The influence of phenomenological philosophy on psychotherapy has been more evident in theoretical work and case history than in clinical technique, while technique has been a major emphasis for existential and behavioral therapies alike. It may be the special contribution of phenomenologically inspired clinicians to reflect while others merely act, but I believe the alienation of these projects is detrimental to both. My purpose in this paper is to bring a piece of phenomenological reflection somewhat closer to technical issues of psychotherapeutic action. The key to doing so is the investigation of the therapist's consciousness alongside that of the client, in clinical terms, investigation of the countertransference. The technical problem I address is the therapist's response to the suicidal client.

Though Binswanger (1958) has given us a masterful account of a patient's consciousness of death, he is maddeningly silent in it about the consciousness of her therapists which one assumes must have been scrutinized in order to free them to testify to her experience. He explains, "we now leave out as far as possible all judgments on this individual, be they moral, esthetic, social, medical, or in any other way derived from a prior point of view, and most of all our own judgment, in order not to be prejudiced by them, and in order to direct our gaze at the forms of existence in which this particular individuality is in-the-world" (1958, p. 268). But the therapist must of course become conscious of prejudices in order to so bracket them.

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Heidegger's (1962) analysis of care as the being of Dasein and death as the horizon revealing this meaning, offers an approach to the investigation of the therapist's attitude and response to the possible death of the client. I will address this problem with reference to a case as constituted not by the patient alone but by the therapists and the patient in a particular setting.

Case History

Philip was a client in a small residential treatment program serving as an alternative to hospitalization for young adults diagnosed as schizophrenic. The orientation of staff led us to reject medical model assumptions about this disturbance and espouse the importance of empathy for the client's experience. We were expected to follow more than lead the client through his suffering. Thus part of the technique of our therapy was to set aside prejudices, but traditional psychiatric prejudices were more easily set aside than the prejudices of everyday life.

Philip at twenty-six years of age had been in and out of hospitals and treatment programs since the age of nineteen. Despite his very promising youthful years, in his sojourn through the mental health world, he had become an expert at failure. Our orientation toward letting the client be a contrast to previous structured therapies and resulted initially in Philip's choice of a hermit-like existence in his room. Occasionally he spoke or ventured from the room, but in the first few months of his residence, he appeared catatonic much of the time. Staff fed him and attended to his personal hygiene as needed. His initial communications were highly enigmatic and buried in schizophrenic language. But in contrast to his silence, they seemed a venture and the staff welcomed them and responded associatively as best we could. Gradually Philip became more sociable but ambivalently so. He also became aggressive and demanding, for example, choking staff members briefly and ordering them about. Alternately, he retreated at times to his former solitude. He became more conscious of time and calculated days backward and forward to various significant life events including time spent with us.

About six months into his residency and during the Thanksgiving holiday, Philip sank into a withdrawal more deeply than before. After several days our consulting psychiatrist hospitalized him, observing him to be dehydrated and near a state of shock. He had refused food or liquid and developed an infection from keeping his eyes open. In the hospital he received anti-psychotic medications. He recovered physically but appeared aloof and somewhat resentful of our visits. When he returned