiment with ourselves in the manner that we do in *technē*: we are not capable of being indifferent to ourselves in the same manner (Heidegger 1924–25: 54).

Phronesis involves a peculiarly intimate kind of self-knowledge, but it does not make the self "available" as *technē* makes its object "avaliable". It is not at our disposal, because we are never at a sufficient distance from it to be able to simply apply it.

Technē, on the other hand, can be learned and forgotten. It is held in reserve, and applied to specific tasks when they present themselves. *Phronesis* does not allow for any "time-outs". The individual always finds himself in an acting situation, and he is always obliged to use his ethical knowledge according to the situation.

Our technical skills in one area does not necessarily generalize to other techniques or to other situations. *Phronesis*, on the other hand, spans the full range of our interactions.

In a sense, *phronesis* thus safeguards us from being too much theoretically oriented. It disrupts our tendency to develop technical and theoretical attitudes towards the world. In praxis, the question is thus not about a poietical work on some material, but it is about forming the *how* of action itself. In a condensed passage, Heidegger aligns this understanding of praxis with Aristotle's doctrine of the mean (*mesotes*) as a way of safeguarding potentiality (*dynamis*): "The how is appropriated only to that extent that Man puts himself in a position *to be ready for any moment*; not routine, but holding-himself-free, *dynamis* in the *mesotes*" (1924: 190).

A Phenomenological Approach to Practical Knowledge in Psychotherapy

What, then, is the relation between the practice of psychotherapy and phenomenological philosophy that I am suggesting?

Herbert Spiegelberg (1972), in his pioneering work, charted out the historical contributions of phenomenology to psychology and psychiatry. There, however, the question of practical knowledge is not a topic at all. In later developments, the discussion about the relation between phenomenology and psychotherapy has often focussed on the specific case of psychoanalysis. I suggest a broader perspective, involving dynamic psychotherapy. In addition, the debates around the scientific status of psychoanalysis have often started out from

[15] Hubert Dreyfus's (1991) pragmatist reading of Heidegger has been very influential on the interpretation of Heidegger when discussing practical knowledge. What I propose is something different. As I see it, the pragmatists applaud Heidegger's way of showing that theory (*theoria*, a gaze on the objects as *vorhanden*) has its roots in our practical comportments in the world (understood as *poiesis*, guided by *techne*, disclosing obects as *zuhanden*). What this position fails to acknowledge is that Heidegger is ultimately directed towards a *praxis* that cannot be reduced to *poiesis*. In his analysis of Dasein as being-in-the-world, Zuhandenheit is not the last instance. The fundamental praxis that Heidegger is exploring is a practical comportment that cannot be affirmed of discarded in accordance with its pragmatic efficiency in the way we understand a technical tool.

a set model of science and discussed whether psychoanalysis is scientific or not (for a critical overview see for example Robinson (1993)). Even the discussions in the late 1960s and early 1970s between Habermas and Gadamer (1971), while theoretically rich and interesting, were still curiously distant from psychoanalytic and psychotherapeutic practice.

The philosophical perspective that I am suggesting affirms the turn in psychotherapy-research towards common factors, but is critical to the tendency in this research to stay with in the discussion of efficiency, as it falls back into a medical model of psychotherapy. It shares Wampold's critique of the medical model, and his interest in finding a better articulation of what is already going on in different forms of psychotherapy, rather than attempting to validate a specific technique[16].

As I see it, the project of exploring aspects of practice that are so basic that we tend to disregard them – or represent them starting off from assumptions that are misleading – is what phenomenological philosophy is all about. This would be a first indication of from where an interface should be attempted[17].

Further, I would argue that a phenomenological framework can offer a conceptual articulation of the different kinds of knowledge involved in the psychotherapeutic profession. Phenomenology, in the sense in which I am using the term here, presents scientific knowledge as only one form of specialized knowledge, while offering a pluralist account for different kinds of knowledge. Most importantly, in this framework it would be possible to account for the practical knowledge of the psychotherapist– without therefore denying the importance of science. Exploring psychotherapeutic practice from a phenomenological perspective would allow us to better understand the interplay of *epistemē*, *technē* and *phronesis*, instead of continuing an unfruitfully reductionist epistemological polemic.

[16] Even within the movement for evidence-based medicine, this is a point that – with some restrictions – is acknowledged: the *practice* of evidence-based-medicine crucially involves the clinician's act of integrating the best available evidence with his "individual clinical expertise".

[17] Please note that I am interested in developing a fruitful interface: this does not mean that phenomenology and psychotherapy are the same thing. I am *not* calling for a transformation of all different psychotherapeutic approaches into one form, called "existential" or "phenomenological" or "humanistic". As I see it, the relation of phenomenology to psychotherapy – in its different forms – is to help clarify the nature of the practice, with a special focus on the question of knowledge.

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FENOMENOLOGINĖ PRAKTINIO ŽINOJIMO PSICHOTERAPIJOJE TRAKTUOTĖ

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Daugelis tarpasmeninį santykį numatančių profesijų darbuotojų, pavyzdžiui, slaugės, socialiniai darbuotojai ar psichoterapeutai, dažnai susiduria su didėjančiu „įrodomojo“ metodo reikalavimo iššūkiu. Diskusijose nuolat pasigirsta profesionalių praktikų nusiskundimų, kad jų profesijoje apčiuopiama esminių žinojimo aspektų, kurie neišsitenka minėtoje paradigmoje. Profesiniai gebėjimai, pačių praktikų teigimu, apima tokias žinojimo formas, kurios nevadintinos „mokslinėmis“ ar „įrodymais grįstomis“, tačiau, nepaisant to, išlieka esminės jų praktikoms. Straipsnyje analizuojama, kaip toks „praktinis žinojimas“ gali būti suprastas remiantis Heideggerio atlikta fenomenologine Aristotelio filosofijos refleksija.

Reikšminiai žodžiai: praktinis žinojimas, psichoterapija, fenomenologija.

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